NRC FORM 366
(7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01 | OHDBS1 (2) | 00-0000-00 (3) | 41111 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 01 | REPORT SOURCE L (6) | 05000346 (7) | 101281 (8) | 121581 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-81-75) On 10/12/81 and 10/13/81, the pump for RE 5029, the Post-Accident Con-
03 tainment Radiation Monitor was found not running. On 10/13/81 and 11/3/81 the pump
04 for RE 5030 was also found off. These occurrences are being reported per Technical
05 Specification 3.3.3.6, Table 3.3-10. There was no danger to the health and safety of
06 the public or station personnel. A redundant system was always operable. In addition,
07 there was no buildup of activity in containment during this time, and no release into
08 the environment.

09 | SYSTEM CODE BB (11) | CAUSE CODE E (12) | CAUSE SUBCODE B (13) | COMPONENT CODE PUMPXX (14) | COMP. SUBCODE X (15) | VALVE SUBCODE Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR 81 | — | SEQUENTIAL REPORT NO. 064 | / | OCCURRENCE CODE 03 | REPORT TYPE X | — | REVISION NO. 2

ACTION TAKEN X (18) | FUTURE ACTION X (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0000 (22) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER X (25) | COMPONENT MANUFACTURER C518 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause was component failure. The flow was discovered to be at approximately 3
11 scfm which is the trip point for low flow. Flow through these monitors tends to de-
12 crease due to pump vane wear. The pump for RE 5030 was replaced and declared operable
13 on 11/21/81. A step was added to Maintenance Work Order IC-MWO-4W2 to check and set
14 flows weekly.

15 | FACILITY STATUS E (28) | % POWER 100 (29) | OTHER STATUS (30) NA | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operator Observation

16 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA

17 | PERSONNEL EXPOSURES NUMBER 000 (37) | TYPE Z (38) | DESCRIPTION (39) NA

18 | PERSONNEL INJURIES NUMBER 000 (40) | DESCRIPTION (41) NA

19 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION NA (43)

20 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) NA

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NRC USE ONLY

DVRs 81-165, 167, 168, 188

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-75

1 DATE OF EVENT: October 12 and 13, and November 3, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Pump for Post-Accident Containment Radiation Monitor RE 5029 was found to be off on October 12, 1981 and October 13, 1981. Pump for Post-Accident Containment Radiation Monitor RE 5030 was found off on October 13
1 and November 3, 1981.

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2772 and Load (Gross MWE) = 915.

Description of Occurrence: On October 12, 1981 while the operator was checking the Victoreen panel, it was discovered that the pump for RE 5029 was not running. The operator restarted the pump. Further checking showed the computer alarm for low flow had come in at 0812 hours, showing that the pump had tripped on low flow.

On October 13, 1981, RE 5030 pump was found off at 1700 hours. The pump was restarted. At 1830 hours on the same date, the RE 5029 pump was again discovered to be tripped. The pump was restarted.

1 On November 3, 1981, the RE 5030 pump was found off at 1400 hours. The pump was restarted and the flow settled out at 4.5 cfm.

These occurrences are being reported under Technical Specification 3.3.3.6, Table 3.3-10 which requires that two post-accident containment radiation monitors be operable at all times.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was due to component failure. The flow was discovered to be at approximately 3 scfm which is the trip point for low flow. Flow tends to be reduced through a radiation monitor with time. This can be attributed to pump vane wear and vibration of the flow control valves.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. A redundant system was always operable. There was no buildup of activity in containment during the time frame and no release into the environment.

Corrective Action: Flow was increased to 4.5 and 5 scfm. A step was added to Maintenance Work Order IC-MWO-4W2 to check and set flows weekly until the REs are replaced with a new design narrow and wide range containment radiation monitoring system under Facility Change Request 80-050.

LER #81-064

Under Maintenance Work Order 81-3932, the pump for RE 5030 was rebuilt and was returned to service on November 21, 1981.

2 Failure Data: Previous pump failures were reported in Licensee Event Reports NP-33-81-49 (81-043) and NP-33-81-64 (81-054).

LER #81-064