

LICENSEE EVENT REPORT

CONTROL BLOCK:

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 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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8	1	0	1	1	7	8
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9

7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | At 2220 hours on September 17, 1978, loud noises were heard emitting from the vacuum

0 3 | pump on Post-Accident Radiation Monitor RE 5030. The radiation monitor was removed

0 4 | from service. There was no danger to the health and safety of the public or unit per-

0 5 | sonnel. The other Post-Accident Radiation Monitor, RE 5029, was operable during the

0 6 | period that RE 5030 was inoperable. (NP-33-78-115)

0 7 |

0 8 |

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9 10 11 12 13 18 19 20
17 LER/RO REPORT NUMBER

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21 22 23 24 26 27 28 29 30 31 32
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33 34 35 36 37 40 41 42 43 44 47
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | A diaphragm inside the pump discharge solenoid valve was found to have cracked. It is

1 1 | believed that this failure was caused by high ambient temperatures inside the radia-

1 2 | tion monitor cabinet. A new diaphragm was installed in the solenoid valve. At 1805

1 3 | hours on September 18, 1978, RE 5030 was declared operable. Facility Change Request

1 4 | 78-299, which requested the installation of a cooling system was prepared.

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1	0
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NA

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Noise

7 8 9 10 12 13 44 45 46 80
1 6 |

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NA

7 8 9 10 11 44 45 80
1 7 |

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7 8 9 11 12 13 80
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NA

7 8 9 11 12 80
1 9 |

Z

NA

7 8 9 10 43 80
2 0 |

N

NA

7 8 9 44 45 80

TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-78-115

DATE OF EVENT: September 17, 1978

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Post-Accident Radiation Monitor RE 5030 inoperable

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2772, and Load (MWE) = 920.

Description of Occurrence: At 2220 hours on September 17, 1978, loud noises were heard emitting from the vacuum pump on Post-Accident Radiation Monitor RE 5030. The radiation monitor was removed from service.

This placed the unit in the Action Statement of Technical Specification 3.3.3.6, which requires that the monitor be repaired within 30 days. The Technical Specification requires the operability of both post-accident radiation monitors while the unit is in Modes 1, 2 or 3.

Designation of Apparent Cause of Occurrence: The apparent cause of the occurrence is attributed to component failure due to design error. A diaphragm inside the pump discharge solenoid valve was found to have cracked. It is believed that this failure was caused by high ambient temperatures inside the radiation monitor cabinet in excess of the maximum design operating temperature.

Analysis of Occurrence: There was no danger to the health and safety of the public or unit personnel. The other Post-Accident Radiation Monitor, RE 5029, was operable during the period that RE 5030 was inoperable.

Corrective Action: Under Maintenance Work Order 78-2178 and I&C Work Order 78-536, a new diaphragm was installed in the solenoid valve. After completion of Surveillance Test ST 5032.01, "Monthly Functional Test of the Radiation Monitoring System", at 1805 hours on September 18, RE 5030 was declared operable. The unit was then removed from the Action Statement of Technical Specification 3.3.3.6.

Facility Change Request 78-299, which requested the installation of a cooling system for RE 5029 and RE 5030, was prepared on June 21, 1978.

Failure Data: This is a repetitive occurrence. Previous failures of post-accident radiation monitors due to high ambient temperatures have been reported in Licensee Event Reports NP-33-78-30, NP-33-78-77, NP-33-78-105, and NP-33-78-111.