

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

0	1
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REPORT SOURCE

L	6	0	5	0	0	3	4	6	7	1	1	2	9	8	3	8	1	2	2	9	8	3	9
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60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

(NP-33-83-97) At 2205 hours on 11/29/83, Rod 7-12 dropped to 0% withdrawn for no apparent reason. The asymmetrical condition caused the Integrated Control System to automatically run the reactor back to 60%. The dropped rod also caused the Station to enter the action statement of T.S. 3.1.3.1c. There was no danger to the health and safety of the public or station personnel since the rod failed in the safe position, and the reactor shutdown margin was maintained.

0	8																80
7	8																90
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP. SUBCODE		VALVE SUBCODE			
R	B	E	A	C	R	D	R	V	E	Z	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	3	0	6	8	1	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	
A	Z	Z	Z	0	0	Y	N	Z	9	9	9						
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50

1 0 It was discovered that the motor programmer phase CC fuse had opened maintaining that  
1 1 phase deenergized. When rod movement occurred, the open phase caused the rod to drop.  
1 2 Control Rod 7-12 was transferred to the auxiliary power supply. No overcurrent evi-  
1 3 dence was found after inspection of circuits, fuse, and fuse holder. The fuse was  
1 4 replaced, and the rod successfully latched and withdrawn to group bank position.

8 9  
FACILITY STATUS (E) (28) % POWER (0) (9) (9) (29) NA OTHER STATUS (30) METHOD OF DISCOVERY (A) (31) DISCOVERY DESCRIPTION (32) Operator observation  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
PERSONNEL EXPOSURES NUMBER (0) (0) (0) (37) TYPE (Z) (38) DESCRIPTION (39) NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
PERSONNEL INJURIES NUMBER (0) (0) (0) (40) DESCRIPTION (41) NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
LOSS OF OR DAMAGE TO FACILITY TYPE (Z) (42) DESCRIPTION (43) NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
PUBLICITY ISSUED (N) (44) DESCRIPTION (45) NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
2 0  
NRC USE ONLY IE

8401060494 831229  
PDR ADOCK 05000346  
S PDR

PHONE: \_\_\_\_\_

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-97

DATE OF EVENT: November 29, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Dropped Rod 7-12

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWt) = 2760 and Load (Gross MWe) = 913.

Description of Occurrence: At 2205 hours on November 29, 1983, Rod 7-12 dropped to 0% withdrawn for no apparent reason. The asymmetric condition caused the Integrated Control System to automatically run the reactor back to  $\geq 60\%$ . The dropped rod also caused the Station to enter the action statement of Technical Specification 3.1.3.1c, which states that power operation may continue provided that within one hour the control rod is restored to operable status or declared inoperable, and the shutdown margin requirement is satisfied.

Designation of Apparent Cause of Occurrence: It was discovered that the motor programmer phase CC fuse had opened maintaining that phase deenergized. When rod movement occurred, the open phase caused the rod to drop.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The rod failed in a safe direction, and the reactor shutdown margin was maintained throughout the incident.

By 2225 hours on November 29, 1983, Control Rod 7-12 was transferred back to its normal power supply and aligned with 6.5% of the group average. This removed the unit from the action statement.

Corrective Action: Control Rod 7-12 was transferred to the auxiliary power supply and then deenergized for fault investigation. No overcurrent evidence was found after inspection of circuits, fuse and fuse holder. The fuse was replaced, the auxiliary power supply reenergized, and the rod was successfully latched and withdrawn to group bank position.

Failure Data: Previous similar events which have occurred were reported in Licensee Event Reports NP-33-82-13 (82-011) and NP-33-83-18 (83-014).

LER #83-068

2 mb



December 29, 1983

Log No. K83-1768  
File: RR2 (NP-33-83-97)

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. 83-068  
Davis-Besse Nuclear Power Station Unit 1  
Date of Occurrence: November 29, 1983

Enclosed are three copies of Licensee Event Report 83-068 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 /smq*

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

JAN 3 1984

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