NRC FORM 366 (7-77)

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U. S. NUCLEAR REGULATORY COMMISSION

	CONTROL BLOCK:
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CON'T	REPORT L 6 0 5 0 0 3 4 6 0 0 8 2 7 8 2 8 0 9 2 4 8 2 9 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80
02	EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) [ (NP-33-82-46) On 8/27/82 during a plant startup, the Once Through Steam Generator 1
013	(OTSG) level reached a maximum of 360" on full range instrumentation. The unit
	entered the action statement of Technical Specification 3.4.5. The Technical Specifi-
015	cation limit of 348" was exceeded for approximately 45 minutes. There was no danger
016	to the health and safety of the public or station personnel. No water entered main
	steam lines, and the boron concentration was sufficient to maintain adequate shutdown
0181	margin in the event of a main steam line break.
7 8	9 SYSTEM CAUSE CAUSE COMPONENT CODE COMP. VALVE SUBCODE SUBCODE
09	$ \begin{array}{c c c c c c c c c c c c c c c c c c c $
	17 LER RO REPORT EVENT YEAR Image: Construction of the second sec
	ACTION FUTURE EFFECT SHUTDOWN TAKEN ACTION ON PLANT METHOD X 18 H 19 Z 20 Z 21 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
	CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)   The cause was operator error during a plant shutdown on 8/23/82. Operators began the
10	
1 1	[cooldown at a point in the Plant Shutdown/Cooldown Procedure PP 1102.10 which they fel
1 2	corresponded to the current plant status. Starting from this point did not address
1 3	Checking the OTSG tube sheet drains to ensure all were open. A memo will be sent to
14	operators advising caution when entering procedures at points other than the beginning s to ensure that preprequisites of previous sections are satisfied. FAGULITY STATUS & POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DISCOVERY DESCRIPTION (32)
1 5	C 28 0 0 0 0 0 NA A 31 Operator Observation
, ,	ACTIVITY CONTENT 12 13 44 45 46 LOCATION OF RELEASE 36 LOCATION OF RELEASE 36 12 (33) 2 (34) NA
7	9 PERSONNEL EXPOSURES (2)
1 7	
1	PERSONNEL INJURIES NUMBER DESCRIPTION (1) 1 0 0 0 0 0 0 0 0
7	B 9 11 12 LOSS OF OR DAMAGE TO FACILITY (43) B210050361 B20924
19	] Z @ NA S PDR
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2 0	$\begin{bmatrix} N \\ 44 \end{bmatrix} \begin{bmatrix} N \\ 68 \\ 69 \end{bmatrix} = \begin{bmatrix} 69 \\ 69 \end{bmatrix} = \begin{bmatrix} 68 \\ 69 \end{bmatrix} = \begin{bmatrix} 69 \\ 64 \end{bmatrix} = \begin{bmatrix} 69 \\ 69 \end{bmatrix} = \begin{bmatrix} 69 \\ 64 \end{bmatrix} = \begin{bmatrix} 69 \\ 69 \end{bmatrix} =$

LICENSEE EVENT REPORT

## TOLEDO EDISON COMPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-82-46

## DATE OF EVENT: August 27, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Steam Generator (SG) 1-1 level greater than 348 inches

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

Description of Occurrence: The plant had reached Mode 3 on August 23, 1982. All but one tube sheet drain on each Once Through Steam Generator (OTSG) were closed. Operators proceeded with a plant cooldown per PP 1102.10, Plant Shutdown/Cooldown procedure. Due to the expected short duration of the cooldown, the OTSGs were not placed in wet layup but instead maintained at 97-99% on the operate range with the startup feedpump. During the subsequent heatup on August 27, 1982, the startup feedwater valve SP7B to OTSG 1 was unisolated, and a slight overfeed condition existed due to leakage by the startup valve. At approximately 1140 hours, operators noticed the increasing OTSG level. It was determined that an insufficient number of lower tube sheet drains were open and operators were sent to isolate SP7B and to ensure the OTSG drains were open. Level reached a maximum of 360 inches on full range instrumentation for OTSG 1, placing the unit in Action Statement (b) of Technical Specification 3.4.5. The Technical Specification limit of 348 inches was exceeded for approximately 45 minutes.

Designation of Apparent Cause of Occurrence: Operators began a plant cooldown at a point in the shutdown procedure which they felt corresponded to the current plant status. However, proceeding from this point in the procedure did not address checking the OTSG tube sheet drains to ensure all were open. As a result, during startup several days later, SG level increased due to an insufficient number of drains being open to handle increased feedwater flow from the leaking startup feedwater valve. The primary cause of this occurrence can be attributed to operator error during shutdown. Preceding steps in the shutdown procedure should have been more carefully reviewed to determine what conditions were applicable and to ensure all precedure addresses a normal cooldown from power assuming all previous steps have been properly taken by operators.

<u>Analysis of Occurrence</u>: There was no danger to the health and safety of the public or to station personnel. Operators promptly reduced level to less than 348 inches. No water entered main steam lines, and the boron concentration was sufficient (1732 ppm) to maintain adequate shutdown margin in the event of a main steam line break. The plant was already in Hot Standby at the time of the occurrence as required by Technical Specification 3.4.5, action (b).

## TOLEDO EDISON COMPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-82-46

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<u>Corrective Action</u>: Operators isolated the startup feedwater valve and opened the remaining lower tube sheet drains to reduce SG level to normal. To prevent a recurrence of this situation, procedure modification T-6768 was made to PP 1102.10, Plant Shutdown/Cooldown Procedure to ensure that all OTSG drains will be opened at the point where OTSG levels are maintained manually using startup feedwater control valves. A memo is to be issued advising operators to exercise more caution when entering procedures at any point other than the beginning to ensure a thorough review of all previous steps in the procedure.

Failure Data: A previous occurrence of OTSG level exceeding Technical Specification limits due to a personnel error was reported in Licensee Event Report NP-33-77-72.

LER #82-042