

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

inoperable. (NP-33-78-65)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

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TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-65

DATE OF EVENT: May 15, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Radiation Monitor RE 2004 inoperable

Conditions Prior to Occurrence: The unit was in Mode 6 with Power (MWT) = 0, and Load (MWE) = 0.

Description of Occurrence: During performance of Surveillance Test ST 5031.04, "Containment Radiation Level Inputs to Safety Features Actuation System (SFAS) Calibration" on May 15, 1978, at 0200 hours, Radiation Monitor RE 2004 could not be calibrated to within tolerance limits. RE 2004, the containment radiation monitor for SFAS Channel 1 was thus inoperable. This occurrence placed the unit in Action Statement 9 of Technical Specification 3.3.2.1.

Technical Specification 3.3.2.1 requires the operability of each of four radiation monitors in all modes. Action Statement 9 requires that the inoperable functional unit be placed in the tripped condition within one hour and that three other units are operable.

At 0910 hours on May 15, 1978, RE 2004 was found to have been in an untripped condition. The radiation monitor had been in the untripped condition since 0700 hours of the same date. The unit was then placed in Limiting Condition for Operation (LCO) 3.0.3, which requires that the unit be placed in at least Hot Standby (Mode 3) within one hour and in Cold Shutdown (Mode 5) the following 30 hours. The unit was in Mode 6 (refueling) at the time of the occurrence, and the required action in LCO 3.0.3 was not applicable.

Designation of Apparent Cause of Occurrence: RE 2004 was replaced with a new detector. The faulty detector is being sent to Victoreen for further analysis.

At 0700 hours on May 15, Instrument and Control personnel were still in the process of performing Surveillance Test ST 5031.04 when a shift change occurred. These personnel assumed that performance of this surveillance test would continue with the next shift. They left the radiation monitor in the untripped condition. This condition was not discovered until 0910 hours on the same day. The reason that the radiation monitor was left in the untripped condition is attributed to personnel error.

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Analysis of Occurrence: There was no danger to the health and safety of the public or unit personnel. Three other containment radiation instrument strings were operable during the period that RE 2004 was inoperable. The SFAS would have performed as designed if high radiation levels inside containment had occurred.

Corrective Action: The radiation monitor and the respective SFAS channel were placed in the tripped condition within one hour as required by the Action Statement. The unit was removed from Limiting Condition for Operation 3.0.3 at 0910 hours on May 15, 1978 when RE 2004 was placed in the tripped condition. The Instrument and Control technicians responsible for leaving RE 2004 in the untripped condition have been informed of the following: In the event of a shift change during the course of this surveillance test, the radiation monitor is to be tripped. No procedure revision was necessary.

The unit was removed from Action Statement 9 of Technical Specification 3.3.2.1 for RE 2004 on May 24 at 1825 hours after replacement of the detector and performance of ST 5031.01, "SFAS Monthly Test".

Failure Data: An SFAS channel has previously been reported to have been inoperable due to defective radiation detection instrumentation in Licensee Event Reports NP-33-77-04, NP-33-77-86, NP-33-77-89, NP-33-77-97 and NP-33-78-35.

An SFAS channel has previously been reported to have been found in an untripped condition in Licensee Event Reports NP-32-77-04 and NP-33-78-39.

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