

LICENSEE EVENT REPORT

CONTROL BLOCK:

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CONT

REPORT SOURCE

DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

2 (NP-33-81-75) On 10/12/81 and 10/13/81, the pump for RE 5029, the Post-Accident Con-

3 tainment Radiation Monitor was found not running. On 10/13/81 the pump for RE 5030

4 was also found off. These occurrences are being reported per Technical Specification

5 3.3.3.6, Table 3.3-10. There was no danger to the health and safety of the public or

6 station personnel. A redundant system was always operable. In addition, there was no

7 buildup of activity in containment during this time and no release into the en-

8 vironment.

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SYSTEM CODE										CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE					COMP. SUBCODE		VALVE SUBCODE		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.		ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER																																																		
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CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS	
1 0	The cause was component failure. The flow was discovered to be at approximately 3
1 1	scfm which is the trip point for low flow. Flow through these monitors tends to de-
1 2	crease due to pump vane wear and vibration of the flow control valves. The pumps were
1 3	immediately restarted and flow increased to 4.5 to 5.0 scfm. A step was added to
1 4	Maintenance Work Order LC-MWO-4W2 to check and set flows weekly.

7 8 9
FACILITY STATUS (1) 5 (E) (28) % POWER (1) 0 0 (29) OTHER STATUS (30) NA METHOD OF DISCOVERY (A) (31) Operator Observation DISCOVERY DESCRIPTION (32)

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)

1 6 Z 33 Z 34 NA 44

LOCATION OF RELEASE (36)

NA 45 8

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0 0 0	(37) Z	(38) NA					

						PERSONNEL INJURIES		
						NUMBER	DESCRIPTION	(41)
1	R					(40)	NA	

7	8	9	11	12
LOSS OF OR DAMAGE TO FACILITY (43)				
TYPE		DESCRIPTION		
1	9	Z (42)	NA	

7 8 9 10
PUBLICITY
ISSUED DESCRIPTION (45)
2 0 N (44) NA
8111190542 811109
PDR ADOCK 05000346
S PDR
NRC USE ONLY

OVERs 81-165, 167 and 168
NAME OF PREPARER David T. Eldred PHONE: (419) 259-5000, Ext. 2

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-75

DATE OF EVENT: October 12 and 13, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Pump for Post-Accident Containment Radiation Monitor RE 5029 was found to be off on October 12, 1981 and October 13, 1981. Pump for Post-Accident Containment Radiation Monitor RE 5030 was found off on October 13, 1981.

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2772 and Load (Gross MWE) = 915.

Description of Occurrence: On October 12, 1981 while the operator was checking the Victoreen panel, it was discovered that the pump for RE 5029 was not running. The operator restarted the pump. Further checking showed the computer alarm for low flow had come in at 0812 hours, showing that the pump had tripped on low flow.

On October 13, 1981, RE 5030 pump was found off at 1700 hours. The pump was restarted. At 1830 hours on the same date, the RE 5029 pump was again discovered to be tripped. The pump was restarted.

These occurrences are being reported under Technical Specification 3.3.3.6, Table 3.3-10 which requires that two post-accident containment radiation monitors be operable at all times.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was due to component failure. The flow was discovered to be at approximately 3 scfm which is the trip point for low flow. Flow tends to be reduced through a radiation monitor with time. This can be attributed to pump vane wear and vibration of the flow control valves.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. A redundant system was always operable. There was no buildup of activity in containment during the time frame and no release into the environment.

Corrective Action: Flow was increased to 4.5 and 5 scfm and no further pump trips were experienced. A step was added to Maintenance Work Order IC-MWO-4W2 to check and set flows weekly until the REs are replaced with a new design narrow and wide range containment radiation monitoring system under Facility Change Request 80-050.

Failure Data: No previous occurrences of this type have been reported.