NEC FORM 366 U. S. NUCLEAR REGULATORY COMMISSION 47.77) * LICENSEE EVENT REPORT CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) - 0 0 3 4 0 H D B S 1 (2) Ø Ø 1(4)0 01 Ø ØØ LICENSEE CODE CONT REPORT 0 0 0 3 4 6 7 0 2 0 3 8 0 81 3 0 1 L (6) Ø 51 0 SOUP EVENT DATE DOCKET EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) (NP-33-83-13) At 1430 hours on 2/7/83 during the performance of the Auxiliary Feed-0 2 water System Channel Functional Test, ST 5071.04, isolation valve MS106A failed to 0 3 close electrically. This made Auxiliary Feedwater Train 1 inoperable and the station 0 4 entered the action statement of Technical Specification 3.7.1.2. There was no danger | 0 5 to the health and safety of the public or station personnel. Auxiliary Feedwater 0 6 Train 2 was operable during the time of this occurrence. 0 SYSTEM CAUSE CAUSE COMP VALVE COMPONENT CODE SUBCODE OP E (12 A (15) H (11 X (13) V V (14 (16)OCCURRENCE REPORT REVISION SEQUENTIAL REPORT NO CODE EVENT NO. LER RO 3 REPORT 0 Ø Ø 0 NUMBER COMPONENT ATTACHMENT NPRD-4 PRIME COMP. ACTION FUTURE EFFECT METHOD HOURS (22) FORM SUS SUPPLIER 10 0 N (25) X X Z (20 Z 10 Y Y (24) 12 10 Ø 18) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) This occurrence was apparently caused by this valve, MS106A, torquing out due to a 110 dirty and improperly lubricated valve stem. The valve stem and drive nut were cleaned and lubricated, and the valve cycled electrically. On 2/7/83, ST 5071.04 was performed satisfactorily, removing the unit from the action statement. MS106A and other] similar valves are being added to the Preventative Maintenance System. 1 4 80 METHOD OF FACILITY OTHER STATUS (30) DISCOVERY DESCRIPTION (32) % POWER 0 9 9 (31) Surveillance Test ST 5071.04 E (28) NA B 5 80 ACTIVITY CONTENT LOCATION CE RELEASE (36) OF RELEASE AMOUNT OF ACTIVITY RELEASED Z 33 Z 34 6 NA NA 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER Ø Z (38)NA PERSONNEL INJURIES 80 DESCRIPTION (41) NUMBER Ø Ø Ø (40) NA 80 OSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION Z (42) NA 8303170449 830308 PUBLICITY NRC USE ONLY ADOCK 05000346 DESCRIPTION (45) PDR N (44) NA S PHONE 419-259-5000, Ext. 565 DVR 83-022 Jim Long NAME OF PREPARER __

TOLEDO EDISON COMPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-83-13

DATE OF EVENT: February 7, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure of Auxiliary Feed Pump 1 Steam Isolation Valve MS106A

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2752.5 and Load (Gross MWE) = 916

Description of Occurrence: On February 7, 1983 at 1430 hours during the performance of the Auxiliary Feedwater System Channel Functional Test, ST 5071.04, isolation valve MS106A failed to close electrically, which made Auxiliary Feedwater Train 1 inoperable. This placed the station in the action statement of Technical Specification 3.7.1.2 which requires the inoperable system be restored within 72 hours or be in Hot Shutdown in 12 hours.

Designation of Apparent Cause of Occurrence: The apparent cause of this occurrence was the valve torquing out due to a dirty and improperly lubricated valve stem.

<u>Analysis of Occurrence</u>: There was no danger to the health and safety of the public or station personnel. Auxiliary Feedwater Train 2 was operable during the time of this occurrence.

<u>Corrective Action</u>: Maintenance Work Order 83-1832 was issued to investigate the control scheme. The torque and limit switches were inspected and found to be set correctly. It was observed that the valve stem was dirty and lacked lubrication. The drive nut was caked with hard dirty grease. The valve stem and drive nut were cleaned and lubricated, and the valve cycled electrically. The applicable portions of Surveillance Test ST 5071.04 were performed satisfactorily, and the station was removed from the action statement at 1900 hours on February 7, 1983. Additinal, MWO 83-2172 has been issued to clean and lubricate the other similar valves. These valves are being added to the Preventative Maintenance System.

Failure Data: There have been no previous failures of MS106A reported. However, a similar occurrence involving a different valve was reported in Licensee Event Report NP-33-79-45 (79-041).

LER #83-010