

CONTROL BLOCK:

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 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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

CON'T

REPORT SOURCE: 0 1 2 8

DOCKET NUMBER: L 6 0 5 0 0 0 3 4 6 7 1 1 0 9 8 3 8 1 2 0 8 8 3 9

EVENT DATE: 60 61 68 69 74 75

REPORT DATE: 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-83-87) On 11/9/83 at 2150 hours, 120 VAC Essential Instrumentation Panel Y2

0 3 was deenergized. This placed the unit in the action statement of Technical Specifica-

0 4 tion 3.8.2.1. At 2300 hours on 11/9/83, Y2 was transferred to its alternate power

0 5 supply. There was no danger to the health and safety of the public or station per-

0 6 sonnel. The redundant channels of instrumentation were available during this power

0 7 loss to Channel 2 equipment.

0	8	7	8	9											80								
SYSTEM CODE					CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE					COMP. SUBCODE		VALVE SUBCODE							
E	B	11	E	12	A	13	C	K	T	B	R	K	14	A	15	Z	16						
EVENT YEAR					SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.												
8	3	21	22	—	23	0	6	1	24	26	—	27	0	3	28	29	L	30	—	31	0	32	
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER							
A	18	Z	19	Z	20	Z	21	0	0	0	0	22	Y	23	Y	24	Z	25	Z	9	9	9	26
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47									

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The loss of Y2 was caused by a blown main fuse in its normal power supply inverter

1 1 YV2. A complete check of the inverter per its technical manual recommendation was

1 2 conducted, and all branch circuit fuses were checked. No problems were found. The

1 3 fuse was replaced and Y2 transferred back to its normal power supply at 0210 hours on

1 4 11/10/83.

8 9
FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)
1 5 D (28) 0 0 0 (29) NA A (31) Operator observation
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
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
1 6 Z (33) Z (34) NA NA
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

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	37	Z	38	NA	39

PERSONNEL INJURIES		NUMBER		DESCRIPTION	
1	8	0	0	0	NA

LOSS OF OR DAMAGE TO FACILITY (43)
TYPE DESCRIPTION
1 9 Z (42) NA
7 8 9 10
8312210244 831208
PDR ADOCK 05000346
S PDR

PUBLICITY		ISSUED		DESCRIPTION		NRC USE ONLY											
2	0	N	(44)	NA	TE22												

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-87

DATE OF EVENT: November 9, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Loss of power to 120 VAC Essential Instrumentation Panel 2

Conditions Prior to Occurrence: The unit was in Mode 3, with Power (MWt) = 0 and Load (Gross MWe) = 0.

Description of Occurrence: On November 9, 1983 at 2150 hours, 120 VAC Essential Instrumentation Panel Y2 was deenergized. This placed the unit in the action statement of Technical Specification 3.8.2.1. As a result of the loss of Y2, the following instrumentation was also deenergized: Reactor Protection System (RPS) Channel 2, Steam and Feedwater Rupture Control System (SFRCS) Channel 2, Remote Shutdown Panel Channel 2, Remote Shutdown Panel Channel 2/Loop 2 Instrumentation, High Pressure Injection (HPI) and Decay Heat Removal Channel 2 flow indication, Chlorine Detector AE5358B, Fuel Handling Radiation Monitor RE8447.

Designation of Apparent Cause of Occurrence: The loss of Essential Instrumentation Panel Y2 power was caused by a blown main fuse on its normal power supply inverter YV2.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The redundant channels of instrumentation were available during this power loss to Channel 2 equipment.

Corrective Action: At 2300 hours on November 9, 1983, Y2 was transferred to its alternate power supply. A complete check of the inverter per its technical manual recommendation was conducted, and all branch circuit fuses were checked. No problems could be found.

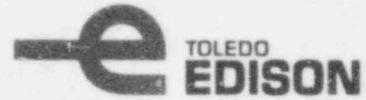
In 1981, Facility Change Request 80-217 was completed to reduce the branch circuit fuses to as low a value as possible. It is believed that the most likely cause of the blown fuse is an intermittent fault on a branch circuit. Fast-acting fuses were used but even with this the manufacturer of the inverter (Cyberex) states that this would not preclude the main fuse from prematurely blowing depending on the point on the voltage curve at the inverter at the instant of a fault.

The blown fuse was replaced, and Y2 transferred back to its normal power supply at 0210 hours on November 10, 1983.

Failure Data: Previous similar occurrences of the loss of a 120 VAC essential instrumentation panel were reported in Licensee Event Reports NP-33-80-74 (80-064) and NP-33-83-14 (83-007).

LER #83-061

Dmb



December 8, 1983

Log No. K83-1666
File: RR2 (NP 33-83-87)

Docket No. 50-346
License No. NPF-3

Mr. James G. Keppler
Regional Administrator, Region III
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

LER No. 83-061
Davis-Besse Nuclear Power Station Unit 1
Date of Occurrence: November 9, 1983

Enclosed are three copies of Licensee Event Report 83-061 which are being submitted in accordance with Technical Specification 6.9 to provide 30 day written notification of the subject occurrence.

Yours truly,

Terry D. Murray

Terry D. Murray
Station Superintendent
Davis-Besse Nuclear Power Station

TDM/ljk

Enclosures

cc: Mr. Richard DeYoung, Director
Office of Inspection and Enforcement
Encl: 30 copies

Mr. Norman Haller, Director
Office of Management and Program Analysis
Encl: 3 copies

Mr. Walt Rogers
NRC Resident Inspector
Encl: 1 copy

DEC 14 1983

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