

LICENSEE EVENT REPORT

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	0	H	D	B	S	I	2			-									3	4	1	1	1	1	1	4			5														
7		8		9			14			15										25										26					30					57			CAT 58	
OWNER		LICENSEE CODE						LICENSE NUMBER															LICENSE TYPE																					

HYPOTHESIS

REPORT SOURCE: 01 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80
DOCKET NUMBER: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20
EVENT DATE: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20
REPORT DATE: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(NP-33-81-78) On 10/26/81 the Station Review Board determined that an event which occurred on 9/19/81 was reportable. On 9/19/81 at 1700 hours while performing surveillance testing, operators discovered that C5762B was de-energized. Radiation monitors RE 5030A,B,C, RE 8446, RE 5327A,B,C, RE 2387, and RE 1412 were declared inoperable, and the station entered the action statement of Technical Specification 3.3.3.1 and 3.3.3.6. There was no danger to the health and safety of the public or station personnel. The redundant channels were operable throughout this occurrence.

0 9		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE	
0	9	B	B	E		A		C	K	T	B	R	K	X	Z
1	2	3	10	11	12	12	13	13	14	15	16	17	18	19	20
LERPRO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.					
17		8 1		0 6 9		0 3		L		0					
21		22		24		26		28		32					
ACTION TAKEN		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER	
A		Z		Z		Z		Y		Z		Z		Z	
18		19		20		21		23		24		25		26	
23		24		25		26		27		28		29		30	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this occurrence was due to a blown power supply fuse in circuit Y103.

1 1 Station electricians replaced the fuse under Maintenance Work Order 81-1019, and the

1 2 applicable portions of ST 5099.05 were successfully completed. At 2030 hours on

1 3 9/19/81 the radiation monitors were declared operable, and the station was removed

1 4 from the action statements.

1 5 E 28 1 0 0 29 NA 30 44
FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32
B B 31 Performance of ST 5099.05 45 46

1 6 Z 33 Z 34 NA 35 44
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE 36
NA 45 46

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

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	2	3	4	5	6

		LOSS OF OR DAMAGE TO FACILITY		(43)
		TYPE	DESCRIPTION	
I	9	Z	NA	

PUBLICITY (45)
ISSUED (44) DESCRIPTION (45)
2 0 N 44 NA

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-78

DATE OF EVENT: September 19, 1981 (determined reportable October 26, 1981)

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Several radiation monitors inoperable due to a blown fuse in circuit Y103

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2765 and Load (Gross MWE) = 910.

Description of Occurrence: On October 26, 1981, the Station Review Board determined that an event documented on September 19, 1981 on Deviation Report 81-135 should have also been reported as a Licensee Event Report. On September 19, 1981 at 1700 hours while performing Surveillance Test ST 5099.04, Shift Channel Check of the Radiation Monitoring System, operators discovered that C57622, Radiation Monitoring System Channel 1 Panel, was de-energized. At that time, radiation monitors RE 5030A,B,C, RE 8446, RE 5327A,B,C, RE 2387, and RE 1412 were declared inoperable. The requirements of the Radiation Monitoring Instrumentation Technical Specification 3.3.3.1 were being met even with the above detectors de-energized. However, the event is reportable because RE 5030A,B,C, must be operable in order to meet the requirements of the Post-Accident Instrumentation Technical Specification 3.3.3.6 which is applicable in Modes 1, 2, and 3.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was due to a blown power supply fuse for circuit Y103.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The redundant channels were operable throughout this occurrence.

Corrective Action: The station electricians replaced the fuse under Maintenance Work Order 81-1019. Applicable portions of Surveillance Test ST 5099.05 were successfully completed.

At 2030 hours on September 19, 1981, radiation monitors RE 5327A,B,C, RE 2387A,B,C, RE 5030A,B,C, RE 8446, and RE 1412 were declared operable and the station was removed from the associated action statements.

Failure Data: No previous occurrences of the loss of power to circuit Y103 and associated equipment due to a blown fuse have been reported.

LER #81-069