

U.S. NUCLEAR REGULATORY COMMISSION
REGION III

Report No. 50-346/86006(DRS)

Docket No. 50-346

License No. MPF-3

Licensee: Toledo Edison Company
Edison Plaza, 300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse Nuclear Power Station, Unit 1

Inspection At: Oak Harbor, OH

Inspection Conducted: February 3-6, 1986

Inspectors: P. R. Wohl *P.R. Wohl*

2-28-86
Date

C.B. Ramsey for
C. B. Ramsey

2/28/86
Date

J.M. Ulie
J. M. Ulie

2-28-86
Date

Approved By: *W.G. Guldemon*
W. G. Guldemon, Chief
Operational Programs Section

2/28/86
Date

Inspection Summary

Inspection on February 3-6, 1986 (Report No. 50-346/86006(DRS))

Areas Inspected: Routine announced inspection of previous inspection findings, licensee event reports, 10 CFR Part 21 reports, and followup of an onsite event. The inspection involved 104 inspector hours onsite by four NRC inspectors. The inspection was conducted in accordance with inspection procedures 92701 and 93702.

Results: No violations or deviations were identified.

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DETAILS

1. Persons Contacted

Licensee

E. Caba, Station Performance Supervisor
D. Missig, Leak Rate Testing Engineer
J. Ewald, Senior Engineer
T. Bloom, Senior Licensing Specialist
J. Lietzow, Licensing Specialist II
S. Quennoz, Group Director, Nuclear Engineering
J. Haverly, Consultant, Fire Protection Compliance Supervisor
P. Regenscheid, Senior Consultant, Fire Protection
R. Strauss, Fire Protection Coordinator
M. Murtha, Fire Protection Systems Engineer
B. Hess, Consultant, Section Manager
R. Elfstrom, Facility Engineer

NRC

W. Rogers, Senior Resident Inspector
D. Kosloff, Resident Inspector

2. Licensee Actions on Previous Inspection Findings

(Closed) Unresolved Item (346/82003-03): This item documented the fact that fire doors 206 and 311 were not labeled as to their fire resistance rating and that no other documentation was available to support that rating. A visual inspection of the doors was performed by the inspector and it was verified that they have been labelled with Underwriters Laboratory labels attesting to a three-hour rating.

(Closed) Violation (346/82003-04A): Inadequate administrative procedures for control of combustible materials. Licensee procedure MP1410.76 is in place to control transient combustibles and welding and cutting activities. During plant tours, the inspectors did not observe conditions that indicate this procedure has not been effectively implemented. No accumulation of combustible materials or violations of welding and cutting procedures were observed by the inspectors. Therefore, this item is closed.

(Closed) Violation (346/82003-04B): Failure to conduct quarterly fire drills during the first and third quarters of 1981. This item is closed based on the inspector's review of the licensee's fire brigade drill attendance sheets for 1984 and 1985. The attendance sheets documented that each fire brigade member selected by the inspector received at least one drill per quarter during 1984 and 1985.

(Closed) Violation (346/82003-05B): This item documented a failure on the part of the licensee to upgrade the fire brigade training to include practice in fighting fires of similar magnitude and complexity to those expected in the plant, use of emergency breathing apparatus under strenuous conditions, and appropriate documentation of drill critiques. The licensee's brigade training program was reviewed and found to appropriately address these concerns; however, during this review it was determined that the licensee does not administer written examinations following fire brigade classroom training sessions and that records of critiques of individual brigade member performance during drills are not maintained. These findings are viewed as training program weaknesses and resolution will be tracked as an open item (346/86006-01(DRS)).

(Closed) Violation (346/82003-07): Unrealistic firefighting practice sessions. This item is closed based on the licensee's contract with Toledo Fire Academy to provide fire brigade training under strenuous conditions that include simulation of the complexities, types and magnitude of fires that could occur in the plant. No observations were made of fire brigade practice sessions; however, from the inspector's review of fire brigade drill critiques, it appears that acceptable fire fighting methods and techniques are exercised by the brigade during drills and practice sessions.

(Closed) Unresolved Item (346/82025-03): This item tracked licensee resolution of NRC concerns relative to the technical accuracy of a document submitted to the NRC relative to certain post-refueling testing activities. In response to these concerns the licensee changed their document issuance procedures. The inspector reviewed these changes and found them adequate; however, it was noted that no single management individual was designated as having responsibility for ensuring that the appropriate groups were assigned review responsibility. The licensee agreed to designate this responsibility in a future procedure change.

(Closed) Violation (346/82029-01): This violation documented a failure on the part of the licensee's Nuclear Operations Training Supervisor (NOTS) to review and approve a reactor theory quiz written by a consultant as required by procedure AD 1828.15 Revision 3. The licensee responded to the violation on December 9, 1982, indicating that the subject examination was subsequently reviewed as required by AD 1828.15, AD 1828.15 Revision 3 was reviewed and found acceptable, and that the responsible individuals were counseled and trained to ensure future compliance. Based on the findings of the original inspection and the licensee's response, it is concluded that this was an isolated occurrence. As such, counseling and retraining in the procedural requirements of AD 1828.15 is viewed as appropriate corrective action. Two other factors support closure of this item. First, the current revision of AD 1828.15, Revision 6, allows the NOTS to either designate another individual to review and approve examinations or have a licensed Senior Reactor Operator perform the reviews and approvals. This provides necessary flexibility while requiring an appropriate quality level of review. The second factor supporting closure of this item is that the licensee is actively pursuing accreditation of their training programs through the Institute of Nuclear Power Operations (INPO). This effort will result in additional levels of control on examination content and quality.

(Closed) Violation (346/83016-01b): Failure to perform spurious signal analysis. This item is closed based on the licensee's corrective actions. Licensee Field Change Request (FCR) No. 84-178 authorized rerouting of Circuit No. 1CBE1602F for Power Operated Relief Valve (PORV) No. RC11 outside of Fire Area U. Circuit No. 1CBE1602F was changed to 1CBE1602K and was rerouted in Conduit No. 48136A from Cable Tray No. 1CLA10 through Room 401 to Room 402 (Fire Area V) where it terminates in junction box No. 4818. Abnormal procedure No. AB1203.05 has been revised to require local manual action for Service Water System Motor Operated Valve Nos. SW2929, SW2930, SW2931, SW2932, and Letdown Cooler Isolation Motor Operated Valve Nos. MV01A, MV02A, MV01B, and MV02B.

(Closed) Unresolved Item (346/83016-06): This item tracked NRC concerns relative to minimum required emergency lighting illumination levels at the auxiliary shutdown panel. This same issue is being tracked by Unresolved Item 346/84010-01.

(Closed) Violations (346/83016-13 and 346/83016-22j): These violations documented a failure on the part of the licensee to establish a fire watch for an inoperable fire damper and an inadequate fire damper surveillance procedure. Failure to establish a fire watch is viewed as an isolated personnel error and is considered closed. As documented in Part II to Inspection Report 50-346/83016, the licensee acceptably revised surveillance procedure ST 5016-11; however, the item was left open pending Region III receipt of a licensee submittal regarding excessive surveillance test failures. During the current inspection, the licensee informed the inspection team that they considered all of their fire dampers unreliable and were going to replace all safety-related and safe shutdown dampers. This was viewed as a long term project. Until completed, the licensee indicated that compensatory measures as required by Technical Specifications would be put in place. Replacement of the subject dampers will be tracked as an open item (346/86006-02(DRS)). Additionally, the inspection team questioned whether Technical Specification compensatory measures were appropriate for extended periods with all required fire dampers inoperable. This will be tracked as an unresolved item pending discussions with the Office of Nuclear Reactor Regulation (346/86006-03(DRS)).

(Open) Open Item (346/83016-15): Failure to control modifications to fire doors. Licensee purchase order 642-2426-48 has retained U.L. to evaluate security field modifications to fire doors. The results of this evaluation are expected to be completed by March 31, 1986. This item will remain open pending the results of U.L.'s evaluation and the licensee's implementation of final corrective actions.

(Closed) Unresolved Item (346/83016-16): Unqualified fire door No. 215. This item is closed based on an exemption granted by the NRC in a letter to the licensee dated August 20, 1984 (A. DeAgazio, NRC to R. Crouse, TECo).

(Closed) Unresolved Item (346/83016-17): This item documented a failure on the part of the licensee to install vehicular barriers to protect outside yard valves and hydrants. The inspector verified on a sample basis that the barriers have been installed.

(Closed) Unresolved Item (364/83016-18): This item documented a failure on the part of the licensee to install pressure reducing devices on hose stations having water supply pressures in excess of 100 PSIG. In response to this item the licensee elected to train their personnel in the use of hoses charged to a pressure in excess of 100 PSIG, to post all hose stations alerting all personnel of the elevated pressures and specifying that only trained personnel should use the hose stations, and informing all station personnel that only trained personnel are to use hose stations. The inspector verified that fire brigade hose training is routinely conducted using hoses charged to greater than 100 PSIG, that all hose stations are appropriately labeled warning of the elevated pressures, and that all personnel are instructed that only appropriately trained personnel are to use hose stations as part of the plant access and badging process.

(Open) Open Item (346/83016-21): Unqualified control room fire door Nos. 509 and 512. Licensee Field Change Request (FCR) 84-178 requires an engineering analysis be performed on door No. 509 in order to justify leaving the door in place. The licensee will pursue a deviation request by March 31, 1986, for door No. 512. This item remains open pending verification of the licensee's corrective actions.

(Closed) Violation (346/83016-22A): This item documented inadequacies in the licensee's surveillance procedures for the electric and diesel fire pumps. As documented in Inspection Report 346/85028 the only issues remaining open at the time of this inspection were vibration testing of the diesel fire pump and the methodology for the development of fire pump characteristic curves. The inspector reviewed the annual test procedures for the fire pumps and determined that the methodology for characteristic curve development has been adequately specified including consideration for pump speed and suction lift and that vibration measurements are now required for the diesel fire pump.

(Closed) Violation (346/83016-22I): Failure to adhere to Staffing Requirements for Fire Protection Program Implementation. During the inspection, the licensee provided the inspectors with an organizational chart that indicated a sufficient number of qualified personnel are responsible for the implementation of the fire protection program. This item is closed based on the licensee's revised organizational structure and discussions with the licensee's staff.

(Closed) Open Item (346/84010-02): Through discussions with the licensee, the inspector learned that two fire detectors located directly over the main steamline isolation valves in the Containment Annulus were disconnected March 7, 1984, as a result of the main steamline isolation valve(s) actuating, causing inadvertent actuations of the detectors. It was the inspector's understanding through discussions with TED's Fire Protection Engineer that the number of operable fire detectors located in

the applicable areas of the Containment Annulus meets the minimum requirements of the National Fire Protection Association (NFPA 72D and 72E) codes. An analysis by the licensee should be performed according to NFPA methods to demonstrate that the number of detectors located in the applicable areas of the Containment Annulus meet NFPA 72D and 72E requirements and should be made available to Region III for review.

On February 6, 1986, the licensee provided the inspector with a review concerning the disconnecting of fire detectors in the Main Steam Line Area. This review indicated the detectors located in Rooms 601 (FDZ 601W) and 602 (FDZ 602) were removed from service due to a high false alarm rate caused by steam in the area when the main steam isolation valves close and the main steam safety valves lift.

The apparent cause of the problem of a high false alarm rate due to steam is that when the detection system was installed in these zones, consideration of the steam effects as described in Paragraph 4-5 of NFPA 72E was not considered.

Paragraph 4-5 of NFPA 72E states in part, "Smoke detectors shall not be installed in areas where normal ambient temperature is likely to exceed 100°F. . . , unless then have been specifically listed for installation at higher or lower temperatures." Consequently, the licensee chose to replace the existing ionization detectors with thermal rate-of-rise type detectors over the main steam line areas.

The inspector performed a tour of Rooms 601 and 602 and observed that eleven (six in Room 601 and five in Room 602) thermal rate-of-rise type detectors have been installed in the immediate area over the main steam lines.

(Open) Open Item (346/84015-03): Potential for Velan check valves not seating properly. The licensee has implemented corrective action on valves in more critical applications. Additional work is necessary to complete this item during the next refueling outage. This item remains open pending final corrective action by the licensee.

(Open) Open Item (346/84029-02): This open item tracks resolution of the discrepancy between the requirements of 10 CFR 50 Appendix J and ANSI N45.4-1072, and the licensee's current Technical Specifications regarding the magnitude of the leak rate to be imposed during the verification phase of a Containment Integrated Leak Rate Test (CILRT). The licensee has prepared a Facility Change Request (FCR) internally identifying the need to revise existing Technical Specifications. This FCR is still in the review and approval process. As such, the NRC has yet to receive a formal request for a change to the Technical Specifications. As the next CILRT is not scheduled to occur until 1988, this does not represent an immediate problem. This item will remain open pending final changes to the licensee's Technical Specifications to establish acceptable values for imposed leakage. These changes must be submitted to the NRC in time to support the scheduled 1988 CILRT.

(Closed) Open Item (346/85008-03): Maximum stroke times allowed during valve inservice test stroke timing. The licensee is adopting component oriented maximum valve stroke times as follows:

- a. Motor-operated valves will be limited to 1.5 times baseline unless more restricted by other requirements.
- b. Air-operated valves with a stroke time baseline less than ten seconds will be limited to 3.0 times baseline.
- c. Air-operated valves with a ten second or greater baseline will be limited to twice baseline.

There are no standards available from which to judge the acceptability of these limits; however, the inspector finds the air-operated valve limits to be reasonable. The motor-operated valve limits do not provide a good measure of valve operability, but are acceptably within current industry practice. Hence, this item is considered closed.

(Closed) Unresolved Item (346/85021-01): Failure of auxiliary feedwater valves, AF599 and AF608, to open on June 9, 1985. The issues related to these two valves are also covered in the Davis-Besse Action Plan and by Inspection Report 483/85030(DRP). Hence, this item can be considered closed. The issue will be tracked as part of the referenced documents.

(Open) Unresolved Item (346/85022-07): Valve MS106 wiring and torque switch problem. This item remains open pending completion of testing and corrective action on valve MS106. Completion is required prior to reactor criticality during plant startup.

(Closed) Open Item (346/85025-05): Failure to stroke test the pressurizer power-operated relief valve. The licensee has agreed to test this valve per NRC recommendations in the ASME Code, Section XI, Inservice Test Program. Hence, this item is considered closed.

(Open) Open Item (346/85025-07): Motor-operated valve closure thrust capability. The licensee is continuing to evaluate MOVATS test results and compare the valve operator closure thrust capability with manufacturer stated closure thrust requirements at design differential pressures. Two valves out of eighty evaluated, AF599 and AF608, have been identified as having thrust capabilities that were too low because of low closure torque switch settings. Four other valves appear to also be in this category, but require additional evaluation. This item remains open pending completion of the licensee's evaluation of all safety-related, motor-operated valves and the completion of all corrective action necessary to assure required closure capabilities.

(Open) Open Item (346/85025-09): Valve differential pressure testing. This item remains open pending the resolution of concerns in this area by NRR, the completion of testing, and evaluation of results by the licensee. This item requires resolution prior to reactor criticality on startup.

(Open) Open Item (346/85028-01): Allegation No. RIII-83-A-0029-01: Test data to support the penetration seals' fire resistance capability did not exist, including test data to show that the six inch silicone foam fire barrier penetration seals are rated for three hours. As discussed in Inspection Report No. 85028, the inspector reviewed two Bisco Fire Test Reports. It was subsequently determined that the two test reports are not applicable to the Davis-Besse site. Consequently, the licensee presented the inspector with four additional Bisco test reports which were determined by the licensee's penetration fire seal review to be applicable to the Davis-Besse site. The inspector's review of the four test reports determined the following:

- a. Bisco Test Report No. 3001-03-B dated May 19, 1980, showed that nine inches of silicone foam (DC3-6548) was installed in a 30" X 30" penetration opening (floor position). A 4" X 24" ladder type cable tray was installed in the penetration opening having a 40% fill of control cables placed in the cable tray. The inspector determined the test performance and its results met NRC guidelines and ASTM E-119 standard acceptance criteria.
- b. Bisco Test Report No. 748-64 dated January 15, 1982, showed that nine inches of silicone foam (SF-20) was installed in a 6" conduit (floor position) having a 40% fill of electrical power cables. The inspector questioned the temperature measurements of Thermocouple (TC) No. 8 which showed that at two hours and ten minutes into the test, this TC reached 346°F, exceeding ASTM E-119 (250°F plus ambient temperature and NRC guidelines (commonly accepted to be 325°F) and 409°F at three hours into the test.
- c. Bisco Test Report No. 748-134 dated May 14, 1984, showed that nine inches of Silicone Foam (SF-20) and seven and one-half inches of SE Foam was installed in a 30" X 30" penetration opening (floor position) which was divided in half (equally) by a piece of M-Board, each half having one solid bottom cable tray and one 4" heavy walled conduit with each penetration having one type of sealant installed on each side of the divided penetration. One of the cable trays and one of the conduits had a 45% fill and the other had a 50% fill.

The inspector questioned the temperature measurements of TC's 1 and 14. TC 1 reached 329°F. at one hour and forty minutes into the test exceeding ASTM and NRC requirements and reached 518° at three hours into the test. TC 14 reached 329°F. at one hour and thirty minutes into the test also exceeding ASTM and NRC requirements and 467°F. at three hours into the test. The Test Report provided justification for the excessive temperatures; however, the inspector indicated further review of the reasons for the excessive thermocouple temperatures and how the test configurations compare to the as-built penetration fire seal installations would be necessary prior to NRC determination of acceptability.

- d. Bisco Test Report No. 748-41, dated April 17, 1981, showed that nine inches of Silicone Foam (SF-20) was installed in varying penetration configurations. It was not clear which configuration(s) the licensee was taking credit for, nor was it clear which TC's identified in the test report were measuring the temperature of the Silicone Foam.

In addition to the specific inspector concerns related to the Bisco Test Reports, the inspector expressed concern that no documentation was available to show that the Bisco Test Reports were reviewed by the licensee for their applicability to the as-installed plant penetration fire seals.

Based on the specific inspector concerns related to the Bisco Test Reports and the concern of the Bisco Test Reports applicability to the as-installed plant penetration fire seals, this allegation remains open. During the inspection visit and at the exit meeting of February 6, 1986, it was discussed that appropriate resolution of this item is required as one of the items to be closed prior to plant restart (prior to entry into Mode 1) from the current outage.

An appropriate resolution the licensee was pursuing at the time of this inspection visit was to contract with a nationally recognized laboratory and have the various plant penetration fire seal configurations tested for the appropriate length of time in which the particular fire seal is required to be maintained as a fire barrier. The licensee was also pursuing resolution through NRR.

(Open) Open Item (346/35028-02): Three maintenance procedures numbered MP 1405.03.1 (Step 8.3), MP 1405.04.3 (Step 6.3) and MP 1405.08.0 (Step 8.3) each indicate that the minimum depth of foam to be installed is 11 inches for low density silicone foam in penetration conduits through a wall or floor, except where the wall or floor thickness is less, then the depth is to be equal to the thickness of the wall or floor.

The three maintenance procedures do not differentiate between fire barrier walls and floors and non-fire barrier walls and floors when mentioning the amount of sealant material to install as does Section 7.2.4.e of Specification No. 7749-M-255Q.

According to the licensee, MP 1405.08.0 was not an approved procedure. Based on the licensee's penetration fire seal review, it was determined that this procedure is no longer applicable to penetration fire seals installed in the plant.

The remaining two maintenance procedures had the necessary changes incorporated for a three hour fire barrier; however, during the licensee's review of the installed plant fire barriers, it was determined that two hour fire barriers exist which were not accounted for in the two remaining maintenance procedures. In addition, according to the licensee, maintenance

procedure numbered MP 1405.06.2 (Step 5.5.5) regarding the proper Kaowool fire seal fill depth, is also applicable as a penetration fire barrier, and as such has been revised to reflect the applicable supporting documentation. The licensee was unable to provide the necessary test report(s) to show that the as-built plant Kaowool configurations have been tested for fire protection purposes. As such, this concern is considered part of Open Item 85028-01 which is discussed in the previous section of this report.

(Closed) Open Item (346/85028-03): Allegation No. RIII-83-A-0029-02: (02) Penetration seals were installed with a two inch overlap on the seal boot instead of the required three inches. The flexible boot seal is designed for use as a pressure barrier (negative pressure boundary).

Bisco's flexible boot seal fabrication procedure (SP504), step 5.3.3, and Bisco's Installation procedure (SP5051), step 7.3, both state that, "A bead of the Bisco RTV Sealant is applied to the inside of the overlap seam and spread to a minimum width of three inches." The Davis-Besse site installer of flexible boot seals (installation of the flexible boot seals is performed on an infrequent basis) interpreted the two steps noted above to mean that the minimum overlap seam is to be three inches.

Subsequently, the licensee, through Bechtel, contacted Bisco personnel who indicated that the overlap axial seam criteria was to be based on the diameter of the pipe penetration being sealed. The inspector requested the licensee to provide documentation to support the vendor's position regarding the overlap seam criteria.

The licensee presented the inspector with Bisco Test Report 748-109 for review. The test report showed that a one inch laminated axial seam and a one inch sealing surface on both pipe and sleeve was the manner in which the overlap axial seam and sealing surface was constructed in the boot seal assembly during the test.

According to the licensee, one of the purposes of this test was to determine the weakest pressure retaining section of the boot assembly. As determined by the test, the clamp assembly failed before the one inch overlap axial seam failed. During discussions with the licensee and a review of documentation, including calculations which were provided to the inspector, the licensee showed that both the overlap axial boot seal seam and the clamp retained pressure greater than the worse pressure expected to occur to a boot seal. According to licensee discussions with Bisco, the reason for stating two and three inch overlaps mentioned in their procedures was for ease of installation only. Specifically, with larger diameter boot seals, it was indicated that it is difficult to work with only a one inch overlap, and specifying two and three inch overlaps was to help in preventing unnecessary rework.

(Closed) Violation (346/85028-04): Allegation No. RIII-83-A-0029-03: (03) Bisco Company procedures SP504, SP505, SP505-1, SP505-2, and SP505-3 were deficient.

The inspector performed an inspection of seven flexible boot seals including measurement of overlap axial seams with assistance from the licensee's staff. Of the seven boot seals inspected, two failed to meet the acceptance criteria as given by the Bisco personnel and five boot seals failed to meet the acceptance criteria as given by the plant installer.

The Bisco Fabrication and Installation procedures also indicate that the RTV sealant material should be allowed to cure for a minimum of sixteen hours before any further work is performed. No TED procedure existed for the responsible Quality Assurance inspector on when to inspect the boot seals' final installation so as to verify that no slippage of the overlap seam had occurred.

The TED procedure(s) established for the installation and fabrication of the flexible boot seals were inadequate in that these procedures failed to provide clear and concise installation, fabrication and inspection instructions.

Subsequently, the licensee developed and approved Toledo Edison Procedure (TED) MP 1700.29.0 dated January 8, 1986, "Fabrication and Installation of Flexible Pressure and Fire Seals." This procedure was presented to the inspector for review. Procedure MP 1700.29.0 identifies minimum overlap axial seam requirements based upon Bisco Test Report 748-109. This procedure also includes several QC verification hold points which will allow for appropriate QC review. The inspector reviewed this procedure and determined it to be adequate for general boot seal applications; however, according to the licensee's staff, additional minor changes to the procedure may occur, if necessary, once installation of the new boot seals has begun and unique boot seal assembly configurations are identified in the field.

On February 5, 1986, the inspector attended a training class on the installation of boot seals. A demonstration of installing a boot seal was shown using the current MP 1700.29.0 procedure along with related administrative, technical, and background information which was also discussed during the course of instruction.

In the licensee's response to this violation, the date scheduled for full compliance was February 21, 1986. However, subsequent to the submittal (dated December 26, 1985), the licensee determined during the field boot seal inspection that identifying the adequacy of the axial overlap seam without removal of the boot was questionable. As a result, the licensee has decided to replace 100% of their boot seal installations. Nonconformance Reports have been written and are being dispositioned. Due to the boot seals application as a negative pressure boundary, it is necessary that the boot seals be in place and their installation verified adequate prior to entry into Mode 4. Replacement of the seals will be followed by the Resident Inspection staff.

3. Licensee Action on Licensee Event Reports

(Closed) Licensee Event Reports (LER) (346/83041-03 and 346/83046-03): These LER's documented deficiencies in the performance of certain fire dampers. As discussed above, the licensee has decided to replace all fire dampers with more reliable models. In the interim, the existing fire dampers have been declared inoperable and Technical Specification required compensatory measures have been implemented. The inspector has no further questions regarding this matter. Replacement of the dampers is being tracked by open item (346/86001-01)DRS)).

(Closed) Licensee Event Report (346/83042-03): Main steamline room fire doors blocked open. This item is closed based on the licensee's corrective actions which included immediately closing the subject doors, posting signs reading "Fire Door, Keep Closed" and added emphasis to employee training (GET) regarding the need to keep fire doors closed.

(Open) Licensee Event Report (346/83069-03): Fire doors did not have required labels attesting to fire rating. Eleven doors were declared inoperable. Fire watches were not established per technical specifications. The NRC granted a licensee exemption request for door No. 215 in a letter dated August 29, 1984, (A. DeAgazio-NRC to R. P. Crouse-TECo). Door Nos. 601 and 602 to the main steamline room remain unqualified. The licensee plans to provide technical justification in the next revision of the FSAR (by March 31, 1986), for leaving these doors in place.

Licensee purchase order 642-2426-48 dated January 23, 1986, was issued to have Underwriters Laboratories, Inc. (U.L.) evaluate doors 320, 321, 322, 323, 427, 428, 429, and 605 for fire resistivity. The results of this evaluation are expected to be completed by March 31, 1986. This item remains open pending the results of the U.L. evaluation and the licensee's implementation of final corrective actions.

(Closed) Licensee Event Report (346/85015-00): Procedure for setting Limatorque valve operators provided by Torrey Pines Technology. The licensee has developed, approved, and is using new procedures that correct deficiencies identified. These are being used to reset all Limatorque operators. The procedures were reviewed by the inspector and the results were reported in Inspection Report 50-346/85027(DRP). This item is considered closed.

4. Licensee Action on 10 CFR Part 21 Reports

(Closed) 10 CFR Part 21 Report (Torrey Pines Technology Limatorque Setting Procedure): The licensee has adopted motor-operated valve torque and geared limit switch settings independent of the Torrey Pines recommendations. Procedures and controls are in place to assure that the desired settings are correctly set in the field, and that the problems identified with the Torrey Pines recommendations are corrected. Manufacturer recommendations are followed for setting the torque switches and the open torque switch bypass is set to open at approximately 20 to 25% of the valve disc travel. This corrects the problems identified and this item is considered closed.

5. Containment Fire

The inspector examined the details involving a containment fire that occurred on February 5, 1986, some time between 3:35 a.m. and 5:05 a.m. This examination included discussions with licensee personnel familiar with the fire incident, a tour by the inspector accompanied by licensee personnel of the containment area involved in the fire, a visual inspection of those materials burned in the fire, and a review of the licensee's written investigation of the circumstances relative to the fire incident.

The information obtained by the inspector regarding the fire incident indicates that at approximately 3:20 p.m. on February 4, 1986, an electrical bus was deenergized, isolating power from the containment at elevation 565 near a letdown isolation valve. This apparently resulted in ongoing work being stopped. air gun, which was being used at the time, was left deenergized with the switch in the "hot on" position. At 3:35 a.m. on February 5, 1986, the electrical power was restored. This resulted in the air gun coming on. The nozzle of the gun, becoming hot, ignited what appeared to be a plastic tool belt on which the gun was lying and an anti-contamination plastic bag located in the area. An individual from the Radiation Protection Department, performing a routine tour of the Containment Building, smelled the products of combustion at approximately 5:05 a.m., reported the fire to the Control Room, and then responded to the area involved. Using a dry chemical fire extinguisher, he extinguished the fire. The Fire Brigade was notified and reported to the fire scene.

There is an ionization type fire detection system installed in the Containment Building; however, it did not activate during the fire. In the inspector's estimation it appeared that the failure of the detection system to activate was due to the location of the materials burning, the open grating ceiling above the fire with pockets separated by beams, the lack of detectors in all beam pockets, and the amount of combustibles consumed (one plastic tool belt and one anti-contamination plastic bag).

Sufficient time was not available for the inspectors to review in detail drawings, ventilation diagrams, or other applicable documentation concerning the Containment Building Fire Detection System design capabilities. From a visual observation of the ceiling configuration directly over the area involved in the fire, it did not appear that the letter of the NFPA code was being violated. The licensee agreed to re-review the Containment Building Fire Detection System to determine its adequacy and, based on certain plant-specific configurations, whether additional fire detectors need to be installed. This re-review of the Containment Building Fire Detection System is considered an open item (346/85006-04(DRS)). NFPA applicable standards as committed to by Toledo Edison and the fire detection system manufacturer's design recommendations should be utilized during the re-review.

No violations or deviations were identified.

6. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which include some action on the part of the NRC, the licensee, or both. Open items disclosed during this inspection are discussed in paragraphs 2 and 5.

7. Exit Interview

The inspectors met with licensee representatives at the conclusion of the inspection on February 6, 1986, and summarized the scope and findings of the inspection. The licensee acknowledged the statements made by the inspectors. The inspectors also discussed the likely informational content of the inspection report with regard to documents reviewed by the inspectors during the inspection. The licensee did not identify any of the documents as proprietary.