NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01	LICENSEE CODE: O H D B S 1 (2)	LICENSE NUMBER: Ø Ø - Ø Ø N P F - Ø 3 (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT (5)

CON'T

01	REPORT SOURCE: L (6)	DOCKET NUMBER: Ø 5 Ø - Ø 3 4 6 (7)	EVENT DATE: Ø 7 Ø 5 7 9 (8)	REPORT DATE: Ø 8 Ø 3 7 9 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 7/5/79 and again on 7/9/79, while conducting surveillance testing on valve MS-106,
03 the Auxiliary Feedwater (AFW) Pump Turbine 1-1 Steam Inlet Valve, it was found that it
04 would not close on a simulated low turbine inlet pressure signal. There was no danger
05 to the health and safety of the public or station personnel. The unit was subcritical
06 and AFW Train 1-2 was operable. (NP-33-79-94)
07
08

09	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	C H (11)	E (12)	A (13)	R E L A Y X (14)	B (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 9	—	Ø 7 7	/	Ø 3	L	—	Ø

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	Z (19)	Z (20)	Z (21)	Ø Ø Ø Ø	Y (23)	Y (24)	A (25)	C 6 4 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of both of these occurrences was component failure. The pins on the control
11 relays were not making proper contact with their socket. Both relays have now been
12 replaced. Both sockets will be replaced to assure proper operation.
13
14

15	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	C (28)	Ø Ø Ø (29)	NA	B (31)	Post maintenance surveillance test

16	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

17	NUMBER	TYPE	DESCRIPTION (39)
	Ø Ø Ø (37)	Z (38)	NA

PERSONNEL INJURIES

18	NUMBER	DESCRIPTION (41)
	Ø Ø Ø (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

19	TYPE	DESCRIPTION
	Z (42)	NA

526 353

7908100406

PUBLICITY

20	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

POOR ORIGINAL

DVR 79-114, 115 NAME OF PREPARER John J. Johnson PHONE: 419-259-5000, Ext. 276

GPO 917-926

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-94

DATE OF EVENT: July 5, 1979 and July 9, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure of MS 106 relays R1 and R3 to energize

Conditions Prior to Occurrence: The unit was in Mode 4 on July 5, and in Mode 3 on July 9, with Power (MWT) = 0, and Load (Gross MWE) = 0.

Description of Occurrence: On July 5, 1979 at 0200 hours while performing Surveillance Test ST 5071.04, "Auxiliary Feedwater System Channel Functional Test", valve MS 106, Auxiliary Feedwater Pump Turbine Steam Inlet Valve 1-1 from Steam Generator 1-1, would not automatically close as designed on a simulated low turbine inlet pressure signal. Since the unit was in Mode 4, the Auxiliary Feedwater System is not required, and no Action Statement was entered. The system was repaired and declared operable at 0145 hours on July 6, 1979. This occurrence is being reported to document a component failure.

A similar failure of MS 106 occurred on July 9, 1979 at 2230 hours while ST 5071.04 was being performed to assure operability after maintenance on a failure of a torque switch which occurred on July 8, 1979 at 1530 hours (Licensee Event Report NP-33-79-85). The unit was in Mode 3 and still in the Action Statement of Technical Specification 3.7.1.2 (as of July 8) which states, "With one Auxiliary Feedwater System inoperable, restore the inoperable system to operable status within 72 hours or be in Hot Shutdown (Mode 4) within the next 12 hours". The system was repaired and declared operable at 0245 hours on July 10, 1979, approximately 36 hours after the Action Statement was entered.

Designation of Apparent Cause of Occurrence: MS 106 was not operating because closing relays R3 and later R1 were not energizing. The relays were initially replaced with new ones but R3 still did not function. The problem was determined to be bad contact between the relay pins and the socket base. It was corrected by bending the pins on R3 out slightly. The second failure on July 9 was corrected by spreading the pins on R1.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. During the first occurrence the unit was in Mode 4 and auxiliary feedwater was not required. During the second occurrence, the unit was subcritical and Auxiliary Feedwater Train 2 was operable.

Corrective Action: The first occurrence was investigated under Maintenance Work Order 79-2441. The R1 and R3 relays were replaced, and the pins on the R3 relay were spread apart to assure good contact. ST 5071.04 was performed on July 6, 1979 to verify operability.

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The second occurrence was investigated under Maintenance Work Order 79-2458. The corrective action for the second occurrence was to spread the pins apart on the R1 relay. ST 5071.04 was performed at 0245 hours on July 10, 1979 to verify operability, removing the unit from the Action Statement. New sockets will be installed on both the R1 and R3 relays to insure proper operation.

Failure Data: There have been other relay failures but none identified to have been caused by poor contact between the pins and the socket base.

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