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	LICENSEE CODE	O H D B S 1 (2)
	LICENSE NUMBER	Ø Ø - Ø Ø Ø Ø Ø - Ø Ø (3)
	LICENSE TYPE	4 1 1 1 1 (4)
	CAT	(5)
CON'T 0 1	REPORT SOURCE	L (6)
	DOCKET NUMBER	Ø 5 Ø Ø Ø 3 4 6 (7)
	EVENT DATE	Ø 6 2 5 8 2 (8)
	REPORT DATE	Ø 8 Ø 5 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-82-35) On June 25, 1982 door 500 was found slightly open. On June 29, 1982,
0 3 door 302 was found partially open. Also, on July 6, 1982 door 426 was found slightly
0 4 open. These are both fire and negative pressure doors. The action statement limita-
0 5 tions of Tech Specs 3/4.9.12 and 3/4.7.10 were being met. There was no danger to
0 6 the health and safety of the public or to station personnel. The door could have
0 7 been closed had the system been needed.
0 8

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
S H (11)	B (12)	A (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 2	—	Ø 3 1	/	Ø 3	L	—	1

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was a design error. The exsiting closure mechanisms are unable to seat the
1 1 doors tightly when released from a nearly closed position. Maintenance work requests
1 2 82-1187-177 and 169 have been written to replace the closure mechanisms on doors 302
1 3 & 500 respectively, with a stronger style mechanism. Door 426 had its mechanism ad-
1 4 justed. All negative pressure door mechanisms will be replaced with this new style.

1 5	FACILITY STATUS: G (28)	% POWER: Ø Ø Ø (29)	OTHER STATUS (30): NA	METHOD OF DISCOVERY: A (31)	DISCOVERY DESCRIPTION (32): Found by operator.	
1 6	ACTIVITY RELEASED: Z (33)	CONTENT OF RELEASE: Z (34)	AMOUNT OF ACTIVITY (35): NA	LOCATION OF RELEASE (36): NA		
1 7	PERSONNEL EXPOSURES NUMBER: Ø Ø Ø (37)	TYPE: Z (38)	DESCRIPTION (39): NA			
1 8	PERSONNEL INJURIES NUMBER: Ø Ø Ø (40)	DESCRIPTION (41): NA				
1 9	LOSS OF OR DAMAGE TO FACILITY (43) TYPE: Z (42)	DESCRIPTION: NA				
2 0	PUBLICITY ISSUED: N (44)	DESCRIPTION (45): NA	NRC USE ONLY			

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PDR ADOCK 05000346
S PDR

DVR #82-075 NAME OF PREPARER Ron Wolfe PHONE: (419) 259-5000 ext. 299

GPO 917-926

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-35

DATE OF EVENT: June 25, June 29, and July 6, 1982

FACILITY: Davis-Besse Unit #1

IDENTIFICATION OF OCCURRENCE: Negative Pressure Doors 302 and 500 found slightly open. (The southwest stairway doors on the 585 and 623 level, respectively in the Auxiliary Building). Door 426 (entrance to No. 2 Electrical Penetration Room) found slightly open.

Conditions Prior to Occurrence: The unit was in Mode 5, with Power (MWT) = 0 and Load (Gross MWE) = 0.

Description of Occurrence: At 0600 hours on June 25, 1982, an operator making his rounds found door 500 not fully closed. In addition, on June 29, 1982 at 0650 hours, door 302 was found partially open. On July 6, 1982 at 1620 hours, door 426 was found slightly open. The doors were immediately closed when discovered.

These doors are fire and negative pressure boundary doors. At the time of the occurrences, there was no operations involving the movement of fuel within the fuel pool or any loads being moved over the pool. The action statement limitations of Technical Specification 3/4.9.12 were being met. Technical Specification 3/4.7.10 for fire barriers was also applicable. With these doors not fully closed the integrity of the fire barriers were degraded.

Designation of Apparent Cause of Occurrence: The cause of these events was a design error. The existing closure mechanisms are unable to completely close the doors under all operating conditions. When the doors are released from a nearly closed position, the closure mechanism is not strong enough to seat the door tightly.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The door could have been closed had the Emergency Ventilation System been needed.

Corrective Action: There have been previous occurrences of open fire and negative pressure doors involving the existing closure mechanisms. Maintenance work requests 82-1187-177 and 169 have been written to replace the closure mechanisms on doors 302 and 500 respectively, with a stronger style mechanism. The closure mechanism on door 426 was adjusted to exert full force on the door. All negative pressure doors' mechanisms will be replaced with this new style. In addition, a monthly preventive maintenance program is now in effect to check for proper operation of the closure mechanisms, handles, latches, and other operating parts on all negative pressure doors.

Failure Data: A previous similar occurrence of an open fire or negative pressure door due to a design deficiency was reported in LER NP-33-82-11 (82-009).

LER #82-031