

(7-77)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

0	1
7	8

REPORT SOURCE

L	6	0	5	0	-	0	3	4	6	7	1	1	0	5	7	9	8	1	2	0	4	7	9	9
60	61	DOCKET NUMBER					68	69	EVENT DATE					74	75	REPORT DATE					80			

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On November 5, 1979, at 1320 hours the unit experienced a loss of essential instru-
0 3 | mentation distribution panel Y2. Being in Mode 5, the unit did not enter the Action
0 4 | Statement of Technical Specification 3.8.2.2, as it only requires three of the 120
0 5 | volt AC essential buses operable in the mode. There was no danger to the health and
0 6 | safety of the public or station personnel. This occurrence is being reported to docu-
0 7 | ment a component failure. (NP-33-79-122)

SYSTEM CODE E B 11		CAUSE CODE E 12		CAUSE SUBCODE A 13		COMPONENT CODE E L E C O N 14				COMP. SUBCODE Z 15		VALVE SUBCODE Z 16					
LER/RO REPORT NUMBER 7 9 8		EVENT YEAR 7 9		SEQUENTIAL REPORT NO. 1 0 7		OCCURRENCE CODE 0 3		REPORT TYPE L		REVISION NO. 1							
ACTION TAKEN A 18		FUTURE ACTION Z 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. Y 24		PRIME COMP. SUPPLIER A 25		COMPONENT MANUFACTURER C 7 8 2 26	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The loss of Y2 was found to be caused by an open resistor in the logic voltage supply

1 1 to the silicon controlled rectifiers (SCRs). The open resistor resulted in short

1 2 circuiting the DC bus due to the firing of the SCRs. The inverter was repaired, and

1 3 on November 8, 1979, the inverter was tested and returned to service.

FACILITY STATUS										% POWER										OTHER STATUS										METHOD OF DISCOVERY										DISCOVERY DESCRIPTION									
G										000										NA										A										Operator observation									
ACTIVITY										CONTENT										AMOUNT OF ACTIVITY										LOCATION OF RELEASE																			
RELEASED										OF RELEASE																																							
Z										NA																																							
PERSONNEL EXPOSURES										DESCRIPTION																																							
NUMBER										TYPE																																							
000										Z																																							
PERSONNEL INJURIES										DESCRIPTION																																							
NUMBER																																																	
000																																																	
LOSS OF OR DAMAGE TO FACILITY										DESCRIPTION																																							
TYPE																																																	
Z										NA																																							
PUBLICITY										DESCRIPTION																																							
ISSUED																																																	
N										NA																																							

1740 507

8001140 997

NRC USE ONLY

PHONE: 419-259-5000, Ext. 294

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-122

DATE OF EVENT: November 5, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Loss of Essential Instrumentation Distribution Panel Y2

Conditions Prior to Occurrence: The unit was in Mode 5, with Power (MWT) = 0, and Load (Gross MWe) = 0.

Description of Occurrence: On November 5, 1979 at 1320 hours, the unit experienced a loss of essential instrumentation distribution panel Y2 caused by a blown fuse on the inverter YV2 output. Being in Mode 5, the unit did not enter the Action Statement of Technical Specification 3.8.2.2 as only three of the 120 volt AC essential buses are required to be operable in this mode. This occurrence is being reported to document a component failure.

1 | Designation of Apparent Cause of Occurrence: The cause of the blown fuse was an open resistor in the logic power supply of inverter YV2. The resistor functioned as a buffer on the input to the inverter logic voltage supply to the silicon controlled rectifiers. When open, the output of the inverter fails low due to uncontrolled firing of the silicon controlled rectifiers. This placed a short across the DC bus which caused fuse F101 to blow causing the loss of the bus.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The unit was shutdown and the three redundant channels were operable while the inverter was inoperable. Essential instrumentation distribution panel Y2 was re-energized from its alternate power source.

1 | Corrective Action: On November 5, 1979 under Maintenance Work Order 79-3487, an investigation was conducted to determine the cause of the blown fuse. When the open resistor was discovered, MWO 79-3504 was written to repair the inverter. On November 8, 1979, the inverter was tested and returned to service.

Failure Data: There have been previous failures of fuses but none due to buffer resistor failure.

1740 308