LICENSEE EVENT REPORT

CONTROL BLOCK |_|_|_|_|_|_| (1–6)

Line	Field	Value
01	LICENSEE NAME (9–14)	OHDBS1
01	LICENSE NUMBER (15–25)	Ø Ø - Ø Ø N P F - Ø 3
01	LICENSE TYPE (26–30)	4 1 1 1 1
01	EVENT TYPE (31–32)	Ø 3
01	CON'T CATEGORY (57–58)	
01	REPORT TYPE (59)	L
01	REPORT SOURCE (60)	L
01	DOCKET NUMBER (61–68)	Ø 5 Ø - Ø 3 4 6
01	EVENT DATE (69–74)	Ø 7 Ø 3 7 7
01	REPORT DATE (75–80)	Ø 7 2 8 7 7

EVENT DESCRIPTION

02 Containment Air Lock outer door would not latch to close. Inner airlock
03 door was kept closed and use of this personnel hatch was ceased until the
04 situation was rectified. This is not a repetitive occurrence.
05 (NP-33-77-18)
06

Line	SYSTEM CODE (9–10)	CAUSE CODE (11)	COMPONENT CODE (12–17)	PRIME COMPONENT SUPPLIER (43)	COMPONENT MANUFACTURER (44–47)	VIOLATION (48)
07	S D	B	P E N E T R	A	C 3 1 Ø	N

CAUSE DESCRIPTION

08 Defective fabrication was responsible for the door's failure to close.
09 A pin was not welded properly in the locking plate assembly, and was
10 subsequently rewelded by station maintenance personnel.

Line	FACILITY STATUS (9)	% POWER (10–12)	OTHER STATUS (13–44)	METHOD OF DISCOVERY (45)	DISCOVERY DESCRIPTION (46–80)
11	B	Ø Ø Ø	NA	A	NA

Line	FORM OF ACTIVITY RELEASED (9)	CONTENT OF RELEASE (10)	AMOUNT OF ACTIVITY (11–44)	LOCATION OF RELEASE (45–80)
12	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	NUMBER (9–11)	TYPE (12)	DESCRIPTION (13–80)
13	Ø Ø Ø	Z	NA

PERSONNEL INJURIES

Line	NUMBER (9–11)	DESCRIPTION (12–80)
14	Ø Ø Ø	NA

OFFSITE CONSEQUENCES

15 NA

LOSS OR DAMAGE TO FACILITY

Line	TYPE (9)	DESCRIPTION (10–80)
16	Z	NA

PUBLICITY

17 NA

ADDITIONAL FACTORS

18 NA

19

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TOLEDO EDISON COMPANY
DAVIS-BESSE UNIT ONE NUCLEAR POWER STATION
SUPPLEMENTAL INFORMATION FOR LER NP-33-77-18

DATE OF EVENT: July 3, 1977

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Failure of Containment Personnel Airlock outer door to latch.

Conditions Prior to Occurrence: The plant was in Mode 4 (Hot Shutdown) with Power (MWT) = 0 and Load (MWE) = 0.

Description of Occurrence: At 2300 hours on July 3, 1977, personnel inside Containment attempted to enter the personnel airlock. The inner door was closed, but the outer door would not latch and was not completely closed. The station was thus placed in the Action Statement of Technical Specification 3.6.1.3. Usage of the personnel air lock was immediately ceased, and admittance to and exit from Containment was via the emergency hatch only until both doors were demonstrated to be operable.

Designation of Apparent Cause of Occurrence: The cause of the event is attributed to fabrication error by the airlock door manufacturer, Chicago Bridge and Iron Company. A pin in the locking plate assembly was not welded properly. It was subsequently rewelded by station maintenance personnel.

Analysis of Occurrence: No danger to the health and safety of the public occurred since integrity of Containment was maintained and no radioactivity was released.

Corrective Action: The pin was rewelded and the airlock declared operable after passing the required Surveillance Test (ST 5061.05) at 1530 hours on July 5, 1977. This removed the station from the Action Statement of Technical Specification 3.6.1.3. Recurrence of a failure of the pin in the locking plate assembly is not expected since the pin is now properly welded.

Failure Data: No previous similar events have occurred.