U. S. NUCLEAR REGULATORY COMMISSION NRC FORM 366 (7.77) LICENSEE EVENT REPORT (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK: Ø Ø Ø Ø Ø Ø ø Ø B S 0 D ICENSE NUMBER LICENSEE CODE CON'T REPORT 5 6(7) ØI 11 1 Ø 2 ØI ØI Ø 3 4 0 1 Ø (6)SOURCE EVENT DATE REPORT DATE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) (NP-33-83-01) At 1005 hours on 1/4/83, loss of power to the loop 2 main feedwater 0 2 block valve initiated a feedwater transient. The transient caused power reduction of 0 3 the plant which resulted in an axial power imbalance in excess of Technical Specifica-04 tion 3.2.1. This event was determined to be reportable 1/14/83. There was no danger 0 5 to the health and safety of the public or station personnel. The negative imbalance 0 6 was an expected response to control rod insertion and presented no safety concern. 0 0 80 CODE COMP. CAUSE CAUSE VALVE CODE SUBCODE COMPONENT CODE SUBCODE Z (14) Z (15 ZI (16) Z (13) Z IB ZI ZI ZI X Z (11 OCCURRENCE REVISION REPORT SEQUENTIAL REPORT NO. CODE TYPE EVENT YEAR LER RO ø Ø 13 8 0101 LI REPORT 3 1 1 NUMBER PRIME COMP SUPPLIER ATTACHMENT SUBMITTED COMPONENT NPRD-4 ACTION SHUTDOWN **FUTURE** Z 1 9 1 9 1 22) FORMSUB IOURS ON PLANT N ](24 Ž | (25 ØI Ø Y Ø ZI Ø (23) 18) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause was the control rod insertion from about 95% to 75% withdrawn during the 1 0 feedwater transient. Withdrawal of the control rods by operators restored imbalance to within limits, removing the unit from the tion statement of Technical Specification 3.2.1.a. 3 4 80 METHOD OF FACILIT (30)DISCOVERY DESCRIPTION (32) OTHER STATUS S POWER Operator observation 9 9 A NA (31)E (28) Ø (29) 80 ACTIVITY CONTENT LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35) RELEASED OF RELEASE NA (33) Z (34) Z NA 6 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER TYPE \$ (31) Z (38) Ø Ø NA 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 0 0 (40) Ø NA 80 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION Z (42) NA 8302230515 830211 PDR ADOCK 05000346 PUBLICITY NRC USE ONLY DESCRIPTION (45) SUED PDR N (44) NA 69 68 419-259-5000, Ext. 461 DVR 83-001 Carl L. Berger SUMAR

## TOLEDO EDISON CGAPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-83-01

DATE OF EVENT: January 4, 1983 (determined to be reportable January 14, 1983)

FACILITY: Davis-Besse Unit 1

12.00

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IDENTIFICATION OF OCCURRENCE: Axial Power Imbalance limit exceeded

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2733 and Load (Gross MWE) = 912

Description of Occurrence: At 1005 hours on January 4, 1983, loss of power to the loop 2 main feedwater block valve initiated a feedwater transient due to the loss of valve position indication to the Integrated Control System (ICS). In response to the transient, the ICS automatically reduced power from 100% to approximately 85% full power by inserting the control rods. The operators noted an imbalance alarm coming in and then clearing. Initial investigation indicated no limits were exceeded. However, later review on January 14, 1983 of a surveillance test, which happened to be being performed at the time of the transient, indicated axial power imbalance was in excess of Technical Specification 3.2.1 limits. As required by the Technical Specification Action Statement 3.2.1.a, the imbalance did not exceed the limit for more than 15 minutes.

Designation of Apparent Cause of Occurrence: The cause of this event was control rod insertion from about 95% to 75% withdrawn in response to the feedwater transient.

<u>Analysis of Occurrence</u>: There was no danger to the health and safety of the public or station personnel. The negative imbalance was an expected response to control rod insertion and presented no safety concern. The imbalance limit involved prevents core damage in the event of a loss of coolant accident and is not a core safety limit.

Corrective Action: Withdrawal of control rods by operators restored imbalance to within limits, removing the unit from Technical Specification Action Statement 3.2.1.a. This was the correct response to such an event. (Facility Change Request 81-277 will correct the condition which caused the runback by powering the block valve position indication out of the ICS.)

Failure Data: There have been no previous similar occurrences.

LER #83-001