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 9 1 7 8 2 (8)	REPORT DATE: 1 Ø 1 4 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 (NP-33-82-53) On 9/14/82 station personnel prepared to flush the vent line on the con-
0 3 centrates storage tank. This required blocking open fire door 101A with a temporary
0 4 hose. Station personnel were present near the door until 1600 hours when the door
0 5 was left unattended for approximately 5 minutes. This placed the unit in the action
0 6 statement of Technical Specification 3.7.10. The hose was removed at 1605 hours, re-
0 7 moving the unit from the action statement.
0 8

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 2	—	Ø 4 8	/	Ø 3	L	—	Ø

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	X (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 apparent cause of the occurrence is a personnel error due to inadequate training
1 1 of station personnel on proper administrative procedures concerning fire protection
1 2 barriers. General Orientation Training was modified to require training on Standing
1 3 Order 30, The Blocking of Penetration Fire Barriers, Fire Doors, and Negative Pres-
1 4 sure Boundary Doors.

1 5	FACILITY STATUS: E (28)	% POWER: Ø 4 1 (29)	OTHER STATUS (30): NA	METHOD OF DISCOVERY: A (31)	DISCOVERY DESCRIPTION (32): Operator Observation

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: Ø Ø Ø (37)	TYPE: Z (38)	DESCRIPTION (39): NA

PERSONNEL INJURIES

1 8	NUMBER: Ø Ø Ø (40)	DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE: Z (42)	DESCRIPTION: NA

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PUBLICITY

2 0	ISSUED: N (44)	DESCRIPTION (45): NA	NRC USE ONLY

DVR 82-105

NAME OF PREPARER: Peter Seniuk PHONE: (419) 259-5000, Ext. 536

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-53

DATE OF EVENT: September 14, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: A fire barrier door was blocked open and unattended for a short period of time

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 1130 and Load (Gross MWE) = 345.

Description of Occurrence: On September 14, 1982, Operations, Maintenance, and Health Physics personnel were assembled in Room 106 adjacent to Door 101A preparing to flush the vent line on the concentrates storage tank. The demineralized water source for flushing was available from the waste evaporator room some 60 feet away via a temporarily installed hose running through Door 101A. The hose was fitted for easy removal utilizing quick disconnects at each end.

At approximately 1530 hours, flushing commenced and continued until 1550 hours at which time all personnel except the supervising engineer left the area for turnover to the afternoon shift. At 1600 hours, the afternoon shift health physics tester arrived and requested to be shown the flush/vent path. The engineer and tester left the immediate vicinity of Door 101A for several minutes. This placed the unit in the action statement of Technical Specification 3.7.10. During this same time period, the day shift equipment operator informed the Shift Supervisor that Door 101A was blocked open with a hose for flushing so that this could be turned over to the afternoon shift for manning. The Shift Supervisor realizing that Door 101A was a fire barrier door immediately contacted the engineer. The hose was removed at 1605 hours, removing the unit from the action statement.

Designation of Apparent Cause of Occurrence: The apparent cause of this occurrence is personnel error due to inadequate training of station personnel on proper administrative procedures concerning fire protection barriers. The personnel involved in the flushing operation were not fully aware of the requirements for blocking open fire barrier doors.

A review of the General Orientation Training Program showed that training on fire barrier and negative pressure area doors was inadequate. The training material did not address the requirements for Shift Supervisor notification and maintaining an hourly patrol sheet. A recent Standing Order 30 approved on August 13, 1982, delineated the requirements for blocking of doors. If this had been properly distributed to all station personnel, this event would not have occurred.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. The subject door was continuously monitored by the engineer in charge of the flushing operation except for several minutes during shift turnover. Even during this time frame, he was in close proximity to the door. The door was blocked open less than one hour, therefore, it did not require a fire watch patrol sheet to be maintained. The Shift Supervisor directed the hose to be removed immediately upon notification, thereby returning the door to operable status.

Corrective Action: The General Orientation Program training was reviewed by a member of the Operations Department to determine its adequacy. After determining that the information being presented was inadequate, the lecture material was modified to require proper training on Standing Order 30, "The Blocking of Penetration Fire Barriers, Fire Doors, and Negative Pressure Boundary Doors".

In addition to this, future changes to significant Standing Orders will be routed to all station personnel individually to ensure that personnel are aware of the changes.

Failure Data: Previous occurrences of fire doors found blocked open have been reported in Licensee Event Reports NP-33-81-92 (81-078), NP-33-82-16 (82-014), NP-33-82-27 (82-022), and NP-33-82-29 (82-026).