

# LICENSEE EVENT REPORT

 CONTROL BLOCK:                  

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01	0	H	D	B	S	1	1	0	0	-	0	0	N	P	F	-	0	3	3	4	1	1	1	1	4	5
7	8	9	14					15	25						26	30				57		58	59			

01	REPORT SOURCE	L	6	0	5	0	-	0	3	4	6	7	0	2	0	1	8	0	8	0	2	2	8	8	0	9						
7	8	60										66					69				74				75				80			

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 2/1/80 at 1222 hours, a reactor operator noticed that he had lost control room posi-  
 03 tion indication for letdown cooler isolation valve MU2A. A check of the disconnect  
 04 switch breaker showed the switch midpositioned between the normal and local position.  
 05 This meant that the valve could not be actuated from the control room or on a Safety  
 06 Features Actuation level 2 initiation. This placed the unit in the action statement of  
 07 T.S. 3.6.3.1. There was no danger to the health and safety of the public or station  
 08 personnel. The redundant isolation valve MU3 was operable. (NP-33-80-16)

09	SYSTEM CODE	C	G	11	CAUSE CODE	B	12	CAUSE SUBCODE	A	13	COMPONENT CODE	C	K	T	B	R	K	14	COMP SUBCODE	E	15	VALVE SUBCODE	Z	16	17	LER/RD REPORT NUMBER	8	0	21	22	SEQUENTIAL REPORT NO.	0	1	2	24	26	OCCURRENCE CODE	0	3	28	29	REPORT TYPE	L	30	31	REVISION NO	0	32	33	X	12	34	A	10	35	Z	20	36	Z	21	37	0	0	0	39	40	ATTACHMENT SUBMITTED	Y	41	42	Y	24	43	A	25	44	G	0	8	0	47	48	49	50	51	52	53	54	55	56	57	58	59	60
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### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause was design deficiency. Someone apparently brushed up against the disconnect  
 11 switch breaker which is located in a heavily traveled hallway. Operators reported con-  
 12 tractors working above the breaker during this time making for more congestion. The  
 13 switch was immediately repositioned and indication returned to the control room. A  
 14 memo was issued to station personnel. FCK 77-234 Supplement 2 has been completed.

15	FACILITY STATUS	E	28	% POWER	1	0	0	29	OTHER STATUS	NA	30	METHOD OF DISCOVERY	A	31	DISCOVERY DESCRIPTION	operator observation	32	16	ACTIVITY CONTENT	Z	33	AMOUNT OF ACTIVITY	NA	34	LOCATION OF RELEASE	NA	35	36	PERSONNEL EXPOSURES	0	0	0	37	38	DESCRIPTION	NA	39	17	PERSONNEL INJURIES	0	0	0	40	41	DESCRIPTION	NA	42	18	LOSS OF OR DAMAGE TO FACILITY	Z	43	DESCRIPTION	NA	44	19	PUBLICITY ISSUED	N	45	DESCRIPTION	NA	46	20
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TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-80-16

DATE OF EVENT: February 1, 1980

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Disconnect switch for letdown cooler isolation valve MU2A found out of position

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2764, and Load (Gross MWE) = 922.

Description of Occurrence: On February 1, 1980 at 1222 hours, a reactor operator noticed that he had lost control room position indication for MU2A, which also meant that he could not operate it from the control room. An equipment operator was dispatched to the disconnect switch breaker. He found the disconnect switch in the midposition between normal (operable from control room) and the local position. This meant that the valve would not have actuated to its safety position upon a Safety Features Actuation System (SFAS) level 2 initiation. The disconnect switch was immediately returned to the normal remote position. Technical Specification 3.6.3.1 requires this containment isolation valve to be operable with an isolation time of less than 15 seconds while in Modes 1, 2, 3, and 4. Therefore, the unit had temporarily entered the action statement which required the inoperable valve be restored to operable status within four hours or be in at least hot standby within the next 6 hours and in cold shutdown within the following 30 hours.

Designation of Apparent Cause of Occurrence: This occurrence is attributed to design deficiency. This type of switch (GE Type SB-1) with a pistol grip handle is easily bumped out of position and can stick in mid-position. This prevents both remote and local operation and also prevents SFAS actuation of the valve. The new switch (GE Type SB-9) to be installed per Facility Change Request 77-234 Revision A will eliminate the possibility of hanging up between contacts (mid-position). This will always insure SFAS's ability to actuate the valve. Someone apparently bumped into this switch and did not realize it was now out of position. The breaker is located in a heavily traveled hallway on the 585' level outside the #2 mechanical penetration room. Operators reported there had been outside contractors working above the breaker during this time, which made the hallway even more congested. It is possible that someone brushed up against the switch handle while stepping around the scaffolding.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Its redundant isolation valve MU3 was operable.

Corrective Action: On February 1, 1980, at 1226 hours, an equipment operator returned the disconnect switch to its normal remote position. This restored control room indication of the valve position. This removed the unit from the action statement of Technical Specification 3.6.3.1.

A memo has been issued to all station personnel to emphasize the importance of these switches and the need to report to the control room any accidental contact with a breaker or any plant equipment, even if it appears that nothing has been affected.

Facility Change Request 77-234 Supplement 2 has been issued to remove the handles from the switches as a temporary correction until the switches can be replaced. This work has been completed.

Failure Data: Previous equipment inoperabilities due to disconnect switches being out of the local position were reported in Licensee Event Reports NP-33-77-38 and NP-33-77-45.

LER #80-012