



EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

At 1615 hours, August 18, 1978, during normal steady state operation in Mode 1, the high level radiation monitor was found to be inoperative, while performing a routine channel check. The high level radiation monitor is required to be operational at all times by Technical Specifications Section 3.3.3.1. Maintenance Request No. 78-479 was issued and the I & C Department notified. The subsequent investigation revealed that a blown fuse had caused the loss of the channel. This is the first occurrence of this nature at this facility.

This is the only channel associated with the accident emergency gamma guard. Other more sensitive radiation monitoring equipment used to monitor specific areas and systems was operational and indicated normally throughout the occurrence. Therefore, based on the above, there were no adverse effects upon the health and safety of the public or plant personnel as a result of this occurrence.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

The root cause of this occurrence has been attributed to a blown fuse. The apparent cause has been attributed to the natural end of life of the component. The fuse is an AGC-2 amp manufactured by Little Fuse. The fuse was replaced in kind, the channel was tested and returned to service at 1800 hours.

An Engineering Design Change is in the design stage, which will replace the channel and add instrumentation.

This occurrence was reviewed by the Plant Operations Review Committee during meeting No. 78-38, held on August 31, 1978. The committee concurred with the actions taken at the time of the occurrence and the future actions proposed, without further recommendations.