

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	0	H	D	B	S	1	2	0	0	0	0	0	0	0	0	0	0	0	3	4	1	1	1	1	4		5																																																																						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
		LICENSEE CODE							LICENSE NUMBER												LICENSE TYPE					CAT 58																																																																								

REPORT
SOURCE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-81-10) On 2/5/81 at 0900 hours, the NRC Site Inspector noticed that the High
03 Pressure Injection Pump 1-2 flow indicator FYI-HP3B read 150 gpm even though the pump
04 was not on. Post Accident Monitoring Instrument High Pressure Injection (HPI) Flow
05 1-2 was declared inoperable. The station entered the action statement of Technical
06 Specification 3.3.3.6 which requires a repair within 30 days. There was no danger to
07 the health and safety of the public or station personnel. HPI Trains 1 and 2 were
08 operable during this time.

SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE					
S	F	E	G	I	N	S	T	R	U	C	Z						
9	10	11	12	13	14	15	16	17	18	19	20						
EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.									
8	1	0	1	1	0	3	L	0									
21	22	23	24	25	26	27	28	29	30	31	32						
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
B	Z	Z	Z	Z	0	0	0	0	Y	Y	N	B	0	4	0		
18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the FYI-HP3B indicator failure was a bad current buffer. Under Mainten-

1 1 ance Work Order IC-263-81, the bad current buffer (FT-HP3B) was repaired, recalibrated

1 2 and then reinstalled. HPI Flow 1-2 was returned to operable status on February 6,

1 3 1981, removing the station from the action statement.

1	4											80	
7	8	9											
FACILITY STATUS			% POWER			OTHER STATUS			(30)				
1	5	E	(28)	0	8	7	(29)	NA				44	
7	8	9	10	11	12	13				45	46		
ACTIVITY CONTENT			DISCOVERY DESCRIPTION			(32)						80	
RELEASED OF RELEASE			METHOD OF DISCOVERY			A			NRC On-Site Inspector				
1	6	Z	(33)	Z	(34)	NA				45	46		
AMOUNT OF ACTIVITY			LOCATION OF RELEASE			(36)						80	
			NA										

PERSONNEL EXPOSURES		TYPE		DESCRIPTION
NUMBER				
1	7	0	0	0
		37	Z	38 NA

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	NA

7		8		9		11		12		
LOSS OF OR DAMAGE TO FACILITY (43)										
TYPE		DESCRIPTION								
1	g	1	2	(42)	NA					

7	8	9	10																	80			
				PUBLICITY	(45)																	NRC USE ONLY	
				ISSUED	DESCRIPTION																		
2	0	N	(44)	NA																	68	69	80

419-259-5000, Ext. 230

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-10

DATE OF EVENT: February 5, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: High Pressure Injection (HPI) Flow Indication (FYI-HP3B) read incorrectly due to bad current buffer

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2412 and Load (Gross MWE) = 792.

Description of Occurrence: On February 5, 1981 at 0900 hours, the NRC Site Inspector was looking over control panels and noticed that FYI-HP3B indicated approximately 150 GPM though no HPI pump was on. Post Accident Monitoring Instrument HPI Flow 1-2 was declared inoperable. The station entered the action statement of Technical Specification 3.3.3.6 which requires this post-accident monitoring instrumentation channel to be operable in Modes 1, 2, and 3. The action statement requires the instrumentation be returned to operable status within 30 days or be in hot shutdown within the next 12 hours.

Designation of Apparent Cause of Occurrence: The loss of Train 2 HPI flow indication in the control room was caused by random failure of a current buffer.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. HPI Trains 1 and 2 were still operable during this time.

Corrective Action: Under Maintenance Work Order IC-263-81, the bad current buffer (FT-HP3B) was repaired, calibrated, and installed. FYI-HP3B was declared operable at 0925 hours on February 6, 1981 which removed the station from the action statement.

Failure Data: There have been no previous occurrences.

LER #81-011