

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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CONT

0	1	L	6	0	5	0	0	0	3	4	6	7	1	1	1	2	7	9	8	0	4	1	3	8	1	9
7	8	60	61	DOCKET NUMBER						68	69	EVENT DATE				74	75	REPORT DATE						80		

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[illegible]

SYSTEM CODE S F (11)		CAUSE CODE C (12)		CAUSE SUBCODE B (13)		COMPONENT CODE C K T B R K (14)				COMP. SUBCODE A (15)		VALVE SUBCODE Z (16)	
LER/RO REPORT NUMBER 7 9 (17)		EVENT YEAR 7 9 (21 22)		SEQUENTIAL REPORT NO. 1 1 0 (24 25 26)		OCCURRENCE CODE 0 3 (28 29)		REPORT TYPE X (30)		REVISION NO. 1 (32)			
ACTION TAKEN B (18)		FUTURE ACTION Z (19)		EFFECT ON PLANT Z (20)		SHUTDOWN METHOD Z (21)		HOURS 0 0 0 (22 23 24)		ATTACHMENT SUBMITTED Y (25)		NPRD-4 FORM SUB. Y (26)	
PRIME COMP. SUPPLIER A (27)		COMPONENT MANUFACTURER W 1 2 0 (28 29 30 31)											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 8 9 METHOD OF 80

ACTIVITY	CONTENT	LOCATION OF RELEASE

PERSONNEL EXPOSURES (20)

PERSONNEL INJURIES

7 8 9 11 12
LOSS OF OR DAMAGE TO FACILITY (42)

7 8 9 10 PUBLICITY NRC USE ONLY

7 8 9 10

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-127

DATE OF EVENT: November 12, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: High Pressure Injection Pump 1-1 failed to start during special testing

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

Description of Occurrence: On November 12, 1979 while testing High Pressure Injection (HPI) Pump 1-1 after a modification for surge suppression in the cubicle, HPI Pump 1-1 failed to start. Maintenance personnel stopped the test and commenced troubleshooting. This led to the identification of a factory defect in the control circuit wiring. A lead had been improperly stripped prior to the lug being crimped, thus the lug was crimped over the insulation rather than the lug being crimped directly to the conductor.

The unit was in Mode 5, and HPI Pump 1-2 was operable during the period that HPI 1-1 was inoperable.

Designation of Apparent Cause of Occurrence: The cause of the occurrence was due to an improperly terminated lug in the breaker control wiring which caused a bad connection. The lug was crimped to the lead insulation rather than the wire. This was due to improper insulation removal when the cabinet was manufactured. The condition was aggravated by the modification work which caused wires in that area to be moved which caused the discontinuity in that circuit. This modification work was being done for the arc suppression for the breaker control circuits.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. HPI 1-2 was operable during the period that HPI 1-1 was inoperable and capable of supplying water to the core in the event of a safety features actuation.

Corrective Action: Under Maintenance Work Order 79-3522, the lead was properly terminated and reinstalled. The breaker was cycled several times and placed back to the original position and the pump started. Following the work, all testing for the arc suppression was completed, and the unit returned to operability at 1327 hours on November 13, 1979. Wiring within the cabinet was inspected, and no other improperly crimped wires were found.

Failure Data: No previously similar occurrences have been identified or reported.

LER #79-110