NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: [| | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	O H D B S 1 (2)	Ø Ø - Ø Ø N P F - Ø 3 (3)	4 1 1 1 1 (4)	(5)
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT

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0 1	REPORT SOURCE L (6)	Ø 5 Ø - Ø 3 4 6 (7)	1 Ø 2 6 7 8 (8)	1 1 2 2 7 8 (9)
		DOCKET NUMBER	EVENT DATE	REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 After maintenance was completed on 10/13/78, operations personnel stroked FW 612 and
0 3 placed it into service. No isolation time data was taken. On 10/26/78 the Opera-
0 4 tions Shift Foreman, while reviewing completed Maintenance Work Orders, discovered
0 5 that FW 612 operation had not been timed as required. He immedia[illegible] performed the
0 6 required surveillance testing. The unit was sub-critical during this time period.
0 7 When FW 612 was stroked after maintenance, it was capable of isolating within the
0 8 required time. (NP-33-78-124)

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S D (11)	A (12)	A (13)	V A L V E X (14)	E (15)	D (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	1 Ø 6	/	Ø 3	L	—	Ø

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	Z (19)	Z (20)	Z (21)	Ø Ø Ø Ø	Y (23)	N (24)	Z (25)	Z Z Z Z (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this occurrence was personnel error in the failure to complete the re-
1 1 quired testing after maintenance. Operations personnel have been advised to monitor
1 2 repair activities on all containment isolation valves more carefully and to make sure
1 3 they get tested before returning them to service.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	G (28)	Ø Ø Ø (29)	NA	B (31)	Shift Foreman Review

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	Ø Ø Ø (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	Ø Ø Ø (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

7811280202

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

DVR 78-160 NAME OF PREPARER David H. Brown PHONE 419-259-5000, Ext. 274

TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-124

DATE OF EVENT: October 26, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Main Feedwater Isolation Valve operation was not timed after maintenance.

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

Description of Occurrence: While the unit was in Mode 5 on October 13, 1978, Main Feedwater Isolation Valve FW 612 was repacked per Maintenance Work Order (MWO) 78-1879. After maintenance on the valve was completed, operations personnel stroked FW 612 and placed it into service. No isolation time data was taken. This made FW 612 "inoperable" according to Surveillance Requirement 4.6.3.1.1 which states that Containment Isolation Valves must be demonstrated operable prior to returning them to service after maintenance is performed on them by performing a cycling test and verifying their isolation times.

The unit entered Mode 4 on October 25, 1978 at 1200 hours. It re-entered Mode 5 at 1406 hours on the same day. The unit re-entered Modes 4 and 3 at 1556 hours and 1830 hours respectively on October 25, 1978.

On October 26, 1978, at 0300 hours, the Operations Shift Foreman, while reviewing completed Maintenance Work Orders, discovered that FW 612 operation had not been timed as required. He immediately performed "Containment Isolation Valve Post-Maintenance Test", ST 5064.01, on the valve to determine its isolation time. FW 612 met the acceptance criteria of Surveillance Test ST 5064.01 and was declared operable on October 26, 1978 at 0340 hours.

Each time the unit entered Mode 4, the "inoperability" of FW 612 placed the unit in the Action Statement of Technical Specification 3.6.3, which states that all Containment Isolation Valves specified in Table 3.6-2 shall be operable with isolation times as shown in Table 3.6-2.

Designation of Apparent Cause of Occurrence: Both incidents were caused by operations personnel error. After maintenance was performed on Main Feedwater Isolation Valve FW 612, it was not tested according to Containment Isolation Valves Post Maintenance Test, ST 5064.01, before entering Mode 4.

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Analysis of Occurrence: There was no danger to the health and safety of the public or unit personnel. The unit was sub-critical during this time period. FW 612 was stroked after maintenance was performed on it and was capable of isolating the #1 feedwater line within the required time.

Corrective Action: At 0300 hours on October 26, 1978, ST 5064.01 was performed on FW 612 to determine its isolation time. The valve met the acceptance criteria of ST 5064.01 and was declared operable on October 26, 1978, at 0340 hours.

Operations personnel have been advised to monitor repair activities on all containment isolation valves more carefully and to make sure they get tested according to ST 5064.01 before placing them back in service.

Failure Data: There have been no previous similar events.

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