

### 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 | N | P | F | - | 0 | 3 | 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

LICENSEE CODE      LICENSE NUMBER      LICENSE TYPE      CAT 58

CON'T  
0 1 | R | E | P | O | R | T | S | O | U | R | C | E | L | 6 | 0 | 5 | 0 | - | 0 | 3 | 4 | 6 | 7 | 1 | 1 | 1 | 9 | 7 | 9 | 8 | 1 | 2 | 1 | 8 | 7 | 9 | 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

REPORT SOURCE      DOCKET NUMBER      EVENT DATE      REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | At 2030 hours on November 19, 1979 while performing surveillance testing, valve MS106 |

0 3 | failed to open. This placed the unit in the action statement of Technical Specifica- |

0 4 | tion 3.7.1.2 which requires that with one pump inoperable, the inoperable pump be re- |

0 5 | paired within 72 hours or the unit be in hot shutdown within the next 12 hours. There |

0 6 | was no danger to the health and safety of the public or station personnel. Auxiliary |

0 7 | Feed Pump (AFP) 1-2 was operable during the inoperability of AFP 1-1. |

0 8 | (NP-33-79-130) |

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0 9 | SYSTEM CODE: C H (11); CAUSE CODE: B (12); CAUSE SUBCODE: C (13); COMPONENT CODE: V A L V O P (14); COMP. SUBCODE: A (15); VALVE SUBCODE: Z (16);

17 | LER/RO REPORT NUMBER: 7 9; SEQUENTIAL REPORT NO.: 1 1 2; OCCURRENCE CODE: 3; REPORT TYPE: L; REVISION NO.: 0;

ACTION TAKEN: D (18); FUTURE ACTION: G (19); EFFECT ON PLANT: Z (20); SHUTDOWN METHOD: Z (21); HOURS: 0 0 0 0 (22); ATTACHMENT SUBMITTED: Y (23); NRPD-4 FORM SUB.: Y (24); PRIME COMP. SUPPLIER: A (25); COMPONENT MANUFACTURER: L 2 0 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The motor operator torque switches were adjusted and surveillance testing successfully |

1 1 | performed on 11/20/79, removing the unit from the action statement. However, disas- |

1 2 | sembly of the motor operator revealed that the cause was actually the worm gear spacer |

1 3 | was installed upside down. The drive sleeve was machined and the worm gear spacer |

1 4 | was reinstalled correctly. |

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1 5 | FACILITY STATUS: G (28); % POWER: 0 0 0 (29); OTHER STATUS: NA (30); METHOD OF DISCOVERY: B (31); DISCOVERY DESCRIPTION: Surveillance Test ST 5071.01 (32)

1 6 | ACTIVITY CONTENT RELEASED: Z (33); AMOUNT OF ACTIVITY: NA (35); LOCATION OF RELEASE: NA (36)

1 7 | PERSONNEL EXPOSURES NUMBER: 0 0 (37); TYPE: Z (38); DESCRIPTION: NA (39)

1 8 | PERSONNEL INJURIES NUMBER: 0 0 (40); DESCRIPTION: NA (41)

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z (42); DESCRIPTION: NA (43)

2 0 | PUBLICITY ISSUED: N (44); DESCRIPTION: NA (45)

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TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-130

DATE OF EVENT: November 19, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Auxiliary Feed Pump 1-1 inoperable

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

Description of Occurrence: At 2030 hours on November 19, 1979 while performing Surveillance Test ST 5071.01, "Auxiliary Feedwater System Monthly Test", valve main steam (MS) 106 failed to open.

This placed the unit in the action statement of Technical Specification 3.7.1.2 which requires that with one pump inoperable, the inoperable pump be repaired within 72 hours or the unit be in hot shutdown within the next 12 hours. The technical specification requires operability of both Auxiliary Feed Pumps (AFPs) while in Modes 1, 2, and 3.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was initially thought to be the torque switch being set too light. However, after taking the limiter torque apart, it was found that the worm gear spacer was installed upside down causing a mushrooming effect on the drive sleeve. This mushroomed area was dragging on the worm gear causing it to turn harder, requiring more torque. This caused the limiter torque to torque out prior to opening the valve.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Auxiliary Feed Pump 1-2 was operable during the inoperability of AFP 1-1.

Corrective Action: Under Maintenance Work Order (MWO) 79-3546, the torque settings were adjusted. Surveillance Test ST 5071.01 was successfully performed on November 20, 1979, and the AFP 1-1 was declared operable. The unit was then removed from the action statement of Technical Specification 3.7.1.2.

Under MWO 79-3704, which was completed on December 12, 1979, the mushroomed drive sleeve was machined for proper tolerance and the worm gear spacer was reinstalled correctly. Surveillance Test ST 5071.01 will be performed to ensure operability of AFP 1-1 as soon as the plant is in Mode 3.

A modification will be made to maintenance procedure MP 1410.32, "Removal and Repair of Limitorque Valve Controls", to ensure the worm gear spacer on all similar limitorques will be installed correctly.

Failure Data: There has been one other similar occurrence reported under Licensee Event Report NP-33-79-85.