



EDISON PLAZA
300 MADISON AVENUE
TOLEDO, OHIO 43652-0001

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Gentlemen:

LER 83-039, Revision 2
Davis-Besse Nuclear Power Station, Unit No. 1
Date of Occurrence - July 26, 1983

Enclosed please find revision 2 to Licensee Event Report 83-039. This revision eliminated FCR 85-0178 as an intended corrective action. The revisions are indicated by a revision bar in the left-hand margin. Please discard or mark superseded any previous copies of this LER.

Yours truly,

Louis F. Storz
Plant Manager
Davis-Besse Nuclear Power Station

LFS/plf

Enclosure

cc: Mr. A. Bert Davis
Regional Administrator
USNRC Region III

Mr. Paul Byron
DB-1 NRC Sr. Resident Inspector

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION, UNIT NO. 1
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-45, REVISION 2

DATE OF EVENT: July 26, 1983

FACILITY: Davis-Besse, Unit No. 1

IDENTIFICATION OF OCCURRENCE: The Unit was in Mode 3, with Power (MWt) = 0 and Load (Gross MWe) = 0

Conditions Prior to Occurrence: At 0710 hours on July 26, 1983, two personnel were exiting the containment building by way of the personnel hatch. While in the tunnel, it was found that the hand wheel for the inner door was all the way in the shut position while the inner door was still partially open. The outer door would open and both personnel exited the personnel hatch tunnel and reshut the outer door. The Shift Supervisor declared the personnel hatch inoperable, and the Unit entered the action statement of Technical Specification 3.6.1.3.

Designation of Apparent Cause of Occurrence: The cause was excessive use which caused wear of the roller cam bearings. With this wear, the door can rebound open while the latching mechanism continues to close. In late May 1983, the personnel hatch manufacturer, Chicago Bridge and Iron, advised Toledo Edison that this is a potential malfunction for their air locks fabricated and installed between 1964 and 1973. During the 1984 Refueling Outage, the vendor representative inspected the lock and suggested modifications to strengthen areas to reduce wear on the bearings.

Analysis of Occurrence:

There was no danger to the health and safety of the public or station personnel. The plant was in Mode 3 in the process of shutting down for the 1983 Refueling Outage. The outer door was verified shut with the exception of the exiting of the two personnel involved.

Corrective Action:

Under MWO 83-4009, the personnel lock was repaired and returned to operable status. A more indepth preventive maintenance program (PM-0745) has been implemented.

During the 1984 Refueling Outage, some suggested refurbishments by Chicago Bridge and Iron (CB&I) were implemented under MWO 1-84-2947-01. Additional modifications were considered for implementation during subsequent outages. However, due to the very successful use of temporary doors in the personnel hatch during outages, wear and tear on the permanent doors has been significantly reduced. Therefore, no additional modifications will be made.

Failure Date: Previous similar occurrences involving containment personnel air lock door failing to latch were reported in Licensee Event Reports NP-33-77-18 (77-018), NP-33-80-92 (80-073), and NP-33-81-80 (81-167).

LER No. 83-039