

CONTROL BLOCK:

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 ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
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0	9		B	B	(11)	E	(12)	G	(13)	I	N	S	T	R	U	(14)	X	(15)	Z	(16)
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EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
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17 REPORT NUMBER 8 2 31 4 9 27 28 29 30 31 32

[illegible]

33 34 35 36 37 40 41 42 43 44

10 After the second occurrence, it was discovered that the micro-processor software was

_____ the problem. A new set of software was programmed by Kaman Sciences Corporation

... of the new software, a faulty flow control valve

1	2	
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1 3 actuator was discovered. A new actuator was installed.

1 a ST 5032.01 was run, and the monitor was declared operable at 1955 hours on 7/27/57.

FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
				Operator discovery

7 8 9 10 12 13 44 45 46 80

RELEASED OF RELEASE				AMOUNT OF ACTIVITY		LOCATION OF RELEASE	
1	6	7	23	7	24	NA	NA

7 8 9 10 11 44 45

PERSONNEL EXPOSURES

(22)

1	7	Ø	Ø	Ø	(37)	Z	(38)	NA
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PERSONNEL INJURIES	
NUMBER	DESCRIPTION (41)
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TYPE	DESCRIPTION
3	NA

7 8 9 10 PUBLICITY 8210280078 821019 NRC USE ONLY

[illegible]

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-58

DATE OF EVENT: September 20 and 22, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Containment Post Accident Radiation Monitor, RE 4597BA, Channels 2 (Particulate) and 3 (Iodine) failed to respond correctly

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2437 and Load (Gross MWE) = 800.

Description of Occurrence: At 2030 hours on September 20, 1982, the Control Room operator noticed that Channels 2 and 3 on RE 4597BA (Containment Post Accident Radiation Monitor) were reading much higher than the redundant monitors channels on RE 4597AA. Upon closer investigation, it was discovered that the readings would go from high to normal to zero intermittently. The monitor was declared inoperable, and the station entered Technical Specification 3.3.3.6, Action (a). No reduction of power was required. I&C personnel reset and reprogrammed the micro-processor and checked the operation. Everything responded correctly. Operations personnel ran Surveillance Test ST 5032.01 and declared the unit operational at 1800 hours on September 21, 1982. At 0150 hours on September 22, 1982, the unit again failed to respond correctly (identical problem), and it was again declared inoperable. The station again entered Technical Specification 3.3.3.6, Action (a).

Designation of Apparent Cause of Occurrence: Upon investigation by I&C personnel, it was discovered that the micro-processor software was the problem. On the first occurrence, the reprogramming was successful. On the second occurrence, a new set of software was programmed by Kaman Sciences Corporation and installed. A factory representative was also sent to site. During checkout of the new software, a faulty flow control valve actuator was also discovered. A new actuator was installed, calibrated, and tested. The new software was tested, and the monitor was released to Operations by the I&C personnel.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The redundant system (RE 4597AA) was operable as were all six containment area radiation detectors.

Corrective Action: On the first occurrence, the reprogramming of the micro-processor was successful. On the second occurrence, the replacement of the software and the new flow control valve actuator corrected the problems with the operation of the monitor. Operations ran Surveillance Test ST 5032.01 at 1555 hours on September 29, 1982 and declared the monitor operational. This removed the station from Action (a) of Technical Specification 3.3.3.6.

Failure Data: There have been no previous similar occurrences.