NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	Licensee Code (2)	OHDBS1
01	License Number (3)	00-00000-00
01	License Type (4)	41111
01	CAT (5)	
01 (CON'T)	Report Source (6)	L
01	Docket Number (7)	05000346
01	Event Date (8)	102182
01	Report Date (9)	111982

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-82-66) At 1115 hours on 10/21/82, and again at 1914 hours on 10/24/82, Safety
03 Features Actuation System (SFAS) Channel 4 Radiation Monitor RE-2007 failed low. On
04 both occurrences, the high radiation output bistable was tripped in accordance with
05 Technical Specification 3.3.2.1, Action Statement 9. There was no danger to the
06 health and safety of the public or station personnel. The remaining three SFAS chan-
07 nel radiation monitors were operable.
08

Line	Field	Value
09	System Code (11)	IB
09	Cause Code (12)	X
09	Cause Subcode (13)	Z
09	Component Code (14)	INSTRU
09	Comp. Subcode (15)	E
09	Valve Subcode (16)	Z

(17) LER/RO REPORT NUMBER

Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
82	—	055	/	03	L	—	0

Action Taken (18)	Future Action (19)	Effect on Plant (20)	Shutdown Method (21)	Hours (22)	Attachment Submitted (23)	NPRD-4 Form Sub. (24)	Prime Comp. Supplier (25)	Component Manufacturer (26)
C	X	Z	Z	0000	Y	Y	N	V115

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The root cause is unknown. A module (readout) check was performed, all cabling was
11 tested for continuity, grounds or shorts, and all connectors and terminal strip connec-
12 tions were inspected, however, no faults were found. On both occurrences, the detec-
13 tors were replaced, Surveillance Test ST 5031.01 run successfully, and RE-2007 de-
14 clared operable, removing the unit from the action statement.

Line	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
15	E	086	NA	A	Operator Observation

Line	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
16	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	Number (37)	Type (38)	Description (39)
17	000	Z	NA

PERSONNEL INJURIES

Line	Number (40)	Description (41)
18	000	NA

LOSS OF OR DAMAGE TO FACILITY (43)

Line	Type (42)	Description
19	Z	NA

8211290543 821119
PDR ADOCK 05000346
S PDR

PUBLICITY

Line	Issued (44)	Description (45)	NRC USE ONLY
20	N	NA	

DVRs 82-125 & 126

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-66

DATE OF EVENT: October 21 and 24, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure of Safety Features Actuation System (SFAS) Channel 4 Radiation Monitor RE-2007

Conditions Prior to Occurrence: The unit was in Mode 1 on both occurrences with Power (MWT) = 2373 and Load (Gross MWE) = 799 on October 21; and Power (MWT) = 2380 and Load (Gross MWE) = 800 on October 24.

Description of Occurrence: At 1115 hours on October 21, 1982 and again at 1914 hours on October 24, 1982, SFAS Channel 4 Radiation Monitor RE-2007 failed low. On both occurrences, the high radiation output bistable was tripped in accordance with Technical Specification 3.3.2.1, Action 9. This placed the unit in a 1 out-of 3 trip condition on SFAS radiation channel monitoring.

On both occurrences, an SFAS alarm on containment radiation fail was received, and the Control Room operator verified a low (off-scale) reading.

There was no power reduction required by either occurrence.

Designation of Apparent Cause of Occurrence: The root cause of these occurrences is unknown. On both occurrences, the failure appeared to be the detector. A module (readout) check was accomplished, and no faults could be found. All cabling was tested (continuity, grounds and shorts), and no faults could be found. All connectors and terminal strip connections were inspected, and no faults were found. The detectors were tested by Maintenance Work Order IC-590-82 and found to be good. The detectors were put on test for a period of three to four days and were subjected to heating, cooling, and vibration, but no fault would recur. The detectors were recalibrated and returned to the I&C storage area.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The remaining three SFAS channel radiation monitors were operable as well as the containment air monitors, the containment high radiation area monitors, and the containment access area radiation monitors. There were no off-site consequences.

Corrective Action: For the first occurrence, corrective action was the replacement of the detector by Surveillance Test ST 5031.04. Operations personnel ran Surveillance Test ST 5031.01 Section 6.2 and declared SFAS Channel 4 operational on October 22, 1982 at 0530 hours. This removed the station from the action statement of Technical Specification 3.3.2.1.

The corrective action for the second occurrence was again to replace the detector by Surveillance Test ST 5031.04. Operations personnel again ran Surveillance Test ST 5031.01 Section 6.2 and declared SFAS Channel 4 operational on October 27, 1982 at 1807 hours. Again, the station was removed from the action statement of Technical Specification 3.3.2.1.

Additional testing was performed as described above, but no definite cause of failure was determined.

Failure Data: There have been twelve previously reported component failures of the SFAS radiation monitors, with only two Licensee Event Reports, NP-33-82-06 (82-005) and NP-33-82-52 (82-047) being reported within the previous year.

LER #82-055