

LICENSEE EVENT REPORT

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

01 | 0 | H | D | B | S | 1 | 2 | 0 | 0 | - | 0 | 0 | N | P | F | - | 0 | 3 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5

CON'T REPORT SOURCE L 6 0 5 0 - 0 3 4 6 7 0 1 1 6 7 9 8 0 2 1 2 7 9 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
02 | During the performance of surveillance testing on 1/2/79 and 1/16/79, heat traced line
03 | temperature measurement points were below the 105°F limit as required by Technical
04 | Specification 4.1.2.2. There was no danger to the health and safety of the public or
05 | unit personnel. It is a procedural practice to flush this line with water after
06 | boron injection is completed. (NP-33-79-15)

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08 | _____

09 | SYSTEM CODE P C 11 CAUSE CODE B 12 CAUSE SUBCODE A 13 COMPONENT CODE Z Z Z Z Z Z 14 COMP. SUBCODE Z 15 VALVE SUBCODE Z 16
17 | LER/RO REPORT NUMBER 7 9 21 22 SHUTDOWN METHOD Z 1 21 36 HOURS 0 0 0 0 22 ATTACHMENT SUBMITTED Y 2 41 NPRD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER A 25 COMPONENT MANUFACTURER Z Z Z Z 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
10 | Both occurrences were caused by the injection of makeup (flush) water after boron in-
11 | jection at a temperature lower than 105°F. The tests were rerun after the heat
12 | tracing restored the temperature. In addition, a Facility Change Request was sub-
13 | mitted to either add a heat exchanger or change the Technical Specification.

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15 | FACILITY STATUS G 28 % POWER 0 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Surveillance Test ST 5011.01 32

16 | ACTIVITY CONTENT RELEASED OF RELEASE Z 33 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 DESCRIPTION N 44 NA 45

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-15

DATE OF EVENT: January 16, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Boron Injection Line Temperature Low

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

Description of Occurrence: During the performance of Section 6 of Surveillance Test ST 5011.01, "Boron Injection Heat Trace Test", on January 16, 1979 at 1130 hours, all line temperature measurement points were below the 105°F limit as required by Technical Specification 4.1.2.2. Also, during this investigation a similar type of occurrence which was not reported was found to have occurred on January 2, 1979 at 1030 hours. During that occurrence, only four of the eight temperature measurement points were below the 105°F minimum required by Technical Specification 4.1.2.2.

Designation of Apparent Cause of Occurrence: Both occurrences were caused by the injection of makeup (flush) water at a lower temperature than 105°. The makeup (flush) water was at a temperature because its storage tanks are outside and maintained only above freezing temperature.

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. The purpose of maintaining the line temperature above 105°F is to prevent boron crystallization which would block the boron injection flowpath. Since it is procedural practice to flush this line with water after boron injection is completed, no line blockage could occur unless the temperature of the line went below or equal to 32°F. The lowest temperature of either occurrence was 66°F. Also, the Boric Acid Addition Tanks (the source of the concentrated boric acid) are normally maintained above 120°F and the line temperature returns to above 105°F whenever the concentrated boric acid is injected.

Corrective Action: The tests were successfully completed after sufficient time was allowed for temperature recovery by the heat tracing after water injection. In addition, a Facility Change Request, FCR 78-508, was submitted to add a heat exchanger to the water injection line, add additional heat trace, or change the Technical Specification to recognize low temperature due to water injection.

Failure Data: There has been one previously reported boron injection line heat tracing test failure on October 9, 1978 (see Licensee Event Report NP-33-78-132).