CENTERIOR ENERGY

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Docket Number 50-346

License Number NPF-3

Serial Number 1-976

March 9, 1992

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Subject: Response to Inspection Report Number 50-346/91016

Gentlemen:

Toledo Edison (TE) has received Inspection Report 91016 (Log Number 1-2605) and provides the following response.

Requirement: 10 CFR Part 50, Appendix B, Criterion V, as implemented by the Toledo Edison Nuclear Quality Assurance Manual, Quality Requirement 5.4.1.2, requires that activities that affect quality shall be prescribed by clear and complete documented procedures and instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these documents.

Violation 91016-01A: Control Work procedure DB-PN-00007, Rev. 1, Attachment 26, requires, in part, that modification training requirements have been met and that functional tests, such as calibrations, have been completed before signing off the specific requirements.

Contrary to the above:

(1) The Maintenance Work Order (MWO) Verification Checklist for MWO 2-90-0059-03, had Block 2 signed and dated October 4, 1991, indicating that training requirements had been met. However, 12 reactor operators/senior reactor operators did not receive their training until October 9 - 10, 1991.

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(2) The MWO Verification Checklist for MWO 2-90-0078-05, affecting modification 90-0078 had Block 5 signed and dated October 13, 1991, indicating that all functional testing had been completed. However, the calibration phase of the level transmitters was not completed until November 2, 1991.

Response to Example (1): Acceptance or Denial of the Alleged Violation

Toledo Edison acknowledges the alleged violation.

Reason for the Violation

During the Seventh Refueling Outage, Modification 90-0059 was implemented to provide manual isolation valves and instrumentation to facilitate inspection and testing of the Service Water System. Prior to returning the system to service, DB-PN-00007, "Control of Work" requires that operator training be completed. However, due to a misunderstanding of the specific requirements as to the training that must be completed prior to closure of a Maintenance Work Order (MWO), all training was not completed prior to returning the system to service. The intent of completing modification training prior to returning a system to service is to ensure that licensed individuals are cognizant of system changes prior to operating those systems.

Nuclear Training was conducting classroom training for Modification 90-0059 during the refueling outage to meet the training requirements. In discussions between Nuclear Training and Operations on October 4, 1991, Modification 90-0059 was being reviewed for completion to allow the Service Water System to be returned to service. It was recognized at that time that twelve licensed individuals had not completed the classroom training. Nine individuals on the on-shift operating crew had completed their watch at 0400 on October 4, 1991. They were scheduled to be in training on their return to work the week of October 7, 1991. At that time, the Control Room Required Reading Book was reviewed and it was determined that all but one of the nine on-shift operating crew members had reviewed the required reading associated with Modification 90-0059. The required reading consisted of a description of procedure changes associated with the modification. The three remaining active licensed individuals that had not received the required training prior to October 4, 1991, were assigned outage-related duties and were not assigned licensed duties.

Based upon the above information and the fact that DB-PN-00007 does not specify the type of training that must be completed, the training for MWO 2-90-0059-03 was signed off as being completed.

Corrective Actions Taken and Results Achieved

The individuals involved in this event have been counseled regarding the importance of properly following procedures. These individuals have been further instructed to ensure all training is complete, regardless of shift assignment, prior to signing the training completion block.

Training for all licensed individuals was completed on October 10, 1991.

Corrective Actions to Prevent Recurrence

Procedures DB-PN-00007, "Control of Work", and NG-EN-00301, "Plant Modification," will be revised to allow for release of a system to Operations prior to training completion provided other administrative controls (i.e., Unit Log entries or Operating Night Orders) are in place to prevent any individual from performing license duties until that individual receives the required training. This action is consistent with the intent of ensuring training is conducted for significant plant modifications prior to licensed individuals operating those systems.

Date When Full Compliance will be Achieved

Full compliance was achieved on October 10, 1991, when all licensed individuals completed training on Modification 90-0059.

In addition, the corrective actions noted above to prevent recurrence will be implemented by September 4, 1992.

Response to Example (2): Acceptance or Denial of the Alleged Violation

Toledo Edison acknowledges the alleged violation.

Reason for the Violation

During the preparation of MWO 2-90-0078-05 for Modification 90-0078, all of the testing requirements were specified as functional tests. These included DB-MI-03245, "Channel Functional Test and Device Calibration of 83C-ISLSP9A6, A7, B8 and B9 SFRCS Steam Generator Actuation Channel 2 Level Inputs" and

DB-SC-03180, "Remote Shutdown, Post Accident Monitoring Instrumentation Monthly Channel Check." Following the completion of work for MWO-2-90-0078-05, functional testing was being performed and it was discovered that DB-MI-03245 and DB-SC-03180 could not be completed prior to system turnover to Operations since the procedures required the system to be placed in service upon test completion. However, DB-MI-03245 was partially completed and the test acceptance criteria were met. The Planner responsible for the modification then signed for the functional testing being completed, intending that DB-MI-03245 and DB-SC-03180 be redefined as Post Modification Tests to be completed after the system was returned to service. However, he neglected to properly document this in the MWO. Upon review of the MWO for closure on October 19, 1991, this discrepancy was identified, the test deficiency was noted and dispositioned as being acceptable. The MWO was closed by Operations and the Modification placed in service on November 3, 1991.

DB-MI-03245 and DB-SC-03180 should have originally been designated as Post Modification Tests instead of Functional Tests. Per DB-PN-00007, the proper actions the Planner should have taken would be to have noted and dispositioned the testing deficiency prior to signing for the completion of functional testing.

Corrective Actions Taken and Results Achieved

The intent of DB-PN-00007 and DB-PF-01025, "Pre-Maintenance and Post-Maintenance Testing Requirements" has been re-emphasized to the individual involved. In particular, the categorization of test requirements was discussed as intended by DB-PF-01025.

As was noted above, the testing deficiency was noted and dispositioned as acceptable. The required testing was completed and the modification was placed in service on November 3, 1991.

Corrective Actions to Prevent Recurrence

Procedures DB-PN-00007 and DB-PF-01025 were reviewed to determine if enhancements could be made to better clarify the specification of proper testing requirements. DB-PF-01025 will be revised to better clarify the proper categorization of test requirements for planners to be used when completing the MWO Test Requirements sheet. Revision of this procedure will be completed by May 15, 1992.

Date when Full Compliance will be Achieved

Full compliance was achieved on November 3, 1991, upon successful completion and review of required testing.

The corrective actions to prevent recurrence noted above will be implemented by May 15, 1992.

Violation 91016-01B: Potential Condition Adverse to Quality Reporting (PCAQ) procedure NG-QA-00702, Rev. 2, step 6.1.5 requires that a new PCAQ be generated if additional potential conditions adverse to quality are found that violate the same requirements addressed in an existing PCAQ, and the existing PCAQ has been closed or sent to Document Systems. Step 6.1.7 requires that if the existing PCAQ is still open, the new condition be identified as a continuation sheet of the original PCAQ.

Contrary to the above, neither a new PCAQ nor a continuation sheet to PCAQ 91-0521 was written as a result of the No. 2 emergency diesel generator failure to develop rated voltage within 10 seconds on November 8, 1991.

Response: Acceptance or Denial of the Alleged Violation

Toledo Edison acknowledges the alleged violation.

Reason for Violation

On November 8, 1991, during performance of the No. 2 Emergency Diesel Generator (EDG) Monthly Surveillance Test, DB-SC-03071, No. 2 EDG was idle started and idle released to full speed. Approximately 30-45 seconds later, the System Engineer noticed an absence of electrical generator output as indicated on the frequency and voltage meters. Within the next five seconds, the No. 2 EDG field flashed and frequency and voltage indicators responded. The System Engineer informed the EDG operators of the indications and proceeded to inform Systems Engineering management. Systems Engineering recommended to the Shift Supervisor to maintain No. 2 EDG paralleled to the grid to ensure operability, and recommended installing a strip chart recorder and performing a fast timed start to verify the ten second start criteria was met. A six channel strip chart was installed while the engine was running and the engine was shut down. Within five to ten minutes, the engine was fast started reaching rated speed and voltage in 7.7 seconds. No abnormalities were noted on the strip chart. Operations maintained the operable status of No. 2 EDG with Systems Engineering concurrence.

Operations and Systems Engineering discussed the similarities between this delay and the failure of No. 2 EDG on October 21, 1991, and concurred that a problem existed which appeared to degrade over time. A decision was made to formulate an action plan to troubleshoot the EDG field flash circuitry. Although System Engineer discussed the plan with Systems Engineering and Operations management on November 1? 199i, the question as to whether or not a PCAQ shou be written to document the discrepancy was not discussed. Following further discussions on November 20, Systems Engineering determined that PCAQR should have been written and initiated PCAQR 91-0584. At this time, the action plan to correct the EDG field flash circuit discrepancy was well underway.

Corrective Actions Taken and Results Achieved

As noted above, PCAQR 91-0584 was initiated on November 20, 1991.

Corrective actions taken as a result of the No. 2 EDG failure on November 8, 1991 and subsequent failures of No. 2 EDG are described in TE's letter of December 6, 1991 (Serial Number 1-967).

In order to reinforce TE management expectations of the PCAQR process, Systems Engineering personnel were briefed on this event and the procedural requirements related to the initiation of PCAQRs was emphasized.

Support of the PCAQR process was further promoted site-wide through an article in the Davis-Besse weekly newsletter. This was completed on March 6, 1992.

Corrective Actions Taken to Prevent Recurrence

Based upon a review of prior PCAQRs and results of a September 1991 Quality Assurance audit, failure to initiate a PCAQR for a condition requiring one is not a wide-spread or repetitive occurrence. In addition, TE believes its existing procedural controls over the PCAQR process are sufficient to prevent recurrence.

Date when Full Compliance will be Achieved

Full Compliance was achieved on November 20, 1991, when a PCAQR for the event described above was initiated.

Should you have any questions or require additional information, please contact Mr. R. W. Schrauder, Manager - Nuclear Licensing, at (419) 249-2366.

Very truly yours,

NKP

cc: A. B. Davis, Regional Administrator, NRC Region III
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