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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

US NUCLEAR REGULATORY COMMISSION APPROVED DW8 NO 3150-0104

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TEXT III more spece is required, use additional NRC Form 3864's! (17)

Description of Occurrence:

AC PERM 166A

On May 9, 1988, at approximately 2300 hours, the plant was operating in Mode 6 and Core alterations were in progress. Maintenance was in progress to change the filter elements of the fuel transfer canal skimmer filter under Maintenance Work Order (MWO) 1-88-0612-00. The filters were changed and permission to transfer the filters along a previously designated the was obtained from the Shift Supervisor.

At approximately 2356 hours, during the transfer of these filters a Safety Features Actuation System (SFAS) (JE) level 1 initiation signal was received and the system actuated on high radiation level. This actuation was caused by passing very near the radiation detectors used to initiate SFAS while transferring the radioactive material.

The operators received a Channel 1 SFAS trip signal in the control room and before the cause for the Channel 1 trip could be determined and reset, Channel 4 tripped initiating SFAS.

This occurrence is being reported according to 10CFR50.73(a)(2)(iv).

Designation of Apparent Cause of Occurrence:

This occurrence was caused by personnel selecting a route for transfer of the radioactive material which passed in close proximity to the Channel 1 and Channel 4 radiation detectors used in the SFAS system for containment isolation. The route utilized for transfer was not the normal route because the normal route was blocked by scaffolding. Operations personnel were not included in the pre-job briefing nor was sufficient preplanning done by shift personnel prior to granting permission for the radioactive material transfer.

Analysis of Occurrence:

The abnormally high radiation level caused a Level 1 SFAS initiation. The system actuated normally and the containment vessel sample and purge lines were isolated and the Emergency Ventilation System (EVS) (VC) started.

This event would not have occurred at a higher power level because the evolution in progress only occurs when the plant is refueling.

Corrective Action:

Radiological Control will revise procedure HP 1607.03 "Transfer of Radioactive Material Within Davis-Besse Nuclear Power Station" by July 31, 1988 to obtain guidance from the Operations Department when transferring radioactive material. Operations Management will discuss this occurrence with the Shift Supervisors to emphasize the potential problems that could occur when transferring radioactive material within the plant.

Failure Data:

This is the first report of SFAS initiation due to transfer of radioactive material.

REPORT NO: NP-33-88-13

PCAQ NO(s): 88-0353

June 8, 1968



EDISON PLAZA 300 M² DISON AVENUE TOLEDO IDHIO 43652-0001

Log No: KA88-0277 NP-33-88-13

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

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

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LER No. 88-012 Davis-Besse Nuclear Power Station Unit No. 1 Date of Occurrence May 9, 1988

Enclosed is Licensee Event Report 88-012, which is being submitted in accordance with 10CFR50.73 to provide 30 day written notification of the subject occurrence.

Yours truly, Build Louis F. Storz Plant Manager Davis-Besse Nuclear Pover Station

LFS/ed

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

> Mr. Paul Byron DB-1 NRC Resident Inspector