

LICENSEE EVENT REPORT

U.S. NUCLEAR REGULATORY COMMISSION

CONTROL BLOCK: _____ (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 | H | D | B | S | 1 | 2 | 0 | 0 | - | 0 | 0 | N | P | F | - | 0 | 3 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5
8 9 14 15 25 26 57 CAT 58
LICENSEE CODE LICENSE NUMBER LICENSE TYPE JO

CON'T
0 | 1 | 0 | 5 | 0 | - | 0 | 3 | 4 | 6 | 7 | 0 | 7 | 2 | 0 | 7 | 8 | 8 | 0 | 8 | 1 | 5 | 7 | 8 | 9
7 8 60 61 68 69 74 75 80
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 | 2 | At 0820 hours on 7/20/78, it was noted that containment vessel to annulus differential
0 | 3 | pressure exceeded the TS 3.6.1.4 limit of +25 inches water gage by 1 inch water gage.
0 | 4 | At 1047 hours on 7/20/78, the purge of the containment building commenced. Contain-
0 | 5 | ment vessel to annulus differential pressure was within allowable limits at 1050 hours
0 | 6 | on 7/20/78. There was no threat to the health and safety of the public or unit person-
0 | 7 | nel. The slight increase above the TS limit would not cause containment vessel inter-
0 | 8 | nal pressure to exceed the design pressure if a LOCA had occurred. (NP-33-78-100) 80

0 | 9 | SYSTEM CODE: S A (11) CAUSE CODE: X (12) CAUSE SUBCODE: Z (13) COMPONENT CODE: V E S S E L (14) COMP. SUBCODE: D (15) VALVE SUBCODE: Z (16)
7 8 9 10 11 12 13 18 19 20
17 LER/RO REPORT NUMBER: 7 8 (21) SEQUENTIAL REPORT NO.: 0 8 3 (24) OCCURRENCE CODE: 0 3 (28) REPORT TYPE: L (30) REVISION NO.: 0 (32)
ACTION TAKEN: G (18) FUTURE ACTION: H (19) EFFECT ON PLANT: Z (20) SHUTDOWN METHOD: Z (21) HOURS: 0 0 0 0 (22) ATTACHMENT SUBMITTED: Y (23) NPRO-4 FORM SUB.: N (24) PRIME COMP. SUPPLIER: A (25) COMPONENT MANUFACTURER: C 3 1 0 (26)
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 | 0 | The cause of this occurrence is both procedural and personnel error. The rate of in-
1 | 1 | crease of pressure was too great to be adequately monitored by the shift check. The
1 | 2 | time span between preparation of the containment purge permit and actual commencement
1 | 3 | of the containment purge was excessive. Containment vessel to annulus differential
1 | 4 | pressure has been added to the control room reading sheets. 80

1 | 5 | FACILITY STATUS: C (28) % POWER: 0 0 0 (29) OTHER STATUS: NA (30) METHOD OF DISCOVERY: B (31) DISCOVERY DESCRIPTION: Surveillance Test ST 5099.01 (32)
7 8 9 10 12 13 44 45 46 80

1 | 6 | ACTIVITY CONTENT RELEASED OF RELEASE: Z (33) Z (34) AMOUNT OF ACTIVITY: NA (35) LOCATION OF RELEASE: NA (36)
7 8 9 10 11 44 45 80

1 | 7 | PERSONNEL EXPOSURES NUMBER: 0 0 0 (37) TYPE: Z (38) DESCRIPTION: NA (39)
7 8 9 11 12 13 80

PERSONNEL INJURIES NUMBER: 0 0 0 (40) DESCRIPTION: NA (41)
7 8 9 11 12 13 80

1 | 8 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z (42) DESCRIPTION: NA (43)
7 8 9 11 12 80

2 | 9 | PUBLICITY ISSUED: N (44) DESCRIPTION: NA (45)
7 8 9 10 80
8001310642
NRC USE ONLY
DVR-78-132 Scott Fulmer PHONE: 419-259-5000, Ext. 267

TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-100

DATE OF OCCURRENCE: July 20, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Containment Vessel to Annulus High Differential Pressure on Plant Startup

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

Description of Occurrence: At 0820 hours on July 20, 1978, it was noted that containment vessel to annulus differential pressure exceeded the Technical Specification limit of +25 inches water gage by 1 inch water gage. This placed the unit in the Action Statement of Technical Specification 3.6.1.4.

Plant Startup Procedure, PP 1102.02 was in progress. At 0350 hours on July 20, 1978, a containment purge permit was initiated due to a containment vessel to annulus differential pressure of +23 inches water gage. At 0820 hours on July 20, 1978, the containment vessel to annulus differential pressure exceeded +25 inches. At 1047 hours on July 20, 1978, the purge of the containment building commenced. Containment vessel to annulus differential pressure was within allowable limits at 1050 hours on July 20, 1978, which removed the unit from the Action Statement of Technical Specification 3.6.1.4.

Designation of Apparent Cause of Occurrence: The cause of this occurrence is both procedural and personnel error. The containment vessel to annulus differential pressure was being monitored by ST 5099.01, "Miscellaneous Instrument Shift Check", which is performed once every eight hours. The rate of increase of containment vessel to annulus differential pressure was too great to be adequately monitored by the shift check.

Additionally, the time span between initiation of corrective action (preparation of the containment purge permit) and actual commencement of the containment vessel purge (6 hours and 57 minutes) was excessive. Proper urgency and followup with regard to the processing of the containment purge permit would have prevented exceeding the technical specification limit.

Analysis of Occurrence: There was no threat to the health and safety of the public or to unit personnel. The slight increase above the technical specification limit would not cause containment vessel internal pressure to exceed the design pressure of 40 psig during a loss of coolant accident condition.

Corrective Action: ST 5099.01, "Miscellaneous Instrument Shift Checks" has been modified to provide additional guidance to the operator concerning when to initiate corrective action to prevent exceeding the limit. Containment vessel to annulus differential pressure has been added to the control room reading sheets (read approximately once every four hours) to provide the operator with trend information.

All affected personnel will be notified of the delay in implementing the release permit and requested to accelerate this process.

Failure Data: On October 18, 1977, the containment vessel to annulus differential pressure technical specification limit was exceeded (Licensee Event Report NP-33-77-81). It was believed the cause of the October, 1977 occurrence was the operation of only one containment air cooler; therefore, the startup procedure was modified to assure two containment air coolers were in operation. Since both containment air coolers were in operation prior to this occurrence, this additional operational experience has shown further corrective action was necessary.

LER #78-083