NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1	O H D B S 1 (2)	Ø Ø - Ø Ø N P F - Ø 3 (3)	4 1 1 1 1 (4)	(5)
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT

CON'T 0 1 REPORT SOURCE L (6) Ø 5 Ø - Ø 3 4 6 (7) DOCKET NUMBER Ø 5 1 7 7 9 (8) EVENT DATE Ø 6 1 3 7 9 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On May 17, 1979, a hole was discovered through a fire barrier floor which had not been
0 3 sealed. Technical Specification 3.7.10 requires all penetration fire barriers to be
0 4 functional at all times. The hole was through the floor of essential low voltage
0 5 switchgear room 428. Conduit filled most of the hole, but the gap between the hole
0 6 and the conduit had not been sealed. There was no danger to the health and safety of
0 7 the public or station personnel. The gap was no wider than 3/8 inch, and there were
0 8 no combustible materials in the immediate area. (NP-33-79-61)

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	A B (11)	D (12)	Z (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 9	—	Ø 5 9	/	Ø 3	L	—	Ø

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	H (19)	Z (20)	Z (21)	Ø Ø Ø Ø	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Station personnel did not complete a survey of all previously completed work items
1 1 since this hole was drilled on 10/2/78, and a similar occurrence was reported on
1 2 11/24/78. The gap was sealed within one hour of notification by QC personnel.
1 3 ST 5016.11 is being conducted to verify no further such violations exist. A training
1 4 meeting was held with maintenance and construction supervisors.

1 5 FACILITY STATUS G (28) % POWER Ø Ø Ø (29) OTHER STATUS (30) NA METHOD OF DISCOVERY Z (31) DISCOVERY DESCRIPTION (32) NA

1 6 ACTIVITY RELEASED Z (33) CONTENT OF RELEASE Z (34) AMOUNT OF ACTIVITY (35) NA LOCATION OF RELEASE (36) NA

2353 301

1 7 PERSONNEL EXPOSURES NUMBER Ø Ø Ø (37) TYPE Z (38) DESCRIPTION (39) NA

1 8 PERSONNEL INJURIES NUMBER Ø Ø Ø (40) DESCRIPTION (41) NA

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

2 0 PUBLICITY ISSUED N (44) DESCRIPTION (45) NA

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NRC USE ONLY

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GPO 917-926

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-79-61

DATE OF EVENT: May 17, 1979

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure to fire block a core drill through a fire barrier

Conditions Prior to Occurrence: The unit was in Mode 5, with Power (MWT) = 0, and Load (Gross MWE) = 0.

Description of Occurrence: On May 17, 1979, it was discovered that during the implementation of Facility Change Request (FCR) 78-373, which was the installation of several new electrical system feeders, a core drill had been made through the floor of essential low voltage switchgear room 428. Technical Specifcation 3.7.10 requires all penetration fire barriers protecting safety related areas shall be functional at all times. The Action Statement requires that if a fire barrier is not functional, a continuous fire watch be established on at least one side of the affected penetration within one hour.

This penetration remained unblocked from approximately October 2, 1978 until May 17, 1979.

This report is being submitted in accordance with Technical Specification 6.9.1.9c.

Designation of Apparent Cause of Occurrence: The instructions for the implementation of FCR 78-373 did not identify the significance of a fire wall and also failed to state any requirements of the Technical Specification 3.7.10. When a previous similar occurrence was discovered (see Licensee Event Report NP-33-78-137), the Facility Change Request was modified to assure all subsequent work was performed in accordance with technical specifications. However, plant personnel did not complete a comprehensive survey of all previously completed work items to insure that the requirements were met.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The fire barrier affected only provides protection for one of two separate essential buses. The only open path was the gap between the conduit and the hole in the floor which was not wider than 3/8 inch. There were no combustible materials in the immediate area.

Corrective Action: Within one hour of notification from station Quality Control personnel, the penetration was blocked. Surveillance Test ST 5016.11 is being conducted to identify any further unblocked fire barrier penetrations. An information meeting was conducted with maintenance and construction supervisory personnel instructing them on fire barrier requirements and of the station procedures pertaining to the proper method of working on fire barriers.

Failure Data: There has been one previously reported similar occurrence, see Licensee Event Report NP-33-78-137.

LER #79-059