

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	0	H	D	B	S	1	2	0	0	-	0	0	0	0	-	0	0	3	4	1	1	1	1	4	5																	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																	
LICENSEE CODE														LICENSE NUMBER										LICENSE TYPE										CAT 58									

0	1	L	6	0	5	0	0	0	3	4	6	7	0	2	1	1	8	3	8	0	3	1	1	8	3	9							
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33							
CCN'T		REPORT SOURCE		DOCKET NUMBER										EVENT DATE										REPORT DATE									

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | (NP-33-83-15) On 2/11/83, Maintenance personnel were removing cage guards from the

0 3 | governor end of the Auxiliary Feedwater Pump Turbines (AFPT). While removing the

0 4 | cage guard from the AFPT 2, the turbine overspeed trip linkage was bumped causing the

0 5 | trip throttle valve to trip and resulted in an AFPT 2 overspeed trip alarm. This

0 6 | placed the unit in the action statement of Technical Specification 3.7.1.2. There

0 7 | was no danger to the public or station personnel. The redundant auxiliary feedwater

0 8 | train was operable.

0	9	C	H	11	A	12	C	13	Z	Z	Z	Z	Z	14	Z	15	Z	16	8	3	21	0	1	1	24	0	3	28	L	30	0	32	Z	9	9	9	26	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE								COMP. SUBCODE		VALVE SUBCODE		LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIA REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.										
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER																						

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause was personnel error. Personnel removing the cage guards were not suffici-

1 1 | ently cautious to prevent tripping the turbine. After determining that the Mainten-

1 2 | ance personnel had accidentally caused the trip, an operator reset the turbine trip

1 3 | at 1437 hours which cleared the overspeed trip alarm. This removed the station from

1 4 | the action statement.

1	5	Z	28	0	9	9	29	NA	30	A	31	Operator observation	32
7	8	9	10	11	12	13	14	15	16	17	18	19	20
FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION					

1	6	Z	33	Z	34	NA	35	NA	36
7	8	9	10	11	12	13	14	15	16
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE			

1	7	0	0	0	37	Z	38	NA	39
7	8	9	10	11	12	13	14	15	16
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			

1	8	0	0	0	40	NA	41
7	8	9	10	11	12	13	14
PERSONNEL INJURIES		NUMBER		DESCRIPTION			

1	9	Z	42	NA	43
7	8	9	10	11	12
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION	

2	0	N	44	NA	45
7	8	9	10	11	12
PUBLICITY ISSUED		DESCRIPTION			

NRC USE ONLY

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-15

DATE OF EVENT: February 11, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Accidental tripping of auxiliary feed pump turbine trip throttle valve

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2744 and Load (Gross MWE) = 922

Description of Occurrence: On February 11, 1983, Maintenance personnel were removing cage guards from the governor end of the auxiliary feed pump turbines under Maintenance Work Order 83-1667. While removing the cage guard from Auxiliary Feed Pump Turbine #2, the turbine overspeed trip linkage was bumped causing the trip throttle valve to trip, and a resulting Auxiliary Feed Pump Turbine #2 overspeed trip annunciator alarm was received at 1435 hours on February 11, 1983. This placed the unit in action item (a) of Technical Specification 3.7.1.2 which requires restoration of the inoperable system within 72 hours or be in Hot Shutdown within the next 12 hours. Both auxiliary feed pump turbines were in the standby condition at the time of this occurrence.

Designation of Apparent Cause of Occurrence: The apparent cause of this occurrence was personnel error. Personnel removing the cage guards were not sufficiently cautious to prevent tripping the turbine.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The redundant auxiliary feedwater train was operable.

Corrective Action: The Control Room dispatched an operator to investigate the Auxiliary Feed Pump Turbine #2 overspeed trip annunciator alarm. He learned from the Maintenance personnel that they had accidentally caused the trip. At 1437 hours on February 11, 1983, the operator reset the turbine overspeed trip and the trip throttle valve trip which cleared the overspeed trip annunciator alarm. This removed the station from action item (a) of Technical Specification 3.7.1.2. The Maintenance Foreman spoke with the Maintenance personnel, stressing the importance of caution while handling bulky items in congested spaces.

Failure Date: There have been no previous similar occurrences.

LER #83-011