

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

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(17) LER/RO REPORT NUMBER [8 3] [21 22]
 ACTION TAKEN [D] (18) FUTURE ACTION [Z] (19)
 EFFECT ON PLANT [Z] (20)
 SHUTDOWN METHOD [Z] (21)
 HOURS [0 0 0 0] (22)
 ATTACHMENT SUBMITTED [Y] (23)
 NPRD-4 FORM SUB [N] (24)
 PRIME COMP. SUPPLIER [N] (25)
 CAUSE DESCRIPTION [F 1 3 0] (26)

2 9 N (44) NA
R 83-137
NAME OF PREPARER Pete Seniuk
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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-72

DATE OF EVENT: September 22, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Low Pressure Injection (LPI)/Decay Heat (DH) Heat Train 2 inoperable due to DH13A not being pinned closed.

Conditions Prior to Occurrence: The unit was in Mode 3, with Power (MWt) = 0 and Load (Gross MWe) = 0.

Description of Occurrence: On September 22, 1983, the unit was in the process of changing from Mode 4 to Mode 3. Prior to entering Mode 3, DH13A, Decay Heat Cooler 1-2 Bypass valve is required to be pinned in its fail safe, closed position to ensure operability of Low Pressure Injection Train 2.

In August of 1982, DH13A was identified to have a sheared keyway per Non-Conformance Report 82-466. At that time, Facility Change Request 82-130 was written to pin DH13A. During the 1983 Refueling Outage, Decay Heat Train 2 was required for service. This required removal of the pin from DH13A.

At 0900 hours on September 22, 1983, maintenance personnel requested permission to pin the stem, secure the handwheel, and remove supply air to the actuator of DH13A. The shift supervisor granted permission. The plant entered Mode 3 at 1250 hours. At 1400 hours, maintenance personnel returned to inform the shift supervisor that the original pin to hold the valve stem closed was sheared and that they were looking for a replacement. Technical Specification 3.5.2, which requires that two independent Emergency Core Cooling System (ECCS) Subsystems be operable in Modes 1, 2 and 3, was violated since DH13A was not pinned in its fail safe, closed position. The action statement requirements were met since the ECCS subsystem, LPI, was returned to operable status within three hours.

Designation of Apparent Cause of Occurrence: Personnel error and procedure deficiencies are the apparent cause of this occurrence.

Due to poor instructions for removal of the pin, the pin was sheared at the beginning of the 1983 Refueling Outage. Some maintenance personnel were aware of the sheared pin but due to other outage requirements the problem was not immediately corrected. On the morning of September 22, 1983, maintenance was informed by operations that DH13A was a mode restraint and was instructed to pin DH13A. The shift supervisor knew that DH13A was being pinned. At approximately 1030 hours the responsible maintenance engineer was informed that DH13A contained a sheared pin. The maintenance engineer did not inform the shift supervisor or operations management of this fact.

Procedure inadequacy was also a contributory cause of this occurrence since the requirement to verify that this valve is secured in the closed position prior to entering Mode 3 is not in the Pre-Startup Checklist or Plant Startup Procedure.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Prior to entering Mode 3, DH13A was verified to be in the closed position using indication lights in the control room. When it was determined that DH13A was not pinned closed, the valve was visually inspected and verified to be in the closed position. In addition, Low Pressure Injection Train 1 was operable throughout this occurrence.

Corrective Action: At 1545 hours on September 22, 1983, a new pin was installed, removing the unit from the action statement. A Temporary Modification was written for PP 1102.01, Pre-Startup Checklist, to ensure that DH13A is pinned prior to entering Mode 3. Facility Change Request 83-075 repaired DH13A during the 1984 Refueling Outage.

1 AD 1844.00, Maintenance Procedure, has been modified to require a Senior Reactor Operator (SRO) level review, independent of the Shift Supervisor, of all maintenance work orders prior to being worked. This is to ensure that a maintenance activity does not create an unintended action statement entry.

Failure Data: There have been no previous similar occurrences.

LER 83-052



June 25, 1985

Log No. K85-928
File: RR 2 (NP-33-83-72)

Docket No. 50-346
License No. NPF-3

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D. C. 20555

Gentlemen:

Enclosed is Revision 1 to Licensee Event Report 83-052. The revisions to the report are indicated by a "1" in the left margin of each page.

Please destroy or mark superseded your previous copy of this report and replace with the enclosed revision.

Yours truly,

Stephen M. Quennoz
Plant Manager
Davis-Besse Nuclear Power Station

SMQ/ljk

Enclosure

cc: Mr. James G. Keppler,
Regional Administrator,
USNRC Region III

Mr. Walt Rogers
DB-1 NRC Resident Inspector

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