(7-77)	LICENSEE EVENT REPORT
1	CONTROL BLOCK
	O H D B S 1 0 0 0 - 0 0 0 - 0 0 3 4 1 1 1 1 0 57 CAT 58 5
CON'T	REPORT L 6 0 5 0 0 3 4 6 7 0 3 1 1 8 2 8 0 4 0 8 8 2 9 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80
0 2	EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) (NP-33-82-16) On 3/11/82 at 1430 hours, an equipment operator found door 101A blocked
03	open by a temporary hose. At the time, contractor personnel were performing a flush
04	of a level instrumentation column. The personnel involved left the area without re-
0 5	moving the hose preventing it from closing completely. The door is a marked fire door.
0,6	An equipment operator was posted at the door until the hose was removed in order to
0 7	meet the requirements of T.S. 3.7.10. There was no danger to the public or station
08	personnel. There was no fire during the occurrence.
09	SYSTEM CAUSE CAUSE CAUSE COMPONENT CODE SUBCODE SUBCOD
	Image: Notice of the second
	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
10	CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) [The cause was due to a construction personnel error. The personnel involved ignored
1	the sign on the door and left the door blocked open. The station requirements for
12	fire and negative pressure doors had been presented to all contractor crafts on 3/5/82.
13	The contractor general foreman was given a written warning and the foreman in charge
14	of the work was issued a 30 day suspension from the Davis-Besse site.
7 8	9 PACILITY STATUS SPOWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32
	9 ACTIVITY CONTENT 3 44 45 46 46 80 80 80 80 80 80 80 8
1 6 7 8	IELEASE OF RELEASE AMOUNT OF ACTIVITY (3) 3 IZ 33 Z 34 NA PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)
1 7 7 8	9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
18	
1 9	9 11 12 LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION Z (42) NA
7 8	9 10 80 9 10 80 9 10 10 9 10 10 9 10 10 9 10 10 15SUED DESCRIPTION (45) 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 100 ck 05000 346 10 100 ck 05000 346 <td< th=""></td<>
7 8 DVR 82	9 10 (210) 259-5000 Ext 2859

TOLEDO EDISON COMPANY DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE SUPPLEMENTAL INFORMATION FOR LER NP-33-82-16

DATE OF EVENT: March 11, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Door 101A blocked open by a temporary hose

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 1911 and Load (Gross MWE) = 617.

Description of Occurrence: On March 11, 1982, at approximately 1430 hours an equipment operator found door 101A to the Maintenance Work Area (Room 109) blocked open by a temporary hose. At the time, contractor personnel were performing a flush of a level instrumentation column. This work required running the hose through door 101A. The personnel involved left the area to take a break, leaving the hose through the door, preventing it from closing completely. This door is a marked station fire door. An equipment operator was posted at the door until the hose was removed in order to meet the requirements of Technical Specification 3.7.10.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was due to a construction personnel error. The personnel involved ignored the sign on the door and left the door blocked open. The station requirements for fire doors and negative pressure doors had been presented to all contractor crafts on March 5, 1982 by the Maintenance Engineer.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. There was no fire during the duration of this occurrence.

<u>Corrective Action</u>: The contractor general foreman was given a written warning and the foreman in charge of the work was issued a 30 day suspension from the site in accordance with the station's standard work rules for contractor personnel.

Failure Data: A previous occurrence was reported in Licensee Event Report NP-33-81-92 (81-078).

LER #82-014