NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: O H D B S 1 ② | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 ③ | LICENSE TYPE: 4 1 1 1 1 ④ | CAT ⑤

CON'T 01 | REPORT SOURCE: L ⑥ | DOCKET NUMBER: 0 5 0 0 0 3 4 6 ⑦ | EVENT DATE: 1 1 2 4 8 3 ⑧ | REPORT DATE: 1 2 2 9 8 3 ⑨

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

(NP-33-83-95) On 11/24/83 at 2100 hours, an equipment operator discovered that Fire Dampers (FD) 1085, 1084, and 1111 were not being continuously monitored as required by Technical Specification 3.7.10. Investigation revealed that the individual performing the fire watch was sitting in the Auxiliary Building southwest stairway observing FD1085 and could not observe FD1084 and FD1111. There was no danger to the health and safety of the public or station personnel. Fire detection and suppression systems are located in the area and were operable.

SYSTEM CODE	A B ⑪
CAUSE CODE	A ⑫
CAUSE SUBCODE	F ⑬
COMPONENT CODE	Z Z Z Z Z Z ⑭
COMP. SUBCODE	Z ⑮
VALVE SUBCODE	Z ⑯

⑰ LER/RO REPORT NUMBER

EVENT YEAR	8 3
SEQUENTIAL REPORT NO.	0 6 7
	/
OCCURRENCE CODE	0 3
REPORT TYPE	X
	—
REVISION NO.	1

ACTION TAKEN	X ⑱
FUTURE ACTION	H ⑲
EFFECT ON PLANT	Z ⑳
SHUTDOWN METHOD	Z ㉑
HOURS ㉒	0 0 0 0
ATTACHMENT SUBMITTED	Y ㉓
NPRD-4 FORM SUB.	N ㉔
PRIME COMP. SUPPLIER	Z ㉕
COMPONENT MANUFACTURER	Z 9 9 9 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

This event is attributable to personnel error in that contract personnel failed to report for work, resulting in a lack of adequate coverage. The contract Shift Supervisor was aware of the problem, but failed to inform the Toledo Edison Shift Supervisor. Upon discovery, the individual was moved to an area where all three fire dampers could be observed.

FACILITY STATUS	E ㉘
% POWER	1 0 0 ㉙
OTHER STATUS ㉚	NA
METHOD OF DISCOVERY	A ㉛
DISCOVERY DESCRIPTION ㉜	Found by an Equipment Operator
ACTIVITY RELEASED	Z ㉝
CONTENT OF RELEASE	Z ㉞
AMOUNT OF ACTIVITY ㉟	NA
LOCATION OF RELEASE ㊱	NA
PERSONNEL EXPOSURES NUMBER	0 0 0 ㊲
TYPE	Z ㊳
DESCRIPTION ㊴	NA
PERSONNEL INJURIES NUMBER	0 0 0 ㊵
DESCRIPTION ㊶	NA
LOSS OF OR DAMAGE TO FACILITY ㊸ TYPE	Z ㊷
DESCRIPTION	NA
PUBLICITY ISSUED	N ㊹
DESCRIPTION ㊺	NA

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PDR ADOCK 05000346
S PDR

NRC USE ONLY

DVR 83-174

NAME OF PREPARER Russ Ebersole

PHONE: (419) 259-5000, Ext. 594

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-83-95

DATE OF EVENT: November 24, 1983

FACILITY: Davis-Besse Unit 1

IDENTIFICATION OF OCCURRENCE: Fire Dampers FD's 1085, 1084, and 1111 were not being continuously fire barrier watched.

Conditions Prior to Occurrence: The unit was in Mode 1, with Power (MWt) = 2766 and Load (Gross MWe) = 919.

Description of Occurrence: On November 24, 1983 at 2100 hours, a plant equipment operator discovered that Fire Dampers 1085, 1084, and 1111 were not being continuously monitored as required by Technical Specification 3.7.10. Investigation by the Shift Supervisor concluded that the individual performing the fire watch was sitting in the Auxiliary Building southwest stairway observing FD 1085. By positioning himself in the stairway, the fire barrier watch individual could not continuously observe Fire Dampers FD 1084 and FD 1111. The individual was instructed by the Shift Supervisor to move to the Radwaste Ventilation Room where he could observe the area where the fire dampers were located.

Designation of Apparent Cause of Occurrence: This event is attributable to personnel errors in that contract personnel failed to report for work, resulting in a lack of adequate coverage for a fire barrier watch post. The contractor Shift Supervisor was aware of the problem, but failed to inform the Toledo Edison Shift Supervisor of the lack of adequate manning for the above mentioned fire barrier watch. A written procedure, AD 1810.00, Fire Protection Program, is available to provide the requirements of fire barrier watches.

Analysis of Occurrence: There was no danger to the health and safety of the public or station personnel since fire detection systems were operable in the unwatched area. Full fire suppression capability was also available, and a complete trained and equipped Fire Brigade was on duty to investigate and, if necessary, combat any occurrence of an incendiary event.

Corrective Action: The contractor has committed to maintain extra personnel to insure that failure of their personnel to report for work does not impact on plant fire barrier watch patrols.

The situation was immediately corrected by the Shift Supervisor at approximately 2100 hours on November 24, 1983. The corrective action, moving the fire barrier watch to the Radwaste Ventilation Fan Area, removed the unit from violation of Technical Specification 3.7.10.

A memo will be written to inform the contractor's Shift Supervisors of the standard and customary practices which will be followed in the event of insufficient manpower to cover all fire barrier watch posts.

Failure Data: There have been no previous similar occurrences.

DmB

TOLEDO EDISON

December 29, 1983

Log No. K83-1765
File: RR 2 (NP-33-83-95)

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

Mr. James G. Keppler
Regional Administrator, Region III
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

Enclosed are three copies of Reportable Occurrence NP-33-83-95, which was incorrectly assigned LER Sequential No. 83-066. The attached copies have been revised to indicate the correct LER Sequential No. 83-067.

Please destroy your previous copies of this report and replace with the attached corrected copies.

Yours truly,

Terry D Murray/SMQ

Terry D. Murray
Station Superintendent
Davis-Besse Nuclear Power Station

TDM/ljk

Enclosure

cc: Mr. Richard DeYoung, Director
Office of Inspection and Enforcement
Encl: copies

Mr. Norman Haller, Director
Office of Management and Program Analysis
Encl: 3 copies

Mr. Walt Rogers
NRC Resident Inspector
Encl: 1 copy