

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Davis-Besse Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 4 6	PAGE (3) 1 OF 0 3
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TITLE (4)  
Inoperable Station Vent Radiation Monitors

EVENT DATE (6)			LER NUMBER (5)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 8	0 9	8 8	8 8	0 1	0 0	0 9	0 6	8 8			0 5 0 0 0

OPERATING MODE (8) U

POWER LEVEL (10) 0 1 0 1 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

20.402(b)	20.405(a)	60.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	60.36(a)(1)	60.73(a)(2)(v)	73.71(a)
20.405(a)(1)(ii)	60.36(a)(2)	60.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 60.73(a)(2)(i)	60.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	60.73(a)(2)(ii)	60.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	60.73(a)(2)(iii)	60.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME C. S. Gordon, Senior Nuclear Specialist	TELEPHONE NUMBER AREA CODE 4 1 1 9   2 1 4 9 1 - 5 1 0 1 0 0
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs
D	I L R I E I	I	K O I Z I O	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On August 9, 1988, with the reactor defueled, it was discovered that both trains of the Station Vent Radiation Monitors were inoperable. This condition existed from 0900 hours on August 2, 1988 to 1527 hours on August 8, 1988. During this period six radioactive releases were made and no grab samples were taken. This is a violation of Technical Specification 3.3.3.10. This condition was caused by an inadequate procedure that did not direct the Instrument and Control technicians to inform the Shift Supervisor which functions were being disabled by the jumpers installed during radiation monitor calibrations and by the failure of a high voltage board. The high voltage board was replaced. By December 1, 1988 all radiation monitor calibration procedures will be revised to add this guidance. A standing order has also been issued to require the operability of associated radiation monitors be verified prior to performing radioactive liquid or gaseous releases. Similar Instrument and Control surveillance procedures will be reviewed by January, 1989, to determine if similar guidance should be included within them.

This condition is being reported in accordance with 10CFR50.73(a)(2)(i)(B).

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Occurrence:

The Station Vent Radiation Monitors (IL) are comprised of two independent monitoring channels. Each channel consists of a normal range monitor and an accident range monitor. On July 27, 1988, with the reactor defueled, Instrument and Control technicians began a calibration of the accident range monitor in Station Vent Radiation Monitor Channel 2. This calibration installed jumpers in the circuits that disabled the annunciator and automatic trip functions for the normal range radiation monitor. On August 2, 1988, at 0900 hours Channel 1 of the Station Vent Radiation Monitor (RE)(Kaman Model KMPIG-HRN) was declared inoperable due to a high voltage failure in the normal range radiation monitor. As a result, both channels of the Station Vent Normal Range Radiation Monitor were inoperable. This condition was not identified until 1312 hours on August 8, 1988, while performing surveillance testing on the Channel 1 normal range monitor. During the period of August 2, 1988 to August 8, 1988, six radioactive releases were made and no grab samples were taken as required by Technical Specification 3.3.3.10. This is being reported in accordance with 10CFR50.73(a)(2)(i)(B).

Designation of Apparent Cause of Occurrence:

This occurrence was caused by an inadequate procedure which did not direct the technicians to inform the Shift Supervisor of which functions were being disabled by the installation of the jumpers directed by the procedure. The Channel 1 normal range radiation monitor failure was caused by a high voltage board failure.

Analysis of Occurrence:

During the period that both channels of Station Vent Radiation Monitors were inoperable six radioactive releases were made. These releases were sampled at their point of origin prior to being released through the station vent. These releases were insignificant and offsite does rates were negligible. Although the vent monitors were Technical Specification inoperable, they would functionally indicate and alarm locally. No alarms were received on the local panel. Additionally, Surveillance Test ST 5099.05 requires the operator to check the status of the Station Vent Radiation Monitors once per shift. This frequency is similar to the grab sample frequency required by the action statement of Technical Specification 3.3.3.10. Therefore, this failure to take grab samples of the station vent had no safety significance.

Corrective Action:

Channel 1 Normal Range Radiation Monitor was repaired under Maintenance Work Order (MWO) Number 1-88-1892-00 and returned to an operable status on August 8, 1988 at 1527 hours. By December 1, 1988, all radiation monitoring calibration procedures will be revised to include guidance to inform the Shift Supervisor of which functions are disabled by the installation of jumpers. In the interim Standing Order 88-062 has been issued to require the operability of the alarm and isolation functions be verified by manually tripping the applicable radiation monitor prior to performing radioactive liquid or gaseous releases.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (if more space is required, use additional NRC Form 366A's) (17)

In addition to the action statements of the Technical Specifications, if these functions are not operable, a continuous watch on the radiation monitor will be established during the release. Similar Instrument and Control surveillance procedures will be reviewed by January, 1989, to determine if similar guidance should be included within them.

Failure Data:

LER 87-009 describes a similar event involving radiation monitors in the Miscellaneous Liquid Radwaste System. The specific calibration procedure that was deficient during that event was revised and a commitment made to revise similar procedures at their next periodic review. This corrective action had not been fully completed at the time of this event as the procedure related to this event had not yet reached its periodic review date, and therefore, had not yet been revised.

REPORT NO: NP-33-88-22

PCAQ NO(s): 88-0618, 88-0621

September 6, 1988



Log No: KA88-0287  
NP-33-88-22

Docket No. 50-346  
License No. NPF-3

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D. C. 20555

Gentlemen:

LER No. 88-018  
Davis-Besse Nuclear Power Station Unit No. 1  
Date of Occurrence August 9, 1988

Enclosed is Licensee Event Report 88-018, which is being submitted in accordance with 10CFR50.73 to provide 30 day written notification of the subject occurrence.

Yours truly,

A handwritten signature in cursive script that reads "Neal F. Bommer for L.F. Storz".

Louis F. Storz  
Plant Manager  
Davis-Besse Nuclear Power Station

LFS/ed

cc: Mr. A. Bert Davis  
Regional Administrator  
USNRC Region III

Mr. Paul Byron  
DB-1 NRC Resident Inspector

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