

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 2 9 O H D B S 1 4 2 15 - 25 3 26 4 1 1 1 1 1 4 57 CAT 58 5

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T

0 1 7 3 L 6 61 5 68 3 4 6 7 69 0 3 1 2 8 2 74 8 75 0 4 0 8' 8 2 80

REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(NP-33-82-18) On March 12, 1982 at 1235 hours, the Shift Supervisor realized that he had not instructed the Control Room operators to start the Control Room ventilation in the recirculation mode during the routine maintenance performed on chlorine detector AE5358A. The work made the detector inoperable, and Technical Specification 3.3.3.7 action statement (a) should have been completed. There was no danger to the health and safety of the public or station personnel. The other normal ventilation detector was operable.

0 9		SYSTEM CODE S G		11	CAUSE CODE A		12	CAUSE SUBCODE A		13	COMPONENT CODE Z Z Z Z Z Z					14	COMP. SUBCODE Z		15	VALVE SUBCODE Z		16												
7	8	9	10		11		12		13					18		19		20																
17		LER RO REPORT NUMBER		EVENT YEAR 8 2		21	22	SEQUENTIAL REPORT NO. 0 1 5		24	25	26	OCCURRENCE CODE 0 3		28	29	REPORT TYPE L		30	REVISION NO. 0		32												
ACTION TAKEN H		FUTURE ACTION Z		18	19	EFFECT ON PLANT Z		20	SHUTDOWN METHOD Z		21	HOURS 0 0 0 0		22	ATTACHMENT SUBMITTED Y		23	NPRD-4 FORM SUB. N		24	PRIME COMP. SUPPLIER Z		25	COMPONENT MANUFACTURER Z 9 9 9		26								
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was operator error by the Shift Supervisor. It had been a standard practice  
1 1 that during this maintenance the detector would be considered inoperable, and the  
1 2 action to be taken within one hour be started immediately. This was in case the work  
1 3 took longer than one hour. The Shift Supervisor has been counseled about the require-  
1 4 ments.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
1	5	E	28	0	6	8	29	NA	A	31	Shift Supervisor observation
7	8	9	10	11	12	13	14	44	45	46	80
ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE					
1	6	Z	33	Z	34	NA	NA				
7	8	9	10	11	12	13	14	44	45	80	
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION					
1	7	0	0	0	37	Z	38	NA			
7	8	9	10	11	12	13	14	80			
PERSONNEL INJURIES		NUMBER		DESCRIPTION							
1	8	0	0	0	40	NA					
7	8	9	10	11	12	13	14	80			
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION							
1	9	Z	42	NA							
7	8	9	10	11	12	13	14	80			
PUBLICITY ISSUED		DESCRIPTION		PDR		NRC USE ONLY					
2	0	N	44	NA	8204200267 820408	346					
7	8	9	10	11	12	13	14	68	69	80	

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-18

DATE OF EVENT: March 12, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: The Control Room ventilation recirculation mode had not been established as required with an inoperable Control Room chlorine detector

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 1885 and Load (Gross MWE) = 610

Description of Occurrence: Optimum operation of the Control Room ventilation chlorine detectors has been dependent on vendor recommended routine maintenance. Prior to starting, Maintenance personnel contacted the Shift Supervisor, obtained his permission, and as dictated by their maintenance procedure, jumpered out the detector in preparation for removal, inspection, and repair. This rendered the detector inoperable. The maintenance activity required more than one hour to complete, but the Control Room ventilation was never started in the recirculation mode as required by Technical Specification 3.3.3.7(a) in order to insure that a single failure from that point will not prevent Control Room isolation and cooling.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was operator error. Though he was aware that the maintenance would render the chlorine detector inoperable, the Shift Supervisor failed to inform the Control Room operators that the maintenance was intended and that Control Room ventilation recirculation was pending. When the maintenance was completed, the Shift Supervisor realized that more than one hour had lapsed since the maintenance began and the technical specification required Control Room ventilation recirculation mode had not been established. This placed the unit in the action statement of Technical Specification 3.3.3.7(a).

Administrative controls (Enclosure 13) attached to the maintenance procedure ensured that operability had been restored upon completion of the maintenance activity, therefore satisfying the requirements of the action statement. Operability had already been restored when the Shift Supervisor realized this infraction had occurred.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. During the time the station was in the action statement, the redundant technical specification Control Room chlorine detector had been operable as well as the non-technical specification chlorine detectors near the chlorine bulk storage and in the chlorine use area. It is expected that, had a chlorine leak occurred, proper precautions would have been taken.

Corrective Action: The responsible individual has been counseled, reaffirming the requirements, and the methods used in completing the routine maintenance have been reviewed and determined as valid.

Failure Data: There have been no previous similar reportable occurrences.

LER #82-015