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: 0 0 - 0 0 N P F - 0 3 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 - 0 3 4 6 (7) | EVENT DATE: 0 2 0 8 8 0 (8) | REPORT DATE: 0 3 0 6 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 2/8/80 at 0100 hours the pressurizer sample system containment isolation valve
03 RC240B would not close. The station entered action statement (d) of Technical Speci-
04 fication (TS) 3.6.3.1 which required the station to be in hot standby (Mode 3) within
05 the next 6 hours. The station was in Mode 3. On 2/15/80 at 0100 hours RC240B again
06 failed to close. This time the station was in Mode 1. The station entered action
07 statement (b) of T.S. 3.6.3.1 which required the penetration be isolated in 4 hours.
08 There was no danger. The redundant isolation valve RC240A was operable. (NP-33-80-18)

09 | SYSTEM CODE: C J (11) | CAUSE CODE: D (12) | CAUSE SUBCODE: Z (13) | COMPONENT CODE: C K T B R K (14) | COMP. SUBCODE: B (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 8 0 | — | SEQUENTIAL REPORT NO.: 0 1 4 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of the first incident was an improper torque switch setting. Under Mainten-
11 ance Work Order 80-1537 on 2/8/80 the settings were readjusted. The valve was declared
12 operable at 1920 hours. The second incident was caused by a stripped screw on the
13 closing contactor. Under MWO 80-1579 the failed torque switch was replaced. The new
14 switch was declared operable by the successful completion of ST 5064.01 on 2/16/80.

15 | FACILITY STATUS: C (28) | % POWER: 0 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): operator observation

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

PERSONNEL EXPOSURES
17 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
18 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

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

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

DVR 80-027 & 80-033 NAME OF PREPARER James P. Rudolph PHONE: 419-259-5000 Ext. 253

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-80-18

DATE OF EVENT: February 8, 1980

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Pressurizer Sample System Containment Isolation Valve RC240B would not close

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

Description of Occurrence: While trying to terminate pressurizer sample flow at 0100 hours on February 8, 1980, operations personnel found that RC240B would not go closed.

This failure put the station in the action statement "d" of Technical Specification 3.6.3.1. This technical specification requires this containment isolation valve to be operable with an isolation time of 30 seconds in Modes 1 through 4. This action statement required the station to be in at least hot standby within the next six hours and in cold shutdown within the following thirty hours.

At 0100 hours on February 15, 1980, RC240B again failed to close. At this time, the unit was in Mode 1 with a gross output of 916 MWe. The station entered the action statement "b" of Technical Specification 3.6.3.1 which required the affected penetration be isolated within four hours by use of at least one deactivated automatic valve secured in the isolation position.

Designation of Apparent Cause of Occurrence: The first occurrence can be attributed to insufficient information on Maintenance Work Orders (MWOs) that concern the troubleshooting and/or repair of Limitorque operators. They did not specify the correct torque switch setting, and it does not require reporting the as found and as left settings. The valve was torquing out due to the torque switch settings in the Limitorque operator. The limits were set at 1.25 for closing and 3.0 for opening. The recommended setpoint for this valve is 2.0 for both opening and closing. When the failure history of RC240B was researched, no documentation could be found that called for the improper setting of the torque switch.

When the valve failed a second time, investigation found that the torque switch was also faulty. A stripped screw on the closing contactor circuit was causing the closing circuit to break before the valve actually torqued out.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The redundant isolation valve (RC240A) was operable had containment isolation been required.

Corrective Action: Under Maintenance Work Order 80-1537 on February 8, 1980, the open and close torque switch settings were set to the recommended value of 2.0, and the valve was stroked several times. The valve was successfully retested per ST 5064.01, "Containment Isolation Valves Post Maintenance Test" and declared operable at 1920 hours on February 8, 1980. This removed the station from the action statement of Technical Specification 3.6.3.1.

On the second valve failure, the torque switch was replaced on February 15, 1980 under Maintenance Work Order 80-1579. The open and close torque switch settings were set at 2.0 and the valve was cycled several times. The valve was again retested per ST 5064.01 and declared operable at 0840 hours on February 16, 1980 which removed the station from the action statement of Technical Specification 3.6.3.1.

As a corrective measure for improper torque switch settings, the open and close setpoints will be stated on any maintenance work order issued that concerns the troubleshooting and/or repair of Limitorque operators. Presently, deviation from the recommended torque switch settings is not allowed without prior Power Engineering approval.

Failure Data: There have been previous failures due to settings which had to be increased within limits to make the valve operable, see Licensee Event Reports NP-33-79-104, NP-33-79-85, NP-33-79-45 and NP-33-78-33.

There have been previous failures due to failed torque switches which were replaced, see Licensee Event Reports NP-33-79-33 and NP-33-77-83.

LER #80-014