

LICENSEE EVENT REPORT

CONTROL BLOCK: 1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 0 H D B S 1 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5

CON'T 01 REPORT SOURCE L 6 0 5 0 0 0 3 4 6 7 0 4 0 9 8 2 8 0 5 0 7 8 2 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 (NP-33-82-24) On April 9, 1982 at 1015 hours the station experienced a loss of 120VAC

03 distribution panel Y2 while in Mode 6. Since Y4 had already been deenergized for rou-

04 tine maintenance, SFAS actuation channel 2 actuated when power was lost to SFAS chan-

05 nel 2, and RPS channel 2 deenergized causing a loss of one channel of Source Range

06 Nuclear Instrumentation. The station entered the action statement of Tech Specs

07 3.8.2.2, 3.3.2.1, and 3.9.2. There was no danger to the health and safety of the pub-

08 lic or to station personnel. The affected safety systems went to their fail safe status.

09 SYSTEM CODE E B 11 CAUSE CODE A 12 CAUSE SUBCODE F 13 COMPONENT CODE C K T B R K 14 COMP. SUBCODE A 15 VALVE SUBCODE Z 16

17 LER/RO REPORT NUMBER 8 2 EVENT YEAR 8 2 SEQUENTIAL REPORT NO. 0 2 0 OCCURRENCE CODE 0 3 REPORT TYPE L REVISION NO. 0

ACTION TAKEN A 18 FUTURE ACTION H 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 ATTACHMENT SUBMITTED Y 23 NRPD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER X 25 COMPONENT MANUFACTURER X 9 9 9 9 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 The loss of Y2 was due to a blown YV2 inverter fuse. The fuse blew when a short to

11 ground occurred during maintenance on the Control Room Emergency Ventilation System.

12 The control power supplied from Y2 to control power panel C6709 was overlooked when

13 the system was tagged out by a contractor personnel. Under MWOs 82-1547 and 82-1595,

14 the fuses were replaced. The responsible person was counseled by the Maintenance Engr.

15 FACILITY STATUS H 28 % POWER 0 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation. 32

16 ACTIVITY CONTENT Z 33 RELEASED OF RELEASE Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36

17 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION NA 39

18 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION NA 41

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43

20 PUBLICITY ISSUED N 44 DESCRIPTION NA 45

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-24

DATE OF EVENT: April 9, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Inadvertant blowing of Inverter YV2 Input Fuse.

Conditions Prior to Occurrence: The unit was in Mode 6, with Power (MWT) = 0 and Load (Gross MWE) = 0.

Description of Occurrence: On April 9, 1982, at 1015 hours, the input fuse to inverter YV2 blew, deenergizing essential 120VAC distribution panel Y2. Due to the fact that essential 120VAC distribution panel Y4 had already been deenergized for routine maintenance per Maintenance Work Order 82-1149, the station entered the action statements of Technical Specifications 3.8.2.2, 3.9.2, and 3.3.2.1. All core alterations and positive reactivity changes were immediately suspended in accordance with the appropriate action statements. Further investigations revealed that the fuse to circuit Y204, Control Room Emergency Ventilation Standby Condensing Unit Panel C6709, was also blown. Circuit Y204 was tagged in the off condition and Y2 was reenergized from alternate supply bus YBR. At that time, 1410 hours, the station was removed from the action statement of T.S. 3.8.2.2. At time 1750, applicable portions of ST 5031.01, Safety Features Actuation System Monthly Test, were successfully completed, and SFAS Channel 2 and RPS Channel 2 were declared operable. At that time, the station was removed from the action statements of T.S. 3.9.2 and 3.3.2.1.

Designation of Apparent Cause of Occurrence: The apparent cause of this occurrence was a personnel error. A contractor performing routine maintenance on the Control Room Emergency Ventilation System 1-2 overlooked the control power supplies from Y2 to the control panel C6709 when tagging out the system for maintenance. Consequently, a short to ground occurred during the removal of a flow switch on the water cooler condenser. This short caused the Y204 and YV2 fuses to blow.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The affected safety systems went to their fail safe status, and the redundant source range NI Channel was operable.

Corrective Action: Inverter YV2 input fuse was replaced per Maintenance Work Order 82-1547. Circuit Y204 was investigated and the fuse replaced per Maintenance Work Order 82-1595. The contractor responsible for this occurrence was counseled by the Maintenance Engineer.

Failure Data: Previous occurrences where a short to ground on a load downstream of the inverter also failed the input inverter fuse were reported NP-33-80-105 (LER 80-081) and NP-33-80-070 (LER 80-056).

LER #82-020