

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
REPORTABLE OCCURRENCE NP-09-78-01

DATE OF EVENT: December 15, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: RE 8432, Service Water System Out Header Radiation Monitor, was inoperable.

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = approximately 2550, and Load (Gross MWE) = approximately 833.

Description of Occurrence: During a routine review of the Shift Foreman's Log on December 15, 1978, at 1200 hours it was discovered that the Service Water System Out Header Radiation Monitor, RE 8432 had been inoperable. In the course of performance of Surveillance Test ST 5032.01, "Monthly Functional Test of the Radiation Monitoring System", at 1230 hours on December 11, 1978, the computer alarm and low flow light for RE 8432 were inoperable. Through conversation with the Instrument and Control Coordinator, it was noted that previous failures had also occurred. In each instance, the inoperability was detected through performance of either Surveillance Test ST 5032.01 or ST 5032.02, "Radiation Monitoring System Channel Calibration". See table below.

Previous Inoperabilities of RE 8432

<u>Date</u>	<u>Reason For Inoperability</u>
November 13, 1978	Low flow light inoperable
October 16, 1978	Low flow light inoperable
May 29, 1978	Low flow alarm wouldn't clear
May 9, 1978	Low flow alarm already present
January 17, 1978	Low flow light on
October 23, 1977	Low flow light inoperable
October 6, 1977	Low flow light inoperable
August 4, 1977	Low flow light inoperable

Exact dates and times for return to operability of RE 8432 cannot in every instance be determined due to lack of awareness of reportability requirements.

In each case, the unit was not in compliance with Environmental Technical Specification (ETS) Table 2.4.3. No Action Statement was applicable.

Designation of Apparent Cause of Occurrence: The apparent cause of the occurrences is component failure due to design error. There is not enough pressure differential to maintain correct sample flow in all modes of operation of the Service Water System. The flow switch tends to stick, and will not operate when there is insufficient flow to keep it flushed out.

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The reason that previous occurrences had not been reported is due to improper interpretation of the Environmental Technical Specifications.

Analysis of Occurrence: There was no danger to the health and safety of the public or to unit personnel. RE 1412 and RE 1413 on Component Cooling Lines 1 and 2, respectively, are upstream from RE 8432 and would indicate activity if any were present. RE 1412 and RE 1413, as well as weekly grab samples, have never indicated any leaks or activity.

Corrective Action: Although the exact dates and times for return to operability of the radiation monitors cannot in every instance be determined, the radiation monitor was repaired and returned to operability in each case. Facility Change Request (FCR) 78-503 has been written suggesting two possible methods of corrective action.

A memo dated January 4, 1979, has been sent to various station personnel to make them more cognizant of the fact that the inoperability of RE 8432, as well as other RE's in the Environmental Technical Specifications, is a reportable occurrence. The Environmental Technical Specifications are currently in the process of revision. Major Modifications to ST 5032.01 and ST 5032.02 have been submitted to emphasize the reportability requirements of those RE's in the Environmental Technical Specifications.

Major Modifications have been written on ST 5032.01 and ST 5032.02, respectively, stating when RE 8432 is inoperable, that the occurrence is reportable.

Failure Data: There have been no previously reported occurrences of the failure of RE 8432.