

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 7 8 9 O H D B S 1 14 2 15 0 0 - 0 0 0 0 - 0 0 25 3 26 4 1 1 1 1 30 4 57 CAT 58 5

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T

0 1 7 8 9 REPORT SOURCE 60 61 L 6 62 0 63 5 64 0 65 0 66 0 67 3 68 4 69 6 70 7 71 0 72 3 73 1 74 1 75 8 76 2 77 8 78 0 79 4 80 0 81 8 82 8 83 2 84 9

DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

(NP-33-82-16) On 3/11/82 at 1430 hours, an equipment operator found door 101A blocked open by a temporary hose. At the time, contractor personnel were performing a flush of a level instrumentation column. The personnel involved left the area without re-moving the hose preventing it from closing completely. The door is a marked fire door. An equipment operator was posted at the door until the hose was removed in order to meet the requirements of T.S. 3.7.10. There was no danger to the public or station personnel. There was no fire during the occurrence.

09		SYSTEM CODE A B		CAUSE CODE A	CAUSE SUBCODE E	COMPONENT CODE Z Z Z Z Z Z						COMP. SUBCODE Z	VALVE SUBCODE Z
7	8	9	10	11	12	13	14	15	16	17	18	19	20
LER RD REPORT NUMBER		EVENT YEAR 8 2		SEQUENTIAL REPORT NO. 0 1 4		OCCURRENCE CODE 0 3		REPORT TYPE L		REVISION NO. 0			
21	22	23	24	25	26	27	28	29	30	31	32		
ACTION TAKEN X		FUTURE ACTION Z		EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N	
33	34	35	36	37	38	39	40	41	42	43	44	45	46
PRIME COMP. SUPPLIER Z		COMPONENT MANUFACTURER Z 9 9 9											
47	48	49	50	51	52	53	54	55	56	57	58	59	60

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was due to a construction personnel error. The personnel involved ignored
1 1 the sign on the door and left the door blocked open. The station requirements for
1 2 fire and negative pressure doors had been presented to all contractor crafts on 3/5/82.
1 3 The contractor general foreman was given a written warning and the foreman in charge
1 4 of the work was issued a 30 day suspension from the Davis-Besse site.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	0	6	9	NA	A	Discovered by an equipment operator	
7	8	9	10	11	12	13	14	15	16
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE			
1	6	Z	Z	NA					
7	8	9	10	11	12	13	14	15	16
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			
1	7	0	0	0	Z	NA			
7	8	9	10	11	12	13	14	15	16
PERSONNEL INJURIES		NUMBER		DESCRIPTION					
1	8	0	0	0	NA				
7	8	9	10	11	12	13	14	15	16
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					
1	9	Z	NA						
7	8	9	10	11	12	13	14	15	16
PUBLICITY		ISSUED		DESCRIPTION					
2	0	N	NA						
7	8	9	10	11	12	13	14	15	16

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NRC USE ONLY

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-82-16

DATE OF EVENT: March 11, 1982

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Door 101A blocked open by a temporary hose

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 1911 and Load (Gross MWE) = 617.

Description of Occurrence: On March 11, 1982, at approximately 1430 hours an equipment operator found door 101A to the Maintenance Work Area (Room 109) blocked open by a temporary hose. At the time, contractor personnel were performing a flush of a level instrumentation column. This work required running the hose through door 101A. The personnel involved left the area to take a break, leaving the hose through the door, preventing it from closing completely. This door is a marked station fire door. An equipment operator was posted at the door until the hose was removed in order to meet the requirements of Technical Specification 3.7.10.

Designation of Apparent Cause of Occurrence: The cause of this occurrence was due to a construction personnel error. The personnel involved ignored the sign on the door and left the door blocked open. The station requirements for fire doors and negative pressure doors had been presented to all contractor crafts on March 5, 1982 by the Maintenance Engineer.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel. There was no fire during the duration of this occurrence.

Corrective Action: The contractor general foreman was given a written warning and the foreman in charge of the work was issued a 30 day suspension from the site in accordance with the station's standard work rules for contractor personnel.

Failure Data: A previous occurrence was reported in Licensee Event Report NP-33-81-92 (81-078).

LER #82-014