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Docket Number 50-346

License Number NPF-3

Serial Number 1-1039

April 15, 1994

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D. C. 20555

Subject: Response to Notice of Violation - Inspection Report
Number 50-346/94002 (DRP)

Gentlemen:

Toledo Edison is in receipt of Inspection Report 94-002 (Log Number 1-2995) and the enclosed Notice of Violation; the response which is provided below.

Violation: 10 CFR Part 50, Appendix B, Criterion V,
94002-01 "Instructions, Procedures, and Drawings," states, in part that "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings ... and shall be accomplished in accordance with these instructions, procedures, or drawings."

Procedure DB-MI-03730, Channel Calibration of Channel 2 Containment Vessel Atmosphere Hydrogen Analyzer, step 4.1.4 specifies that if, during performance of the procedure, any malfunction is found which could prevent the fulfillment of channel functional test requirements, the shift supervisor and Instrumentation and Control (I&C) department supervisor shall be notified immediately.

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Operating Companies
Cleveland Electric Illuminating
Toledo Edison

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Contrary to the above, on September 3, 1993, during performance of DB-MI-03730, revision 00, maintenance personnel identified a malfunction in containment hydrogen analyzer channel 2 which would prevent the fulfillment of channel functional test requirements and did not immediately notify the shift supervisor and I&C department supervisor.

This is a Severity Level IV Violation (Supplement I).

Response:

Acceptance or Denial of the Alleged Violation

Toledo Edison accepts the alleged violation.

Reason for the Violation

On September 3, 1993, calibration of containment hydrogen analyzer (CHA) Channel 2 was in progress. In accordance with section 8.2.4 of DB-MI-03730, the technician performing the calibration was in the process of lifting leads from terminal strip TS1 in panel C3801. During this process, the technician inadvertently shorted the 120 VAC line voltage to ground which resulted in Channel 2 CHA power supply fuse Y218 blowing.

The technician, aware that Channel 1 was the standby channel, noted that power indicating lights for both channels were off. The technician was not aware that this was the proper indication for Channel 1. The standby CHA channel has been maintained as a normally de-energized circuit since the Eighth Refueling Outage. The technician believed that his actions in Channel 2 had caused Channel 1 to de-energize because both channels are located in the same cabinet.

The technician inappropriately attempted to verify the condition of CHA Channel 1 by trying to start the Channel 1 sample pump. The sample pump did not start and the technician correctly contacted the Control Room and his supervisor.

It was later discovered that CHA Channel 1 power supply fuse Y119 had also blown. Consequently, both CHA channels were coincidentally inoperable. It is believed that fuse Y119 blew as a result of the attempted start of the Channel 1 sample pump due to the fuse being potentially under-rated. This condition is being evaluated under Potential Condition Adverse to Quality Report (PCAQR) 93-0415.

No Technical Specification (TS) violation occurred because both power supply fuses were replaced and power was restored to both CHAs well within the 72 hour outage time allowed by TS 3.6.4.1 for two inoperable CHAs.

Nevertheless, the action the technician took in attempting to start the CHA Channel 1 sample pump was outside of the scope of DB-MI-03 JO and is considered an equipment control deficiency. It is the expectation of Davis-Besse management that manipulation of station equipment should only be performed under the cognizance of Operations personnel, unless the manipulation is specifically within the scope of a Maintenance Work Order (MWO) or procedure. This expectation is generally understood by plant staff and is adequately proceduralized. However, in the case of surveillance/periodic test procedure performance, training of maintenance personnel was not sufficient.

Corrective Actions Taken and Results Achieved

Potential Condition Adverse to Quality Report (PCAQR) 94-0241 was initiated on March 2, 1994, to document concerns identified with equipment control issues related to the loss of power to both containment hydrogen analyzers.

A memorandum from the Operations Manager dated March 31, 1994, was distributed to all site personnel. The memorandum provides information and guidance on management expectations regarding manipulation of equipment that may affect plant operations.

The equipment control deficiency described in this response was discussed with the involved technician and at an I&C Maintenance shop meeting. In addition, equipment and procedural control issues were discussed at the Vice President - Nuclear's staff meeting on April 13, 1994. The meeting was attended by plant supervisory personnel.

Corrective Actions to Prevent Recurrence

This issue will be a topic of discussion at continuous training sessions for all maintenance craft and first line maintenance supervisory personnel. These sessions will be complete by June 30, 1994.

Maintenance staff personnel will complete required reading of this response by May 20, 1994.

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Date When Full Compliance will be Achieved

Full compliance will be achieved by June 30, 1994,
following completion of the continuing training
sessions referenced above.

Should you have any questions or require additional information,
please contact Mr. William T. O'Connor, Manager - Regulatory Affairs,
at (419) 249-2366.

Very truly yours,

*Smuel again
for DC Shelton*

AVA/eld

cc: J. B. Martin, Regional Administrator, NRC Region III
S. Stasek, DB-1 NRC Senior Resident Inspector
G. West, Jr., NRC Project Manager
Utility Radiological Safety Board