

LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (2)	C H D B S 1
	LICENSE NUMBER (3)	Ø Ø - Ø Ø Ø Ø Ø - Ø Ø
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	Ø 5 Ø Ø Ø 3 4 6
	EVENT DATE (8)	Ø 7 Ø 4 8 2
	REPORT DATE (9)	Ø 8 Ø 5 8 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-82-37) On July 4, 1982, Auxiliary Feedpump 1-2 Service Water Supply Line Iso-
0 3 lation Valve, SW6, was found out of its required position. The valve was found dur-
0 4 ing the performance of PT 5186.01. This occurrence is a violation of AD 1839.02,
0 5 "Operation and Control of Locked Valves" and is being reported per Tech Spec
0 6 6.9.1.9.c. There was no danger to the health and safety of the public or to station
0 7 personnel. The Auxiliary Feedwater System was not required for safe operation of the
0 8 plant during this occurrence.

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

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	Ø 3 2	/	Ø 3	L	—	Ø

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
H	G	Z	Z	Ø Ø Ø Ø	Y	N	Z	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause is attibuted to personnel error, however, the responsible person(s) was not
1 1 determined. The operators were counselled as to their responsibilities in performing
1 2 locked valve operations. AD 1839.02 was modified to require a management Davis-Besse
1 3 Tagging Supervisor to personally unlock a valve required to be repositioned and to
1 4 lock it when it is restored.

1 5	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	G	Ø Ø Ø	NA	B	During Performance of PT 5186.01

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE (42)	DESCRIPTION
	Z	NA

PUBLICITY

2 0	ISSUED (44)	DESCRIPTION (45)
	N	NA

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PDR ADOCK 05000346
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NRC USE ONLY

DVR 82-078

NAME OF PREPARER Bill O'Conner

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-37

DATE OF EVENT: July 4, 1982

FACILITY: Davis-Besse Unit #1

IDENTIFICATION OF OCCURRENCE: A locked valve was discovered unlocked and not in its required position.

Conditions Prior to Occurrence: The unit was in Mode 6, with Power (MWT) = 0 and Load (Gross MWE) = 0.

Description of Occurrence: On July 4, 1982, operations personnel discovered that auxiliary feedpump 1-2 service water supply line isolation valve, SW6, a locked open valve, was closed. The valve was found in the wrong position during the performance of PT 5186.01, "Locked Valve Verification Periodic Test." The operators logged the out of position valve, SW6, in the Locked Valve Log until a determination could be made as to the reason for the valve being out of its required open position. The valve was subsequently restored to the "open" position on July 16, 1982 after a thorough investigation of the Tagging Log, Maintenance Work Orders, and Surveillance Test procedures. This occurrence is a violation of AD 1839.02, "Operation and Control of Locked Valves" which states that when required to be in an abnormal position the respective valve be logged in the "Locked Valve Log."

This occurrence is being reported per Technical Specification 6.9.1.9.c which requires 30 day written notification of occurrences in which inadequacies in the implementation of administrative or procedural controls which threaten to cause a reduction of the degree of redundancy provided in reactor protection systems or engineered safety features systems are observed.

Designation of Apparent Cause of Occurrence: The occurrence is attributed to personnel error. A thorough investigation indicates that SW6 had been placed in an abnormal condition (closed), subsequently restored to its normal position (open) locked and independently verified "open" during the performance of the Auxiliary Feedpump 1-2 Overspeed Trip Test, PT 5150.01 on June 24, 1982. Prior to this SW6 had been verified "locked open" on June 10, 1982 during the performance of the monthly Locked Valve Verification Periodic Test, PT 5186.01. The investigation concluded that personnel error was the cause of SW6 being closed but it was undetermined from which person or persons this occurrence originated.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Since the unit was in Mode 6 at the time of the occurrence, the auxiliary feedwater system was not required for safe operation of the plant.

Corrective Action: AD 1839.02 was modified to provide better management control over the authorized use of the locked valve keys. The revised procedure requires that a management Davis-Besse Tagging Supervisor (DBTS) personally

unlock the padlock on the valve required to b repositioned. Also, the DBTS must personally lock the valve in the required p sition when the valve is later restored. As a secondary corrective action the Operations Engineer personally counselled all operators who had possession of a locked valve key during the subject time frame. This discussion stressed the operator's responsibilities in performing locked valve operations and proper logging of these valves.

Failure Data: Previous similar occurrences were reported in NP-33-82-12 (82-010) and NP-33-82-19 (82-017).

LER #82-032