

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
Davis-Besse Unit 1

DOCKET NUMBER (2)
0 5 0 0 0 3 4 6

PAGE (3)
1 OF 0 3

TITLE (4)
Incorrect Termination of a Continuous Fire Watch

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 4	0 4	8 8	8 8	0 0 9		0 0	0 5	0 4	8 8		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) 5

POWER LEVEL (10) 0 0 1 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(e)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.408(a)(1)(i)	<input type="checkbox"/> 50.38(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(e)
<input type="checkbox"/> 20.408(a)(1)(ii)	<input type="checkbox"/> 50.38(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)
<input type="checkbox"/> 20.408(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.408(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.408(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME: Charles S. Gordon, Senior Nuclear Specialist, Technical Planning

TELEPHONE NUMBER: 4 1 1 9 2 1 4 9 1 - 5 1 0 1 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On April 4, 1988 at approximately 1800 hours it was determined that an inoperable fire barrier existed with no detection on either side and a continuous fire watch was not in place. This condition was caused by personnel error during the initial fire watch evaluation and had existed since June 24, 1986. A continuous fire watch was posted at 1845 hours on April 4, 1988. Subsequently Maintenance Work Order (MWO) 1-88-0449-00 was performed to repair the door. This MWO did not repair all of the door deficiencies which made it inoperable as a fire barrier. The Assistant Shift Supervisor determined by reviewing existing work documents that the door would be returned to an operable status following completion of this MWO. Another MWO 2-86-0431-09 incorrectly implied that Door 422 was operable when this door was shut. When MWO 1-88-0449-00 was completed the Assistant Shift Supervisor declared the door operable and terminated the fire watch at 0900 on April 5, 1988. Fire Protection personnel later noticed that no continuous watch was in place at Door 422 and informed the Shift Supervisor. He re-established the continuous watch at 1545 hours.

Outstanding Fire Protection MWO's will be reviewed by June 30, 1988 to ensure compensatory measures have been identified for each Fire Protection related MWO. Effective June 1, 1988 all new Fire Protection MWO's will be reviewed to ensure that appropriate compensatory measures are identified.

A procedure, DB-FP-00009, and a standing order have also been written to provide guidance to the Shift Supervisor concerning implementation of compensatory Fire Protection measures.

This event is being reported in accordance with to 50.73(a)(2)(1)(B).

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Davis-Besse Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 4 6 8 8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 8	0 0 9	0 0	0 2	OF	0 3

TEXT (if more space is required, use additional NRC Form 366A (1) (17))

Description of Occurrence:

On April 4, 1988, while developing a list of inoperable fire protection equipment, it was determined that Fire Barrier AB1-N/422-S (NF) was inoperable due to deficiencies on Fire Door 422 and did not have detection (IC) on either side. Further review indicated that a continuous watch was not in place as required by Technical Specification 3.7.10. The Shift Supervisor was informed at approximately 1800 hours and a continuous watch was put in place at 1845 hours. This condition had existed since June 24, 1986 due to personnel error when making the initial evaluation of fire barrier operability. (A roving watch was established instead of a continuous watch).

Repairs were initiated on Door 422 under MWO 1-88-0449-00. This MWO repaired deficiencies identified during the first quarter of 1988 by the performance of PT 5116.15 but did not correct all deficiencies necessary to return Door 422 to an operable status. The Assistant Shift Supervisor determined by reviewing the completed MWO package and related MWO 2-86-0431-09 that Door 422 would be returned to an operable status following completion of MWO 1-88-0449-00. MWO 2-86-0431-09 stated that Door 422 would be rendered inoperable by having the door held open during repairs and in the event of a problem the door could be closed.

At 0900 on April 5, 1988, the continuous watch was terminated with the belief that Fire Barrier AB1-N/422-S had been returned to an operable status. Later that day at approximately 1100 hours, Fire Protection personnel noticed that the fire watch had been terminated and notified the Shift Supervisor who reported that his work documents showed the door to be operable. Subsequent investigation revealed that the door was still inoperable. (ie MWO 2-86-0431-09 was still outstanding). The Shift Supervisor was informed of the investigation's finding at approximately 1500 hours. The fire watch was restored at 1545 hours.

Designation of Apparent Cause of Occurrence:

The initial event originated on June 24, 1986 when it was incorrectly determined that an hourly fire watch was sufficient to satisfy the Technical Specification requirements, rather than a continuous fire watch.

The inappropriate termination of the continuous fire watch was caused by an inadequate review of fire protection requirements on MWO 2-86-0431-09 which failed to identify that the conditions requiring repair render Door 422 inoperable at all times.

Analysis of Occurrence:

Fire Door 422 is located in a frequently traveled area and would be observed often providing early detection of a fire. Door 422 is located between stairwell AB-1 and vestibule Room 423. Both areas contain minimal combustible material. Therefore this event has no actual or potential safety significance.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Davis-Besse Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 4 6	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Corrective Action:

A continuous fire watch was put in place at Fire Barrier AB1-N/422-S.

Station Procedure DB-PN-00007 requires that the Fire Protection Coordinator determine the effects of maintenance on fire protection system equipment and operability. This requirement will be re-emphasized with the Fire Protection Coordinators and by June 30, 1988, Fire Protection will review all outstanding MWO's relating to Fire Protection systems and features to ensure compensatory measures have been correctly identified for each MWO.

A procedure DB-FP-00009, has been written and will be effective by May 9, 1988 to provide the Shift Supervisor and Fire Protection personnel guidance to assist them in determining the appropriate fire watch requirements. A standing order number 88-047 has been revised by Operations personnel to provide temporary guidance for implementation and termination of compensatory measures for inoperable Fire Protection equipment including consultation with Fire Protection Compliance.

Effective June 1, 1988 the fire engineer will review each new fire Protection MWO to ensure that appropriate guidance on compensatory measure is included.

Additionally a list is being prepared that shows room by room which Technical Specification fire barriers are inoperable and their respective deficiencies. This list will include a schedule of when these deficiencies will be repaired. This will be complete by July 15, 1988.

Failure Data:

This is the third report of missed continuous fire watches due to personnel error, LERs 87-005 and 88-005. Previous corrective actions for LER 88-005 had not yet been fully implemented.

REPORT NO: NP-33-88-09

PCAQ NO(s): 88-0289, 88-0290

May 4, 1988



Log No: KA88-0271
NP-33-88-09

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

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

Gentlemen:

LER No. 88-009
Davis-Besse Nuclear Power Station Unit No. 1
Date of Occurrence April 4, 1988

Enclosed is Licensee Event Report 88-009, which is being submitted in accordance with 10CFR50.73 to provide 30 day written notification of the subject occurrence.

Yours truly,

A handwritten signature in cursive script that reads 'Louis F. Storz'.

Louis F. Storz
Plant Manager
Davis-Besse Nuclear Power Station

LFS/ed

cc: Mr. A. Bert Davis
Regional Administrator
USNRC Region III

Mr. Paul Byron
DB-1 NRC Resident Inspector

IE22
11