

LICENSEE EVENT REPORT

CONTROL BLOCK: 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 99 100

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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REPORT SOURCE L 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 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(NP-33-81-12) On 2/18/81 at 0430 hours, control room normal ventilation dampers tripped shut. No power was available to Chlorine Detector 1 above the control room or to Chlorine Detector #1 in the block house by the chlorine car. The chlorine detection system was declared inoperable, and the station entered the action statement of Technical Specification 3.3.3.7. There was no danger to the health and safety of the public or station personnel. The control room emergency ventilation system (CR EVS) was placed in the recirculating mode within the required one hour.

SYSTEM CODE A A (11) CAUSE CODE X (12) CAUSE SUBCODE Z (13) COMPONENT CODE I N S T R U (14) COMP. SUBCODE E (15) VALVE SUBCODE Z (16)

EVENT YEAR 3 1 (17) SEQUENTIAL REPORT NO. 0 1 3 (18) OCCURRENCE CODE 0 3 (19) REPORT TYPE T (20) REVISION NO. 1 (21)

ACTION TAKEN A (22) FUTURE ACTION Z (23) EFFECT ON PLANT Z (24) SHUTDOWN METHOD Z (25) HOURS 0 0 0 (26) ATTACHMENT SUBMITTED Y (27) NRC-4 FORM SUB. N (28) PRIME COMP. SUPPLIER L (29) COMPONENT MANUFACTURER A 3 8 1 (30)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

The cause of this event was a blown 10 amp fuse in circuit Y111. Due to added heat tracing, the 10 amp fuse was not adequate in this circuit. FCR 77-356 Supplement 7 had been written to install a 15 amp fuse but was not implemented prior to this event. Under MWO 81-1019, the blown fuse was replaced, and the detectors restored to operable status.

FACILITY STATUS E (31) % POWER 1 0 (32) OTHER STATUS NA (33) METHOD OF DISCOVERY operator observation (34)

ACTIVITY CONTENT Z (35) AMOUNT OF ACTIVITY NA (36) LOCATION OF RELEASE NA (37)

PERSONNEL EXPOSURES NUMBER 0 0 (38) TYPE Z (39) DESCRIPTION NA (40)

PERSONNEL INJURIES NUMBER 0 0 (41) DESCRIPTION NA (42)

LOSS OF OP DAMAGE TO FACILITY TYPE Z (43) DESCRIPTION NA (44)

PUBLICITY ISSUED N (45) DESCRIPTION NA (46)

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NRC USE ONLY

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-12

DATE OF EVENT: February 18, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Control Room Ventilation Chlorine Detection System inoperable.

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2772 and Load (Gross MWE) = 920

Description of Occurrence: On February 18, 1981 at 0430 hours the control room ventilation dampers tripped shut. An investigation showed no power available to the Chlorine Detector 1 above the control room or to the Chlorine Detector 1 in the block house. The Chlorine Detection System was declared inoperable. The station entered the Action Statement (a) of Technical Specification 3.3.3.7 which required that within one hour the station initiate and maintain operation of the control room ventilation system in the recirculation mode of operation. The Control Room Emergency Ventilation System was placed in recirculating mode within the one hour required limit.

Designation of Apparent Cause of Occurrence: The cause of this event was a blown 10 amp fuse in the Essential 120 VAC Instrument Distribution Panel "Y1" for circuit Y111. This caused a loss of the #1 Side Chlorine detectors. Prior to this event, Facility Change Request 77-356, Supplement 7 had been written to install a 15 amp fuse in the Circuit Y111 in lieu of the 10 amp fuse. This supplement was written because the 10 amp fuse was not adequate in this circuit due to added heat tracing. However, this supplement was not implemented prior to this event, and consequently the fuse blew due to the increased load in the circuit.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The loss of power to the chlorine detectors caused the normal ventilation damper to close per design. The control room emergency ventilation system was then available to maintain the control room habitat.

Corrective Action: Maintenance electricians replaced the blown fuse the same morning under Maintenance Work Order 81-1019. This restored the chlorine detection system to an operable condition and removed the station from Action Statement (a) of Technical Specification 3.3.3.7. The control room emergency ventilation system was shutdown, and the normal control room ventilation was started at 0525 hours on February 18, 1981.

Facility Change Request 77-356 Supplement 7 has been implemented to install the correct fuse size.

Failure Data: Previous failures of the chlorine detection system were reported in Licensee Event Reports NP-33-77-31 and NP-33-77-108.

LER # 81-013