NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01 | O H D B S 1 (2) | Ø Ø - Ø Ø Ø Ø Ø - Ø Ø (3) | 4 1 1 1 1 (4) | CAT (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE

CON'T 01 | REPORT SOURCE L (6) | DOCKET NUMBER Ø 5 Ø Ø Ø 3 4 6 (7) | EVENT DATE Ø 5 Ø 5 8 1 (8) | REPORT DATE Ø 6 Ø 4 8 1 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-81-36) On 5/5/81 it was confirmed by reviewing the Unit Log and the surveillance
03 test computer schedule that a liquid release had been made from the Miscellaneous
04 Waste Monitor Tank while the Radwaste Monitors RE1878A and RE1878B were inoperable due
05 to their testing date being exceeded. Release 706 was made on 5/1/81 but the test
06 late date was 4/28/81. There was no danger to the public or station personnel.
07 When the test was performed, it verified that the monitors had, in fact, been operable
08 and that no release limits had been exceeded.

09 | SYSTEM CODE M C (11) | CAUSE CODE A (12) | CAUSE SUBCODE A (13) | COMPONENT CODE I N S T R U (14) | COMP. SUBCODE E (15) | VALVE SUBCODE Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR 8 1 | — | SEQUENTIAL REPORT NO. Ø 2 8 | / | OCCURRENCE CODE Ø 3 | REPORT TYPE L | — | REVISION NO. Ø

ACTION TAKEN H (18) | FUTURE ACTION Z (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS (22) Ø Ø Ø Ø | 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)

10 The cause was personnel error on the part of the Shift Supervisor who permitted the
11 release without remaining cognizant that the monthly functional test had exceeded its
12 late date. Therefore, the monitor was technically inoperable. A memo will be written
13 to the appropriate supervisory personnel reinforcing their responsibility to review
14 the test schedule and ensure the equipment is properly tested.

15 | FACILITY STATUS E (28) | % POWER Ø 9 9 (29) | OTHER STATUS (30) NA | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Unit Log Review

16 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA

PERSONNEL EXPOSURES

17 | NUMBER Ø Ø Ø (37) | TYPE Z (38) | DESCRIPTION (39) NA

PERSONNEL INJURIES

18 | NUMBER Ø Ø Ø (40) | DESCRIPTION (41) NA

LOSS OF OR DAMAGE TO FACILITY (43)

19 | TYPE Z (42) | DESCRIPTION NA

PUBLICITY

20 | ISSUED N (44) | DESCRIPTION (45) NA | NRC USE ONLY

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DVR 81-071 NAME OF PREPARER Robert Kocis/Jan Stotz PHONE: (419) 259-5000, Ext. 25

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-36

DATE OF EVENT: May 5, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Liquid release made while radiation monitors RE1878A and RE1878B were inoperable due to their testing date being exceeded

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2750 and Load (Gross MWE) = 915

Description of Occurrence: On May 5, 1981, it was confirmed by reviewing the Unit Log and the surveillance test computer schedule that a liquid release had been made from the Miscellaneous Waste Monitor Tank while the Miscellaneous Radwaste Monitors RE1878A and RE1878B were technically inoperable. The Monthly Functional Test ST 5032.01 late date passed at 0455 hours on April 28, 1981. Environmental Technical Specification 2.4.2.d states that if these monitors are inoperable for a period exceeding 72 hours, no release from a radioactive liquid waste tank shall be made and any release in progress shall be terminated. The release was started at 0405 hours on May 1, 1981 and was completed at 0610 hours the same day. This finding is being reported under Environmental Technical Specification 5.4.2 for exceeding a limiting condition for operation.

Designation of Apparent Cause of Occurrence: The cause is a personnel error on the part of the Shift Supervisor who permitted the release without remaining cognizant that the monthly functional test, which is performed by operations personnel, had exceeded its late date. Therefore, the monitor was technically inoperable. The test was shown on the operations section of the schedule as overdue.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. When the calibration test and functional test was performed later on May 1, 1981, it verified that the monitor had been, in fact, operable during the release. No release limits had been exceeded.

Corrective Action: A memo will be written to the appropriate supervisory personnel reinforcing their responsibility of reviewing the Surveillance Test Schedule and seeing that tests are performed within the deadline. Tests not being performed on schedule will render the equipment technically inoperable. Administrative controls will also be modified to establish better controls of Technical Specification required radiation monitor surveillance testing.

Failure Data: There have been no previous reports of releases being made with inoperable monitors in excess of Environmental Technical Specification limits.

LER #81-028