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This occurrence is being reported under 10CFR50.73(a)(2)(iv).

YIA and by 15:20 hours the trip bistables were reset.

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49C Form 368

NRC Form 366A (9-83)	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								UCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85					
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Description of Occurrence:

On April 1, 1986 at 10:23 hours Levels 1 through 5 of SFAS actuated. Prior to the event, SFAS Channel 2 was de-energized for maintenance. Power to SFAS Channel 1 was lost when Y1, the essential power supply to SFAS Channel 1, was de-energized. Y1 was de-energized when a washer fell from a lifted lead of a fan failure detector in RPS Channel 1 which is also powered by Y1. The washer shorted out the terminal block in the cabinet. The lack of power to two SFAS channels caused a 2 of 4 logic condition and initiated SFAS.

All SFAS required equipment responded properly. No injection occurred since the High Pressure Injection (HPI) and Containment Spray (CS) Pumps were electrically disconnected per procedure in Mode 5.

The following anomalies were found during the actuation: 1) All Level 2 safety actuation monitoring (SAM) lights for Channels 1 and 2 did not respond due to loss of their power supply (Y1), 2) Several valves had no red/green indication due to loss of power from Y1, and 3) The SAM lights for valves CC1495, HV5439, HV5440, HV5716, and CV5301 did not show flashing indication when blocked and repositioned. The cause of the last anomaly is still undetermined. The valves are functional and all other aspects of their indications are operating. Investigation into the cause is continuing and a revision to this report will be submitted when the cause is determined.

Five fuses in Yl were found blown after the actuation. They were in YVl inverter, YlO6 for RPS Channel 1, YllO for a relay cabinet and a meter on DC MCC 1, Yll3 for a BWST heat trace panel, and Yll4 for a freeze protection panel.

At 11:30 hours all SFAS actuated equipment was secured. SFAS Channel 2 was reenergized by 14:10 hours. At 15:20 hours all tripped bistables in SFAS Channel 1 vere reset.

At 12:00 hours the notification was made via the Emergency Notifications System as required by 10CFR50.72(b)(2)(ii). This report is being submitted in accordance with the 10CFR50.73(a)(2)(iv) requirement to report an automatic actuation of an Engineered Safety Feature.

Designation of Apparent Cause of Occurrence:

The de-energization of Yl was due to a washer falling and shorting the terminal block in the bottom of the cabinet when a fan failure detector lead on RPS Channel 1 was lifted during maintenance. The maintenance person properly taped off the lifted lead but did not notice there was a washer under the lead which fell causing an electrical short circuit. This caused an overcurrent condition which blew fuses.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

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Since SFAS Channel 2 was de-energized, a 2 of 4 logic condition existed and Levels 1 through 5 actuated.

Analysis of Occurrence:

RC Porm 366A

There was no compromise of plant or public safety due to this event. All equipment required to actuate as part of SFAS in Mode 5 performed its function.

The Borated Water Storage Tank (BWST) values did not realign since they are presently tagged closed as a precaution during Reactor Goolant Pump seal work. The Decay Heat Pump already running continued recirculating reactor coolant, The second pump started and also recirculated reactor coolant.

Containment Spray Pumps and the High Pressure Injection Pumps were tagged out of service per procedure as a precaution in Modes 5 and 6 and therefore did not start. These would have been available for injection if the event had occurred in Modes 1 through 4. In Mode 1 the unit would trip since the power auctioneer circuit is part of RPS Channel 1.

Corrective Action:

At 11:30 hours all SFAR and ced equipment was restored. SFAS Channel 2 was reenergized by 14:10 hours. At 15:20 hours all tripped bistables in SFAS Channel 1 were reset. No equipment was damaged in the cabinet where the short occurred. The blown fuses are being replaced.

The incident which initiated the event has been discussed with I&C maintenance personnel. This discussion included the cause of the event with an emphasis placed on this particular potential hazard and on those of a similar nature.

Further study is being conducted into how to reduce the effects of short circuits in the essential inverters as part of the System Review and Test Program. This will include a study of why all five of these fuses blew during the event. The study is expected to be completed within one year.

Failure Data:

This is the second inadvertent full SFAS actuation in 1986. Prior to these occurrences the last full SFAS actuation occurred in 1980.

REPORT NO.: NP-33-86-20

DVR NO(s): 86-074

April 28, 1986



Log No. KA86-127 File: RR 2 (NP-33-86-20)

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

U. S. Nuclear Regulatory Commission Document Control Desk Washington, D. C. 20555

> LER No. 86-016 Lawys-Rosse Nuclear Power Station Unit 1 Date of Occurrence: April 1, 1986

Enclosed is Licensee Event Report 86-016 which is being submitted in accordance with 100PRS0.73, to provide 30 day written not fiscation of the subject occurrence.

Yours truly,

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Louis F. Storn Plant Manager Davis-Besse Nuclear Power Station

LFS/ed

Enclosure

cc: Mr. James G. Keppler Regional Administrator USNRC Region III

> Mr. Paul Byron DB-1 NRC Resident Inspector

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