(7.77) LICENSEE EVENT REPORT CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CON'T EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) (NP-33-80-92) On 10/8/80 at 0520 hours maintenance personnel discovered that the inner door of the containment personnel lock could not be latched. The door was declared inoperable, and the station entered the action statement of Technical Specification 0 4 3.6.1.3a. There was no danger to the healt's and safety of the public or station personnel. Unit personnel were able to use the emergency air lock while repairs were being conducted on the personnel lock. The other door of the personnel lock was operable. SYSTEM CAUSE COMP COMPONENT CODE SIDI N OCCURRENCE REVISION SEQUENTIAL REPORT REPORT NO CODE NO. 7 013 NUMBER PRIME COMP COMPONENT ATTACHMENT SUBMITTED NPRD-4 (22) HOURS 10 10 A (25) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause was two broken CAMROL cam follower bearings in the control linkage of the door operating mechanism. The numerous operations of the personnel lock mechanism during this outage, coupled with rough operation contributed to the failure. Under MWO 80-3370 the broken cam follower bearings were replaced. ST 5061.04 was successfully performed at 1610 hours on 10/10/80 and the personnel lock was declared operable; METHOD OF (30) OTHER STATUS DISCOVERY DESCRIPTION (32) % POWER A (31) Discovered during normal operation 80 ACTIVITY CONTENT AMOUNT OF ACTIVITY (35 LOCATION OF RELEASE (36) RELEASED\_OF RELEASE PERSONNEL EXPOSURES 80 DESCRIPTION (39) PERSONNEL INJURIES DESCRIPTION (41) MUMBER 0 0 (40) LOSS OF OR DAMAGE TO FACILITY DESCRIPTION Z (42) 8011110322 NRC USE ONLY DESCRIPTION (45) DVR 80-173 James Syslo 419-259-5000, Ext. 253 NAME OF PREPARER -PHONE .

## TOLEDO EDISON COMPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-80-92

DATE OF EVENT: October 8, 1980

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: The inner door of the containment personnel lock could not be latched.

Conditions Prior to Occurrence: The unit was in Mode 3 with Power (MWT) = 0 and Load (Gross MWE) = 0.

Description of Occurrence: On October 8, 1980 at 0520 hours, a problem was discovered during normal operation of the personnel lock for transport of maintenance personnel and equipment. The inner door of the containment personnel lock could not be latched. The door was declared inoperable, and the station entered the action statement of Technical Specification 3.6.1.3a. The technical specification requires the air lock to be operable in Modes 1, 2, 3, and 4. The action statement requires the airlock to be restored to operable status within 24 hours or be in at least hot standby within the next six hours and in cold shutdown within the following 30 hours.

Designation of Apparent Cause of Occurrence: The cause of this problem was two broken CAMROL cam follower bearings in the control linkage of the door operating mechanism. The cam follower bearings are the link between the door roller chain drive shaft and the door operating interlock mechanism. The numerous operations of the personnel lock door mechanism during the outage coupled with rough operation contributed to the failure. Rough operation would result in severe shocking of the cam follower bearings which could cause failures such as were found in this occurrence. Rough is being defined as operating the mechanism too fast.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. Unit personnel were able to use the emergency air lock while repairs were being conducted on the personnel lock. The other door of the personnel lock was operable.

Corrective Action: Under Maintenance Work Order 80-3370, the broken cam follower bearings were replaced and all the interlock mechanism cams were reset in their proper positions. ST 5061.05 was successfully performed at 1610 hours on October 10, 1980, and the personnel lock was declared operable.

Signs cautioning slow, careful operation of the personnel lock doors have been in place for more than a year and were still in place prior to this reported failure.

Failure Data: A previous similar occurrence was reported in Licensee Event Report NP-33-77-18.