(7-77)

LICENSEE EVENT REPORT

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

0 | O H D B S 1 ② | 0 0 - 0 0 M P F - 0 3 ③ | 4 1 1 1 1 ④ | ⑤
LICENSEE CODE 9–14 | LICENSE NUMBER 15–25 | LICENSE TYPE 26–30 | CAT 57–58

CON'T 0 1 | REPORT SOURCE L ⑥ | 0 5 0 - 0 3 4 6 ⑦ | 0 1 2 4 7 8 ⑧ | 0 2 1 5 7 8 ⑨
60 | DOCKET NUMBER 61–68 | EVENT DATE 69–74 | REPORT DATE 75–80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 On 1/24/78, the personnel airlock failed its leak rate test. This placed the unit in
0 3 the Action Statement (A.S.) of Tech Spec 3.6.1.3. The leak was stopped and the unit
0 4 removed from the A.S. within seven hours. On 1/25/78, the escape airlock failed its
0 5 leak rate test, again placing the unit in the A.S. of Tech Spec 3.6.1.3. This leak
0 6 was also stopped, removing the unit from the A.S. within ten hours. In both cases,
0 7 only the exterior door leaked excessively; the interior door maintained containment
0 8 integrity. (NP-33-78-15)

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
S A ⑪	E ⑫	B ⑬	V A L V O P ⑭	X ⑮	Z ⑯

⑰ LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
7 8	—	0 1 2	/	0 3	L	—	0

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	0 0 0 0	Y ㉓	Y ㉔	A ㉕	C 3 1 0 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 The apparent cause of this occurrence is that the shaft seal (teflon packing) loosened
1 1 due to routine use of personnel and escape lock (exit/entry to containment). The
1 2 shaft seals were tightened to prevent excessive leakage. Maintenance is investigat-
1 3 ing the replacement of the seals to prevent recurrence.
1 4

1 5 FACILITY STATUS E ㉘ | % POWER 0 7 5 ㉙ | OTHER STATUS ㉚ NA | METHOD OF DISCOVERY B ㉛ | DISCOVERY DESCRIPTION ㉜ Surveillance Test ST 5061.02

1 6 ACTIVITY RELEASED Z ㉝ | CONTENT OF RELEASE Z ㉞ | AMOUNT OF ACTIVITY ㉟ NA | LOCATION OF RELEASE ㊱ NA

PERSONNEL EXPOSURES
1 7 NUMBER 0 0 0 ㊲ | TYPE Z ㊳ | DESCRIPTION ㊴ NA

PERSONNEL INJURIES
1 8 NUMBER 0 0 0 ㊵ | DESCRIPTION ㊶ NA

LOSS OF OR DAMAGE TO FACILITY ㊸
1 9 TYPE Z ㊷ | DESCRIPTION NA

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PUBLICITY
2 0 ISSUED N ㊹ | DESCRIPTION ㊺ NA | NRC USE ONLY

DVR 78-019 & 020

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TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-15

DATE OF EVENT: January 24 and 25, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Overall air lock leakage rate for personnel and escape lock exceeded Technical Specification limit.

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2079 and Load (MWE) = 700.

Description of Occurrence: At 2200 hours on January 24, 1978, during the performance of Surveillance Test, ST 5061.02, "Volumetric Leakage Test", for the personnel lock, the leakage rate exceeded the allowable leakage rate of Technical Specification 3.6.1.3. This placed the unit in the Action Statement of Technical Specification 3.6.1.3, which requires both containment airlocks operable in Modes 1, 2, 3, and 4. Leakage was detected at the shaft seal on the lower handwheel of the exterior door.

At 1600 hours on January 25, 1978, during the performance of the Volumetric Leakage Test, ST 5061.02, of the escape lock, the leakage rate exceeded the allowable leakage rate of Technical Specification 3.6.1.3, placing the unit in the Action Statement of Technical Specification 3.6.1.3. Leakage was detected at the shaft seal on the lower and upper handwheel of the exterior door.

Designation of Apparent Cause of Occurrence: The apparent cause of this occurrence is the shaft seal (teflon packing) loosened due to routine use of personnel and escape lock (exit/entry to containment).

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. There was no leakage detected on the interior door on both the personnel and escape lock which would have prevented any leakage from containment leaking to an outside area if containment isolation had been needed.

Corrective Action: The shaft seal of the lower exterior door handwheel on the personnel lock was tightened per Maintenance Work Order 78-213 and the Volumetric Leakage Test, ST 5061.02 was successfully completed at 0500 hours on January 25, 1978. This removed the unit from the Action Statement of Technical Specification 3.6.1.3.

The shaft seals on the lower and upper exterior door handwheel on the escape lock were tightened per Maintenance Work Order 78-219 and the Volumetric Leakage

Test was successfully completed at 2200 hours on January 25, 1978. This removed the unit from the Action Statement of Technical Specification 3.6.1.3. For both incidents, the test was completed well within the 24 hour time requirement of the Action Statement. Maintenance is investigating the replacement of the seals to prevent recurrence.

Failure Data: There have been no previously reportable occurrences of excessive personnel hatch leakage.

LER #78-012