

LICENSEE EVENT REPORT

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

[0][1] [0][H][D][B][S][1] [2][0][0]-[0][0][0][0][0]-[0][0] [3][4][1][1][1][1] [4] [5]

CON'T [0][1] REPORT SOURCE [L] [6][0][5][0][0][0][3][4][6] [7][1][2][0][1][8][2] [8][0][2][0][1][8][3] [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) (NP-33-82-80) On 12/1/82 at 0900 hours, the Shift Supervisor discovered that the Control Room Ventilation System Chlorine Detector AE5358B had been taken out of service on 11/30/82 without placing the Control Room in the recirculation mode within one hour per the action statement of Technical Specification 3.3.3.7. On 12/3/82 at 0845 hours, chlorine detector AE5358A failed, placing the unit in the action statement of Technical Specification 3.0.3 since AE5358B was still out of service. There was no danger. Chlorine detectors located near the chlorine storage tanks were operable.

[0][9] SYSTEM CODE [P][C] [11] CAUSE CODE [A] [12] CAUSE SUBCODE [X] [13] COMPONENT CODE [I][N][S][T][R][U] [14] COMP SUBCODE [E] [15] VALVE SUBCODE [Z] [16]

[17] LER/RO REPORT NUMBER [8][2] [21] EVENT YEAR [8][2] [22] SEQUENTIAL REPORT NO. [0][6][5] [24] OCCURRENCE CODE [0][3] [28] REPORT TYPE [X] [30] REVISION NO. [1] [32] ACTION TAKEN [H] [18] FUTURE ACTION [Z] [19] EFFECT ON PLANT [Z] [20] SHUTDOWN METHOD [Z] [21] HOURS [0][0][0][0] [22] ATTACHMENT SUBMITTED [Y] [23] NPRD-4 FORM SUB. [N] [24] PRIME COMP. SUPPLIER [Z] [25] COMPONENT MANUFACTURER [Z][9][9][9] [26]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) [1][0] The cause of the 12/1/82 event is personnel error. The MWO was not written and authorized correctly and the personnel working on AE5358B did not follow the instructions on the MWO explicitly. A memo has been sent to the responsible personnel. The cause of the 12/3/82 event was a detector malfunction. AE5358A was declared operable at 0910 hours on 12/3/82. AE5358B was demonstrated operable on 12/12/82 removing the unit from the action statement.

[1][5] FACILITY STATUS [E] [28] % POWER [0][9][9] [29] OTHER STATUS [NA] [30] METHOD OF DISCOVERY [A] [31] DISCOVERY DESCRIPTION [Discovered by Shift Supervisor] [32]

[1][6] ACTIVITY CONTENT [Z] [33] RELEASED OF RELEASE [Z] [34] AMOUNT OF ACTIVITY [NA] [35] LOCATION OF RELEASE [NA] [36]

[1][7] PERSONNEL EXPOSURES NUMBER [0][0][0] [37] TYPE [Z] [38] DESCRIPTION [NA] [39]

[1][8] PERSONNEL INJURIES NUMBER [0][0][0] [40] DESCRIPTION [NA] [41]

[1][9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] [42] DESCRIPTION [NA] [43]

[2][0] PUBLICITY ISSUED [N] [44] DESCRIPTION [NA] [45]

DVRs 82-150 & 82-151 NAME OF PREPARER Ted Lang/Linda Makatura PHONE 419-259-5000, Ext. 535/238

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NRC USE ONLY

GT 7-726

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-80

DATE OF EVENT: December 1, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Chlorine detectors inoperable

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2741 and Load (Gross MWE) = 909

Description of Occurrence: On December 1, 1982 at 0900 hours, the Shift Supervisor discovered that Facility Change Request (FCR) work had been initiated which caused the Control Room Ventilation System Chlorine Detector AE5358B to become inoperable. This invoked the action statement of Technical Specification 3.3.3.7, which with one chlorine detector inoperable requires the station to initiate and maintain the Control Room Ventilation System in the recirculation mode within one hour, restore the inoperable detector within 30 days, or be in at least Hot Standby within the next 6 hours, and in Cold Shutdown within the following 30 hours. The Shift Supervisor immediately put the Control Room Ventilation System on the recirculation mode following the action statement of Technical Specification 3.3.3.7. The plant remained on the recirculation mode until December 12, 1982, when FCR work was completed and operability of AE5358B was demonstrated, removing the station from the action statement of Technical Specification 3.3.3.7.

1 | On December 3, 1982, at 0845 hours, an Instrument and Control (I&C) mechanic discovered, during routine operations, that chlorine detector AE5358A was inoperable. Since AE5358B was still out of service for FCR modifications, Technical Specification 3.0.3 was invoked. At 0910 hours, the chlorine detector AE5358A was returned to service after the detector was cleaned, the drip rate adjusted, and Surveillance Test ST 5037.02 was performed to prove operability.

No unit power reductions resulted from the occurrences.

1 | Designation of Apparent Cause of Occurrence: The cause of the December 1, 1982 occurrence was personnel error. Work on chlorine detector AE5358B was first started on November 11, 1982 under an FCR 81-258 work order with AE5358B out of service. This FCR work involved rerouting the piping to the detector. Due to a lack of correctly fitting parts, the work was not immediately completed. On November 22, 1982, the detector was temporarily restored to service since the old sample piping was still intact. Working under the previous Maintenance Work Order (81-258-01), the job proceeded on November 30, 1982 with instructions added in an improper position on the work order not to make a connection to the chlorine detector. The original work order was not written with sufficient steps to clearly define when the equipment was to be taken out of service. On the following morning, December 1, 1982, the Shift Supervisor discovered the inopera-

bility of the detector, due to disconnected sample piping, and the action statement of Technical Specification 3.3.3.7 was entered.

The December 3, 1982 occurrence, failure of AE5358A, was the result of a component failure - a detector malfunction.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. In addition to the Control Room Ventilation System Chlorine Detectors, local chlorine detectors are placed near the chlorine storage cylinders which would close the intake dampers and isolate the Control Room in the event of a chlorine tank car rupture.

Corrective Action: A memorandum has been sent to personnel involved with performing, writing, and authorizing work orders. The memorandum will point out that work orders must be written clearly and specifically enough to ensure that equipment is removed from service only with proper authorization. It also stated that if the work order is changed in any way, it must be rerouted per Administrative Procedure AD 1844.00 for new approvals and that all work order instructions must be explicitly followed.

Chlorine detector AE5358A was repaired under the I&C generic maintenance work order 019-82 (Heating, Ventilation and Air Conditioning Control Room), tested for operability by Surveillance Test ST 5037.02, and returned to service at 0910 hours the same day. This removed the unit from the actions required by Technical Specifications 3.0.3 and 3.3.3.7.

Failure Data: There have been no previous occurrences involving the failure to place the Control Room Ventilation System in the recirculation mode per the action statement of Technical Specification 3.3.3.7. A previous occurrence of a detector failure has been reported in Licensee Event Report NP-33-81-19 (81-018).

LER #82-065