NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1 | O H D B S 1 (2) | 0 0 - 0 0 N P F - 0 3 (3) | 4 1 1 1 1 (4) | | (5)
LICENSEE CODE — LICENSE NUMBER — LICENSE TYPE — CAT

CON'T 0 1 REPORT SOURCE L (6) | 0 5 0 - 0 3 4 6 (7) | 0 4 1 7 7 8 (8) | 0 5 1 2 7 8 (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On April 17, 1978 at 1530 hours, the air flow through Post-Accident Radiation Monitors
0 3 RE 5029A,B,C was found to be oscillating. The monitor was declared inoperable at 1548
0 4 hours, placing the unit in the Action Statement of Technical Specification 3.3.3.6,
0 5 which requires two Post-Accident Containment Radiation Monitors while in Modes 1, 2,
0 6 or 3. There was no danger to the health and safety of the public or unit personnel.
0 7 The redundant Containment Post-Accident Radiation Monitor was operable.
0 8 (NP-33-78-45)

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
B B (11)	X (12)	X (13)	I N S T R U (14)	X (15)	Z (16)

LER/RO REPORT NUMBER (17)	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	0 3 8	/	0 3	L	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	X (25)	X X X X (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The apparent cause of the occurrence was either component failure or improper installa-
1 1 tion. Inspection of RE 5029 piping showed that pieces of the vacuum relief valve had 1
1 2 entered the pump, rendering it inoperable. The vacuum relief valve, as well as the
1 3 pump, were replaced under Maintenance Work Order 78-841.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 6 7 (29)	NA	A (31)	NA

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

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LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-45

DATE OF EVENT: April 17, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure of Post-Accident Radiation Monitors RE 5029A, B, and C

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 1851, and Load (MWE) = 623.

Description of Occurrence: On April 17, 1978 at 1530 hours, the air flow through Post-Accident Radiation Monitors RE 5029A, B, and C was found to be oscillating. The monitor was declared inoperable at 1548 hours, placing the unit in the Action Statement of Technical Specification 3.3.3.6. The Technical Specification requires the operability of two Post-Accident Containment Radiation Monitors while in Modes 1, 2 or 3. The Action Statement requires that the inoperable radiation monitor be returned to service within 30 days, or the unit must be placed in Hot Shutdown (Mode 4) within the next 12 hours. 1

Designation of Apparent Cause of Occurrence: The apparent cause of the occurrence was either component failure or improper installation. Inspection of RE 5029 piping showed that pieces of the vacuum relief valve (Victoreen #844-1-9) had entered the pump, rendering it inoperable. The vacuum relief valve may have been improperly installed when the pump was replaced on April 7, 1978 (see Licensee Event Report NP-33-78-30). 1

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. The redundant Containment Post-Accident Radiation Monitor was operable had an accident requiring containment post-accident radiation monitoring occurred. No other systems were affected.

Corrective Action: The unit was removed from the Action Statement of Technical Specification 3.3.3.6 at 1030 hours on April 30, 1978, when the unit entered Mode 4. Under Maintenance Work Order 78-841, all electrical circuits in RE 5029 were checked and overloads reset. Operation in automatic and manual modes was checked from the control room. The vacuum relief valve, as well as the pump, were replaced.

The monitor was returned to operability at 0130 hours on June 25, 1978 after performance of Surveillance Test ST 5032.01, "Monthly Functional Test of the Radiation Monitoring System". This was prior to entry into Mode 3, as required by Technical Specification 3.3.3.6.

LER #78-038

Failure Data: Previous pump-related problems with Containment Post-Accident Radiation Monitors have been reported in Licensee Event Report NP-33-78-30. 1

LER 78-038