

LICENSEE EVENT REPORT

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---------------|---|---|---|---|----|----|----------------|---|---|---|---|---|---|---|---|---|----|----|--------------|---|---|---|----|----|--------|--|----|
| 0 | 1 | 0 | H | D | B | S | 1 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5 | | | |
| 7 | 8 | 9 | LICENSEE CODE | | | | | 14 | 15 | LICENSE NUMBER | | | | | | | | | | 25 | 26 | LICENSE TYPE | | | | 30 | 57 | CAT 58 | | 80 |

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| 0 | 1 | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 4 | 6 | 7 | 1 | 0 | 2 | 1 | 8 | 2 | 8 | 1 | 1 | 1 | 9 | 8 | 2 | 9 |
| 7 | 8 | REPORT SOURCE | | 60 | 61 | DOCKET NUMBER | | | | | | 68 | 69 | EVENT DATE | | | | 74 | 75 | REPORT DATE | | | | 80 | | |

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | (NP-33-82-65) On 10/21/82, I&C personnel performed a routine flush on RE-1878 A&B.

0 3 | This procedure involved running an air hose through Door 107 to the REs which was veri-

0 4 | fied to be fully closed by the I&C personnel before leaving the area at 1015 hours.

0 5 | At 1030 hours, an operator found the door partially open and blocked by the hose. This

0 6 | placed the unit in the action statement of T.S. 3.6.5.2. There was no danger. With

0 7 | the door open, the effectiveness of the Emergency Ventilation System is reduced, how-

0 8 | ever, a negative pressure would still be created.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 0 | 9 | A | A | 11 | A | 12 | X | 13 | Z | Z | Z | Z | Z | Z | 14 | Z | 15 | Z | 16 | 17 | 8 | 2 | 18 | 0 | 5 | 4 | 19 | 0 | 3 | 20 | 0 | 21 | Z | 22 | 0 | 0 | 0 | 0 | 23 | Y | 24 | N | 25 | Z | 26 | 9 | 9 | 9 | 9 | 27 | |
| 7 | 8 | SYSTEM CODE | | 9 | 10 | CAUSE CODE | 11 | CAUSE SUBCODE | 12 | COMPONENT CODE | | | | | 13 | 18 | COMP. SUBCODE | 19 | VALVE SUBCODE | 20 | LER RO REPORT NUMBER | 21 | EVENT YEAR | 22 | SEQUENTIAL REPORT NO. | 23 | OCCURRENCE CODE | 24 | REPORT TYPE | 25 | REVISION NO. | 32 | ACTION TAKEN | 33 | FUTURE ACTION | 34 | EFFECT ON PLANT | 35 | SHUTDOWN METHOD | 36 | HOURS | 37 | ATTACHMENT SUBMITTED | 40 | NPRD-4 FORM SUB. | 42 | PRIME COMP. SUPPLIER | 43 | COMPONENT MANUFACTURER | 44 | 47 |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause is personnel error in that whoever went through the door did not verify that

1 1 | the door mechanism fully closed the door. The I&C personnel involved were counseled on

1 2 | maintaining a continuous watch when a hose is run through a door. An available empty

1 3 | pipe penetration above the door will be used for any subsequent flushes.

| | | | | | | | | | | | | | | | | | | |
|---|---|-----------------|----|---|---------|---|----|----|--------------|----|---------------------|-------------------------------------|----|----|-----------------------|--|----|----|
| 1 | 5 | E | 28 | 0 | 8 | 6 | 29 | NA | 30 | A | 31 | Found by Primary Equipment Operator | 32 | | | | | |
| 7 | 8 | FACILITY STATUS | | 9 | % POWER | | 10 | 12 | OTHER STATUS | 13 | METHOD OF DISCOVERY | | 44 | 45 | DISCOVERY DESCRIPTION | | 46 | 80 |

| | | | | | | | | | | | | | | |
|---|---|--------------------------------------|----|---|----|--------------------|----|----|----|----|---------------------|--|----|----|
| 1 | 6 | Z | 33 | Z | 34 | NA | 35 | NA | 36 | | | | | |
| 7 | 8 | ACTIVITY CONTENT RELEASED OF RELEASE | | 9 | 10 | AMOUNT OF ACTIVITY | | 11 | 44 | 45 | LOCATION OF RELEASE | | 36 | 80 |

| | | | | | | | | | | | |
|---|---|----------------------------|---|---|----|------|----|-------------|----|----|----|
| 1 | 7 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39 | | |
| 7 | 8 | PERSONNEL EXPOSURES NUMBER | | 9 | 11 | TYPE | 12 | DESCRIPTION | | 13 | 80 |

| | | | | | | | | | | |
|---|---|---------------------------|---|---|----|-------------|----|----|----|----|
| 1 | 8 | 0 | 0 | 0 | 40 | NA | 41 | | | |
| 7 | 8 | PERSONNEL INJURIES NUMBER | | 9 | 11 | DESCRIPTION | | 12 | 41 | 80 |

| | | | | | | | | | | | | |
|---|---|------------------------------------|----|----|----|-------------|--------|-----|-------|----------|---|-----|
| 1 | 9 | Z | 42 | NA | 43 | 8211290385 | 821119 | PDR | ADOCK | 05000346 | S | PDR |
| 7 | 8 | LOSS OF OR DAMAGE TO FACILITY TYPE | | 9 | 10 | DESCRIPTION | | 11 | 43 | 80 | | |

| | | | | | | | | | | |
|---|---|------------------------------|----|----|----|--------------|--|----|----|----|
| 2 | 0 | N | 44 | NA | 45 | | | | | |
| 7 | 8 | PUBLICITY ISSUED DESCRIPTION | | 9 | 10 | NRC USE ONLY | | 58 | 69 | 80 |

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-65

DATE OF EVENT: October 21, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Negative Pressure Boundary Door 107 not fully closed

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWT) = 2380 and Load (Gross MWE) = 800.

Description of Occurrence: On October 21, 1982, Instrument and Control (I&C) personnel were in the process of performing a routine flush on RE-1878 A&B. This procedure involved running an air hose to the RES through Door 107, the access door from the No. 2 Emergency Core Cooling System (ECCS) Pump Room (Room 115) to the Miscellaneous Waste Monitor Tank Room (Room 114). As this operation takes a couple of hours to complete, the test personnel verified Door 107 was closed and not blocked by the hose and left the area about 1015 hours to work another job. At about 1030 hours, the Primary Equipment Operator found Door 107 partially open and blocked by the hose. This placed the unit in the Action Statement of Technical Specification 3.6.5.2, which requires Door 107 to be closed in order to maintain shield building integrity. The door was immediately closed, thus removing the unit from the Action Statement. The person or persons using Door 107 after the I&C people left the area, and exactly how the hose was moved to hinder door closure, could not be identified.

Designation of Apparent Cause of Occurrence: The cause of this occurrence is personnel error in that whoever went through the door did not verify that the door mechanism fully closed the door.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. With the door slightly open, the effectiveness of the Emergency Ventilation System is reduced, however, a negative pressure would still be created.

Corrective Action: When informed the door was opened, the I&C personnel immediately returned to the area to continually monitor the door. The I&C Maintenance Supervisor and I&C Foreman inspected the test rig and verified that Door 107 would fully close on its own with the hose in place under the corner of the door. All personnel involved were counseled by the Maintenance Engineer that just verifying the door closed is insufficient and that when any hose is run through a door, a continual watch is required on the door. Approval was obtained from Facility Engineering to temporarily utilize an available empty capped pipe in the penetration above the door for future flushes to prevent recurrence of the flush hose blocking this door. In addition, Facility Change Request 79-308 has been initiated to replace this detector with snowplow type which will not require flushing.

The root cause of this event is that some people fail to verify that each door they pass through does in fact completely close on its own.

The Station has initiated the following preventive actions to minimize recurrence. General Orientation Training has been upgraded, special memos have been published, specific indoctrination has been given to all work groups, personnel have been disciplined when they have been specifically identified as being responsible, and heavier duty door closures have been installed throughout the plant. A preventive maintenance program to check door closures has been instituted. The Station continues to investigate this problem and will be initiating further corrective actions.

Failure Data: Seven previous occurrences have been reported involving the loss of shield building integrity due to an open door; however, only three of these occurrences, NP-33-82-05 (82-004), NP-33-82-11 (82-009), and NP-33-82-17 (82-016) have been reported within the previous year.

LER #82-054