

LICENSEE EVENT REPORT

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

[0][1] [O][H][D][B][S][I] [2] [][][] - [][][] [N][P][F] - [][][] [3] [3] [4] [1] [1] [1] [1] [1] [4] [5]

CON'T [0][1] REPORT SOURCE [L] [6] [][][] [5] [][][] - [][][] [3] [4] [6] [7] [1] [2] [1] [9] [7] [9] [8] [][][] [1] [1] [5] [8] [][] [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0][2] ITT Grinnell personnel performing calculations for IE Bulletin 79-02 discovered that [0][3] the design of one seismic support on High Pressure Injection Line 1-1 exceeded the [0][4] slenderness design ratio of 200 used by ITT Grinnell. This deficiency is being re- [0][5] ported under T.S. 6.9.1.8.i as an item requiring remedial action to prevent operation [0][6] in a manner less conservative than that assumed in the accident analysis. There was [0][7] no danger to the health and safety of the public or station personnel. The support [0][8] is not required for normal system operation. (NP-33-79-154)

[0][9] SYSTEM CODE [S][F] (11) CAUSE CODE [B] (12) CAUSE SUBCODE [Z] (13) COMPONENT CODE [S][U][P][P][O][R][T] (14) COMP. SUBCODE [B] (15) VALVE SUBCODE [Z] (16)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1][0] The error is not due to a general deficiency in the original design methods used by [1][1] ITT Grinnell but was caused by a failure to correctly evaluate the slenderness ratio [1][2] for the affected support. Modifications to the seismic support were completed by 0800 [1][3] hours on December 23, 1979 under Facility Change Request 79-445.

[1][5] FACILITY STATUS [G] (28) % POWER [][][] (29) OTHER STATUS [NA] (30) METHOD OF DISCOVERY [C] (31) DISCOVERY DESCRIPTION [During analysis for IE Bulletin 79-02] (32)

[1][6] ACTIVITY CONTENT RELEASED OF RELEASE [Z] (33) [Z] (34) [NA] AMOUNT OF ACTIVITY [NA] (35) LOCATION OF RELEASE [NA] (36)

[1][7] PERSONNEL EXPOSURES NUMBER [][][] (37) TYPE [Z] (38) DESCRIPTION [NA] (39)

[1][8] PERSONNEL INJURIES NUMBER [][][] (40) DESCRIPTION [NA] (41)

[1][9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] (42) DESCRIPTION [NA] (43) PUBLICITY [NA] (44)

[2][0] ISSUED [N] (44) DESCRIPTION [NA] (45)

POOR ORIGINAL

1783 359

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-154

DATE OF EVENT: December 19, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Design of seismic support 33-CCB-2-H46 on High Pressure Injection (HPI) Line 1-1 did not meet the slenderness ratio that is required

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

Description of Occurrence: While performing calculations for IE Bulletin 79-02, ITT Grinnell personnel discovered the design of seismic support 33-CCB-2-H46 on HPI Line 1-1 exceeded the slenderness ratio design criteria of 200 used by ITT Grinnell. The analysis was performed assuming the worst case design basis earthquake loading, however, the analysis failed to correctly evaluate the slenderness ratio.

This design deficiency was discovered while the unit was in cold shutdown during a unit outage. This incident is being reported in accordance with Technical Specification 6.9.1.8.i.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was design errors by ITT Grinnell in the initial calculations of the stresses and deflections in this hanger. This design error was discovered while calculating base plate forces and moments for the analysis required by IE Bulletin 79-02. The error is not due to a general deficiency in the original design methods used by ITT Grinnell but was caused by a failure to correctly evaluate the slenderness ratio for the affected support.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. This support is not required for normal system performance but is required only to protect the system from a worst case condition of maximum earthquake loading. HPI String 1-2 was operable if an earthquake had occurred.

Corrective Action: The existing pieces of angle iron were replaced with 3 x 3 x 1/4" and 2 x 2 x 1/4" structural tubing. The affected hanger modifications were completed by 0800 hours on December 23, 1979, prior to the unit returning to operation. Work was performed under Facility Change Request 79-445.

Failure Data: There have been two previously reported similar occurrences, see Licensee Event Reports NP-32-79-08 and NP-32-79-13.

LER #79-133

1783 360