

# LICENSEE EVENT REPORT

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

0 1 | O | H | D | B | S | 1 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 1 | 4 | 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35  
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

0 1 | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 4 | 6 | 7 | 0 | 9 | 2 | 5 | 8 | 1 | 8 | 1 | 1 | 0 | 6 | 8 | 1 | 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35  
CON'T REPORT SOURCE DOCKET NUMBER OR EVENT DATE REPORT DATE

0 2 | EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)  
0 3 | (NP-33-81-67) On 9/25/81, the Resident NRC Inspector found door 108 (detergent waste  
0 4 | drain tank and pump room) open. This is a negative pressure boundary door and is re-  
0 5 | quired to be closed. The door was again found open on 10/1/81 by the Shift Supervisor,  
0 6 | Technical Specification 3.6.5.2 requires that all shield building integrity isolations  
0 7 | be closed at all times except for normal passage. There was no danger to the health  
0 8 | and safety of the public or station personnel.

0 9 | SYSTEM CODE: A A (11) CAUSE CODE: E (12) CAUSE SUBCODE: B (13) COMPONENT CODE: X X X X X X (14) COMP. SUBCODE: Z (15) VALVE SUBCODE: Z (16)  
17 | LER NO REPORT NUMBER: 8 1 (17) SEQUENTIAL EVENT NO.: 0 5 5 (18) OCCURRENCE CODE: 0 3 (19) REPORT TYPE: L (20) REVISION NO.: 1 (21)  
ACTION TAKEN: H (22) FUTURE ACTION: Z (23) EFFECT ON PLANT: Z (24) SHUTDOWN METHOD: Z (25) HOURS: 0 0 0 0 (26) ATTACHMENT SUBMITTED: Y (27) NPR-4 FORM SUB.: N (28) PRIME COMP. SUPPLIER: Z (29) COMPONENT MANUFACTURER: Z 9 9 9 (30)

1 0 | CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)  
1 1 | Due to door latching mechanism failures, personnel believed there was a chance of being  
1 2 | locked in the room. The lower door handle was broken at the time of these occurrences  
1 3 | making is possible to lock someone in the room. A memo was issued to station super-  
1 4 | vision to review with all personnel the station requirements on negative pressure  
1 5 | boundary doors. FCR 81-265 was issued to correct the door latch mechanism failures.

1 5 | FACILITY STATUS: E (28) % POWER: 0 9 9 (29) OTHER STATUS: NA (30) METHOD OF DISCOVERY: D (31) DISCOVERY DESCRIPTION: NRC Resident Inspector observation (32)

1 6 | ACTIVITY CONTENT RELEASED OF RELEASE: Z (33) Z (34) AMOUNT OF ACTIVITY: NA (35) LOCATION OF RELEASE: NA (36)

1 7 | PERSONNEL EXPOSURES NUMBER: 0 0 0 (37) TYPE: Z (38) DESCRIPTION: NA (39)

1 8 | PERSONNEL INJURIES NUMBER: 0 0 0 (40) DESCRIPTION: NA (41)

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE: Z (42) DESCRIPTION: NA (43)

2 0 | PUBLICATION ISSUED DESCRIPTION: N (44) NA (45) NRC USE ONLY: \_\_\_\_\_ (68-69)

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DVR 81-142 & 149 NAME OF PREPARER: Kevin Melstad PHONE: (419) 259-5000, Ext. 250

TOLEDO EDISON COMPANY  
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE  
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-67

DATE OF EVENT: September 25, 1981, and October 1, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Negative pressure door 108 was left open

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2772 and Load (Gross MWE) = 910.

Description of Occurrence: At 1600 hours on September 25, 1981, the Resident NRC Inspector, while performing a plant tour, found door 108 (detergent waste drain tank and pump room ) open. This is a negative pressure boundary door and is required to be closed.

The door was immediately shut per Technical Specification 3.6.5.2 which requires all shield building integrity isolations to be closed except for normal passage.

This door was again found open on October 1, 1981, at 1230 hours by the Shift Supervisor who immediately had the door closed.

Designation of Apparent Cause of Occurrence: The cause of the occurrence was due to component failure. Some station and construction personnel have felt that the closing of this door is a safety problem as the door latching mechanism handles have broken off in the past preventing exiting from the room. The lower door handle was broken at the time of this occurrence making it possible to lock someone in the room. There is a Gaitronics unit inside the room so that if this occurs, the person may call for assistance. The door was not blocked open and would have been pulled closed by pressure differential in the event of emergency ventilation system actuation.

Analysis of Occurrence: There was no danger to the health and safety of the public or to Station personnel. There was no cause for the emergency ventilation system to operate in the emergency core cooling system rooms.

Corrective Action: A memo to Station supervision was issued by the Station Superintendent to review with the persons working under them the necessity for following the Station requirements on negative pressure boundary doors. Facility Change Request 81-265 was issued to correct problems with the latch mechanism dog failures. The lower broken handle was removed on October 2, 1981, to prevent anyone from being trapped and will be repaired as soon as the parts are received. The upper latching mechanism was operable allowing the integrity of the negative pressure boundary to be maintained.

Failure Data: A similar finding was reported in Licensee Event Report NP-33-80-79 (80-006) in which nine occurrences of negative pressure boundary doors being left open were identified. There were no previous occurrences of negative pressure boundary doors being left open due to perceived safety problems.

LER #81-055