

June 17, 1985

NOTE TO: William J. Dircks
Executive Director for Operations

FROM: C. J. Heltemes, Jr., Director
Office for Analysis and Evaluation
of Operational Data

SUBJECT: STATUS REPORT FROM THE NRC INCIDENT
INVESTIGATION TEAM AT DAVIS BESSE

The following reflects conversation with E. Rossi, NRC Team Leader, as of 6:00pm Sunday, June 16, 1985:

1. As noted in previous reports, activities completed last week included: several meetings with the licensee and the Region; interviews with individuals that were in the control room during the event and other key people (IE Operations Superintendent; two reactor operators on the board; Plant Manager, and Operations Superintendent); discussion with the licensee on the sequence of events; and discussions with the Resident concerning the event and the licensee actions.
2. Also completed last week were discussions with the licensee and the Region involving the "freezing" of plant equipment. The objective of these discussions was to assure that the licensee's plan for troubleshooting the equipment was systematic; that no critical information would be lost; and that traceability would be maintained over the equipment. A critical list of equipment that would be quarantined and covered by these procedures was defined (see attached). The licensee agreed that prior to initiating work on this equipment, the team would meet on the procedure to be implemented and comments would be provided as appropriate. Approval was not requested. The team has worked with the licensee to assure that the first few items of equipment will be worked on in series in order to provide experience with these procedures and assure their adequacy before equipment is worked on in parallel.. There are no "holdpoints" in the procedures. The licensee will document the actions and findings associated with the "troubleshooting" for discussion with the team. All equipment on the equipment freeze list will be retained and be available for further test or evaluation if needed.

3. Another action completed on Saturday was a detailed tour of the plant including inspection of the equipment involved in the event. The tour was recorded via photographs and tape recordings. The tour highlighted to the team the complexity and extent of effort required to complete some actions. Some examples of this included: five actions outside the control room to get the startup feedwater pump returned to service. Four valves (suction, discharge, and two valves for pump cooling had to be repositioned) and fuses had to be installed for the pump motor. One individual performed these actions; however, the five actions involved different places in the plant.
4. It was mentioned that both AFW pumps tripped on overspeed in trying to regain AFW flow; and the two discharge/isolation valves were closed by operator error. It was then discovered that the valves could not be reopened from the control room. This was unexpected and remains under investigation (note that the two valves, 599 and 608, are normally opened and were closed by error).
5. The sequence of events is currently under review by the team. It is not clear, for example, whether the first flow to the steam generators was from the startup feedwater or an AFW pump. Further discussions will be held with the licensee to resolve such uncertain items.
6. Transcripts continue to be taken of all discussions. Discussions, generally, are of two types: (a) general meetings with multiple licensee personnel; and (b) interviews with individual personnel. Arrangements are being made to have the transcripts made available to be read in order that any inaccuracies can be noted and corrected. In the case of individual interviews, opportunity to review the transcripts will be provided only to those individuals who participated in the actual interview. Copies of the transcripts will not be permitted, and the transcripts will not be made public. The current approach, based on ELD comments, is to put all transcripts in the Public Document Room at the time that the transcripts are released to the licensee.
7. The team recognizes there is a concern about the potential generic implications of the Davis Besse event to other plants. However, the team has not identified any generic considerations at this time, and since the reasons for the equipment malfunction and failures are not yet known, the team believes there is no basis or need to issue any specific instructions or information to other licensees via an IE Bulletin or Information Notice.

8. On Friday afternoon, June 14, at 1:30pm, a press conference was held. Participating from the NRC were T. Ippolito, E. Rossi, and R. Newlin. The press conference was attended by 15-20 individuals representing 3 or 4 television networks and members of the press. The conference lasted approximately 40 minutes and was terminated when all questions had been answered. Press activity at this time has seemed to diminish greatly.
9. Future activities of the team are to: (a) finish interviews of non-licensed plant personnel onsite during the event; (b) continue to review and reconcile the sequence of events; and (c) obtain information on the failure modes of quarantined equipment. It is estimated that the interviews will be finished June 18, and that discussions on the sequence of events can be finished perhaps on June 19. The team will then concentrate on information regarding plant equipment and anticipates leaving the site Friday evening, June 21. It may be necessary to return to the site sometime next week in order to obtain the final results of the troubleshooting of the failed equipment.
10. The team learned that INPO may be proceeding with the issuance of a Significant Event Report discussing the Davis Besse event.

(signed)

C. J. Heltemes, Jr., Director
Office for Analysis and Evaluation
of Operational Data

Attachment:
As Stated

cc w/attachment:
H. Denton
J. Taylor
J. Keppler
E. Rossi

6/12/85

EQUIPMENT FREEZE

The following list of items is the licensee's proposal for continued quarantine:

1. MFP's turbine and controls
2. SFRCS and associated instrument channels
3. AuxFeed pump turbines and controls
4. MSIVs including controls - actuating circuits, pneumatic supplies
5. S/U feed valve SP-7A and controls
6. Source range instrument channels
7. Turbine bypass valve SP-13A2 - any other components for which there is found an indication of water hammer damage
8. PORV and controls and actuation system
9. Main steam safety valves
10. AF 599 and 608 valves, actuators, and controls

This item was released by the Fact-Finding Team:

1. SPDS

This item was added by the Fact-Finding Team:

1. SW valve and controls on AFW alternate supply

It is agreed that no work will be done in the proximity of, or on, this equipment.

The licensee agreed to complete a walkdown of the Main Steam System by appropriate personnel to identify any additional damage that may have been caused by water hammer.

The Fact-Finding Team stated that:

- (a) If required for safety, work shall proceed.
- (b) Surveillance requirements of the Technical Specifications should be satisfied.
- (c) The team should be advised of any actions taken in the two areas above.