NRC FORM 366 (7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (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 (3) | 4 1 1 1 1 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 3 4 6 (7) | 1 0 1 1 8 1 (8) | 1 1 1 0 8 1 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-81-74) On 10/11/81 at 1100 hours, it was determined that an hourly fire watch
0 3 had been missed for three hours in the steam line area of the A/C equipment room ves-
0 4 tibule, Elevation 643'. The hourly watch was established at 0100 hours when panel
0 5 C6713 alarmed. The action statement of Technical Specification 3.3.3.8 requires an
0 6 hourly fire watch be established when a required fire detector is inoperable. There
0 7 was no danger to the health and safety of the public or station personnel. The
0 8 operation of the plant was not affected.

0 9

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
A B (11)	A (12)	X (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 1	—	0 6 5	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	H (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was a personnel error during the turnover period between shifts. The shift
1 1 going off duty did not properly inform the shift coming on of the fire watch on panel
1 2 C6713. The fire watch was re-established at 1100 hours and continued until the alarm
1 3 was cleared at 1300 hours. A memo was sent to the responsible personnel reinforcing
1 4 proper turnover of fire watches.

1 5 | FACILITY STATUS: E (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Fire watch log review

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

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

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

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

PUBLICITY
2 0 | ISSUED: N (44) | DESCRIPTION (45): NA

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NRC USE ONLY

DVR 81-163

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TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-74

DATE OF EVENT: October 10, 1981

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Alarms on Panel C6713 located on Elevation 643' A/C equipment room vestibule resulted in the establishment of a fire watch patrol

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2758 and Load (Gross MWE) = 916.

Description of Occurrence: Fire Detection Panel C6713 was in alarm due to fire detection zones in the steam line area being actuated by steam. A fire watch patrol was established at 0100 hours. The fire watch was continued with no interruptions until 0700 hours. Shift turnover occurred approximately between 0700-0800 hours. During this period of transition between shifts, the fire watch was not turned over properly between personnel. This situation resulted in a discontinuation of fire watches between 0800-1000 hours. At 1100 hours, the fire watch was properly continued until 1300 hours when the alarms cleared from the panel. Surveillance Requirement 4.3.3.8 was exceeded during the occurrence.

Designation of Apparent Cause of Occurrence: The event occurred due to personnel error during the turnover period between shifts. The shift coming off duty did not properly inform the shift coming on duty of the fire watch on panel C6713.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The event did not affect the operation of the plant, and there was no degradation to the fire protection detection system.

Corrective Action: The fire watch was continued properly at 1100 hours until 1300 hours when the alarms cleared from the fire detection zones. A memo referring to this incident was sent to the responsible personnel for the fire watches to reinforce the importance of proper fire watch turnover. The memo should alleviate such problems in the future.

Failure Data: LER NP-33-79-134 (79-115): The Contact Logging System went down and a fire watch was established on all affected zones. Designated personnel were doing a surveillance test on the diesel fire pump and the watch. The log sheet at the time did not specify the surveillance requirements and an hourly fire watch was not performed.

LER #81-065