NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01	LICENSEE CODE: O H D B S 1 (2)	LICENSE NUMBER: Ø Ø Ø Ø Ø Ø Ø Ø Ø Ø Ø (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT (5)

CON'T

01	REPORT SOURCE: L (6)	DOCKET NUMBER: Ø 5 Ø - Ø 3 4 6 (7)	EVENT DATE: Ø 1 2 2 8 1 (8)	REPORT DATE: / 2 2 Ø 8 1 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 (NP-33-81-06) On 1/22/81 at 0850 hours a station personnel reported that door 306
03 (fuel handling area, elevation 585) was partially open. With this door open, the
04 spent fuel pool emergency ventilation system would not have been able to maintain the
05 spent fuel pool area at a negative pressure of ≥ 1/8 inch water gauge. The action
06 statement of T.S. 3.9.1.2 prohibits fuel handling operations and movements of loads
07 over the pool without an operable system. These restrictions were not violated.
08 There was no danger to the health and safety of the public or station personnel.

09	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	S H (11)	E (12)	B (13)	X X X X X X (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	Ø Ø 7	/	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
E (18)	Z (19)	Z (20)	Z (21)	Ø Ø Ø Ø	Y (23)	N (24)	L (25)	[illegible] 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The door was immediately closed and latched. The cause of the finding was a door
11 closure which needed adjustment. It was not closing hard enough to latch the door.
12 Maintenance Work Order 81-1187-009 was issued the same day to check and adjust the
13 closure.
14

15	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	G (28)	Ø Ø Ø (29)		A (31)	noticed while walking through plant

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

PERSONNEL EXPOSURES

17	NUMBER	TYPE	DESCRIPTION (39)
	Ø Ø Ø (37)	Z (38)	NA

PERSONNEL INJURIES

18	NUMBER	DESCRIPTION (41)
	Ø Ø Ø (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

19	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

20	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

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DVR 81-010 NAME OF PREPARER Jan Stotz PHONE (419) 259-5000, Ext. 225

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-06

DATE OF EVENT: January 22, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Spent Fuel Pool Emergency Ventilation System inoperable due to unlatched door 306

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

Description of Occurrence: On January 22, 1981 at 0850 hours, an Instrument and Controls mechanic reported that door 306 (fuel handling area, elevation 585') was not latched. The door closing device did not fully close the door. Since the door opens into the area that the spent fuel pool emergency ventilation system draws from, the door would be pulled further open when the system started. With the door open, the system would not be able to maintain the storage pool area at a negative pressure of $\geq$ 1/8 inches water gauge relative to the outside atmosphere. Technical Specification 3.9.1.2 requires two independent emergency ventilation systems servicing the storage pool area to be operable whenever irradiated fuel is in the pool. The action statement prohibits the movement of fuel and crane operation with loads over the storage pool until at least one system is restored to operable status. These restrictions were not violated.

Designation of Apparent Cause of Occurrence: The cause of the occurrence was a door closing device which needed adjustment. When the door was pulled shut by the person that found it ajar, it did latch and remain closed. Apparently, the door had been opened and then allowed to close itself but the closing device did not latch the door.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. There were not any fuel movements or crane operations with loads over the pool during this time. Had the spent fuel pool emergency ventilation system been needed, it could have been started and would have created a negative pressure in the area even though it would not have been able to reach the $\geq$ 1/8 water gauge negative pressure.

Corrective Action: The door was immediately closed and latched. Maintenance Work Order 81-1187-009 was issued the same day to adjust the door closing device. The door closures will be included on a preventive maintenance program.

Failure Data: There have been no previous incidents caused by a door closure needing adjustment. Previous reports of doors being blocked open were reported in Licensee Event Reports NP-33-80-56 (80-047) and NP-33-80-79 (80-066).

LER #81-007