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OPERATING MODE (9)			-	THIS REPORT IS SUBMITTED PURSUANT TO			20.405(c)			50,73(a)(2)(iv)			73.71(b)			
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During a surveillance test, it was found that both Control Room Emergency Ventilation chiller control switches in the Gontrol Room A/C Equipment Room were in the "OFF" position. This rendered both Control Room Emergency Ventilation System trains inoperable. The cause is believed to be personnel error, failure to return the switches to "ON" after preventive maintenance. As a result, nameplates were placed above the switches to require that the Shift Supervisor is notified prior to turning off. The preventive maintenance procedures were modified to inform the Shift Supervisor that the Control Room Emergency Ventilation System unit being checked will be inoperable and to require that the switches are verified to be on after the preventive maintenance is performed. Also, personnel who perform maintenance on the system were counseled about this event.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)		
		YEAR SEQUENTIAL REVISION NUMBER			
Davis-Besse Unit 1	0 5 0 0 0 3 4 6	8 4 - 0 1 0 1 5 - 0 1 0 0	12 OF 0 12		

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Description of Occurrence: On May 7, 1984, the unit was operating at approximately 94% power. At 0930 hours, during the performance of Control Room Emergency Ventilation System (EVS) Monthly Surveillance Test, ST 5076.01, the operators discovered that the control switches for both Control Room EVS chiller units on Panels C6706 and 6707 in the Air Conditioning Equipment Room were in the "OFF" position. This rendered both Control Room EVS trains inoperable, placing the station in Technical Specification Action Statements 3.0.3 and 3.7.6.1.

The operator immediately reported this condition to the Shift Supervisor who then conferred with a Maintenance staff member. When no apparent reason was found for the controllers being in the "OFF" position, the operator was instructed to place the switches to the "ON" position. At 0935 hours, these switches were returned to "ON", removing the station from the action statements. Surveillance Test ST 5076.01 was then successfully run on both Control Room EVS units.

This event is reportable under 50.73(a)(2)(i) for being in a condition prohibited by Technical Specifications, both Control Room EVS units being inoperable.

Designation of Apparent Cause of Occurrence: The reason for the chiller control switches being in the "OFF" position is personnel error. The personnel performing the preventive maintenance on this system failed to return the switches to the "ON" position. This maintenance is performed by both contractor and Toledo Edison personnel.

Analysis of Occurrence: The normal Control Room Heating, Ventilation and Air Conditioning (HVAC) System was in service at the time of the occurrence. In the event of a chlorine accident or radioactive release, the Control Room HVAC would have functioned to automatically isolate the Control Room to protect Operations personnel. If a situation were to occur where the normal Control Room HVAC would be automatically shutdown, the Control Room Emergency Ventilation System may not have been able to provide cooling for the Control Room over a long period of time. This, of course, would be noticed by the operators, and adequate time would be available for corrective action. If no corrective action was taken in a timely manner, the Control Room temperature could have risen to 110 degrees, requiring a unit shutdown.

Corrective Action: Under Maintenance Work Order 1-84-0195-01, a nameplate was put above the switches to more clearly identify them and to require that the Shift Supervisor be notified prior to turning these switches off.

The Preventive Maintenance Instructions (1188 and 1189) were modified to require that the switches are to be verified to be in the "ON" position after the preventive maintenance is performed. The personnel who perform the preventive maintenance were counseled on this event and informed of the consequences.

Failure Data: There have been no previous failures of this nature.

Report No: NP-33-84-05

DVR No(s): 84-061



June 6, 1984

Log No. K84-668 File: RR 2 (NP-33-84-05)

Docket No. 50-346 License No. NPF-3

U. S. Nuclear Regulatory Commission Document Control Desk Washington, D. C. 20555

Gentlemen:

LER No. 84-005 Davis-Besse Nuclear Power Station Unit 1 Date of Occurrence: May 7, 1984

Enclosed is Licensee Event Report 84-005, which is being submitted in accordance with 10CFR50.73, to provide 30 day written notification of the subject occurrence.

The system code for corponent failures was taken from the old LER instruction book since the new IEEE-805 is not yet available.

Yours truly,

Terry D. Murray

Station Superintendent

Davis-Besse Nuclear Power Station

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TDM/ljk

Enclosure

cc: Mr. James G. Keppler, Regional Administrator, USNRC Region III

> Mr. Walt Rogers DB-1 NRC Resident Inspector

JCS/001