DMB

TOLEDO EDISON

JOE WILLIAMS, JR.
Senior Vice President - Nuclear
(419) 249-2300
(419) 249-5223

Docket No. 50-346

License No. NPF-3

Serial No. 1-651

July 16, 1986

Mr. C. E. Norelius, Director
Division of Reactor Projects
United States Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr. Norelius:

Toledo Edison has received Inspection Report No. 50-346/86012 (Log No. 1-1400) and provides the following response.

Violation:
86012-01

Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained. In addition, 10 CFR 50, Appendix B Criterion V states in part, "Activities affecting quality shall be prescribed by . . . and shall be accomplished in accordance with these instructions, procedures, and drawings." Section 5.1.1 of the licensee's Nuclear Quality Assurance Manual (NQAM) states, "Division directors performing activities covered by this QA Manual shall ensure these activities are carried out in accordance with approved procedures."

The licensee failed to accomplish this, as demonstrated by the following examples:

a. Administrative Procedure AD 1845.03.0, "Facility Change Request (FCR) Implementation", Section 7.1.7, states, "Operator training is coordinated and completed prior to equipment/system return to service."

Contrary to the above, an emergency diesel generator (EDG) was declared operable on, or about, March 11, 1986, when modification work performed under FCR 84-189 was completed; however, 27 licensed operators and 20 non-licensed operators had not completed training as of March 12, 1986.

8610060205 860716
PDR ADOCK 05000346
Q PDR

JUL 18 1986

A001

b. The Design Review checklist (Item 5) in Nuclear Facility Engineering Procedures NFEP-011, "Conceptual Design," and NFEP-090, "Design Verification," requires that environmental design considerations be reviewed.

Contrary to the above, the licensee installed two Control Room Emergency Ventilation System control cabinets as a part of FCR 85-0265. The seismically qualified cabinets were installed under nonseismically supported water lines and the licensee did not consider the environmental conditions that would result from a waterline break.

c. Enclosure 2 of Administrative Procedure AD 1838.00.12 "Surveillance and Periodic Test Program," requires that test personnel "Record all test deficiencies on test deficiency list. "Section 4.2 of Administrative Procedure AD 1838.02.13, "Performance of Surveillance and Periodic Tests" states that "The Test Deficiency List is provided to ensure that all test deficiencies . . . are recorded . . .".

Contrary to the above, a test deficiency that occurred during the performance of Surveillance Test ST 5030.12.13, "Channel Functional Test of the Reactor Trip Module Logic and Control Rod Drive Trip Breakers", was not recorded on a Test Deficiency List.

Response: Acceptance or Denial of the Alleged Violation

Toledo Edison acknowledges the alleged violation.

86012-01a Reason for the Violation

The cause of this nonconformance appears to be inadequate procedures to ensure that the required operator training is conducted prior to equipment/system return to service following a Facility Change Request (FCR) implementation. The procedural inadequacies are: 1) lack of proper guidance in determining training completion and 2) the procedures contain certain inconsistencies which lead to confusion concerning the exact training requirements.

AD 1845.02, FCR Initiation and Development, describes the process for the initial request, review and approval for issuing of an FCR for implementation. AD 1845.02 requires a Training Notification form be supplied to the Training Department. The Training Notification form notifies Training of the work to be performed by the FCR. Training determines what training is required to ensure operator awareness of equipment/system changes. The responsible

Training Coordinator determines what type of training is required and assigns a scheduled completion date. This training may consist of formal class training, required reading, briefing prior to assuming watchstanding duties, or some other method deemed appropriate by the Training Coordinator. The original Training Notification form is then returned to the Facility Modification Department (FMD). The Training Notification form is a scheduling tool and does not verify that the training has been completed.

AD1845.03, FCR Implementation, Section 7.1.7 states, "Operator training is coordinated and completed prior to equipment/system return to service." AD1845.03 also requires completion of an FCR/MWO Work Verification Checklist. One of the activities verified by the checklist is that "...the required operator training has been completed or scheduled as applicable to meet the equipment operability needs."

AD1845.04, FCR Closeout, requires completion of the FCR/MWO Work Verification Checklist. The Cognizant Modification Coordinator is to determine if the training requirements have been met by reviewing the completed and signed off (by the Training Coordinator) original Training Notification form.

As stated previously, the approved procedures verify the required training is scheduled and do not verify the completion of training. Thus, if delays in training were incurred the training may not be completed prior to equipment return to service.

In the specific case of FCR 84-189, Resolution of EDG Problems, the conservative approach was taken (formal training) to ensure adequate training was conducted. Formal training was scheduled and the original Training Notification form was returned to FMD. The FCR/MWO Work Verification Checklist step was completed verifying that the required operator training had been completed or scheduled by reviewing the original Training Notification form. Training recognized that the scheduled date would not be met and the determination was made that the training could be accomplished by required reading. The required reading was distributed for review; however, the reviews were not accomplished prior to returning the EDG to service. Verification of actual training completion or notification that the training may not be completed as scheduled was not clearly required by procedure.

Corrective Actions Taken And Results Achieved

The training concerning FCR 84-189 has been completed. The Modification Coordinators have been given instructions to contact Training to verify that the required training has been completed. In addition, the Shift Supervisors have been instructed not to return the affected equipment/ system to service prior to reviewing documentation verifying that the training has been completed.

Corrective Action To Be Taken To Avoid Further Violation

AD1845 series procedures for FCR initiation, development, implementation, and closeout is being reviewed for clarity and improved guidance concerning training verification. The procedures will be revised as necessary.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved with the issuance of specific guidance concerning training verification. The AD1845 series concerning the FCR process will be revised as necessary by August 22, 1986.

86012-01b Reason for the Violation

The cause of this error has been determined to be: 1) inadequate initial review/documentation during the design review walkdown conducted prior to FCR origination, and 2) inadequate technical review of the FCR.

Station heating of Room 603, Mechanical Equipment Room for the Control Room Normal and Emergency Ventilation System, is provided by hot water duct heaters. The hot water heating system is non-safety-related and nonseismically qualified. Facility Change Request (FCR) 85-265 installed Control Room Emergency Ventilation System (CREVS) control cabinets (C5714 and C6715)in the vicinity of hot water lines associated with Room 603 hot water heating.

Part of the FCR initiation review process at Davis-Besse involves a review assuring that any new component installed in the plant will not adversely affect the operation of the plant. The review also assures that safety-related components are protected from potential hazards. These reviews are generally conducted by the Architect Engineer (A/E).

The design review walkdown follows the guidelines set forth in USAR Section 3.6 for evaluation of adverse effects to safety-related equipment due to pipe-rupture accidents. Specifically, for evaluation of safety-related equipment in the vicinity of non-seismic pipe outside containment.

For the items of concern (FCR No. 85-265), four hot water lines in the vicinity of electrical cabinets C6714 and C6715 were not documented as potential hazards by the individuals responsible for locating the cabinets because the water lines are not directly above the cabinets. Water/steam spray and flooding should have been evaluated for adverse effects to the cabinets.

Corrective Actions Taken and Results Achieved

The cabinets have been determined to be classified as NEMA 12 enclosures (drip proof and splash proof). Conduits entering the cabinets have been sealed thereby maintaining the NEMA 12 rating. The cabinets are located in Room 603 on supporting channel which is 5 3/16 inches high. The maximum flood elevation in this room is three inches. Therefore, neither water/steam spray or flooding in the room is likely to affect the cabinets.

In order to stress the importance and significance of water pipes relative to location of equipment, instructions to individuals responsible for locating the equipment have been revised. A more detailed checklist was added to assure that all potential hazards (e.g., non-seismic, pipe whip, jet impingement, water environment, missiles) are considered and documented.

Corrective Actions to be Taken to Avoid Furthur Violation

As part of the Performance Enhancement Program (PEP) and the Davis-Besse Course of Action (COA) report, Nuclear Engineering is in the process of improving and strengthening overall performance. This involves changes and additions to the Engineering staff (including supervisory positions) and improving training (i.e., development of plant modifications by working side by side with experienced Toledo Edison and contractor personnel as appropriate). This also includes development and improvement of procedures. These improvements are intended to promote in-house development of modifications improved safety evaluations and reviews, and less dependance on outside non-Toledo Edison support activities.

Date When Full Compliance Will be Achieved

Compliance has been achieved by verifying that the cabinets are capable of withstanding water spray.

Instructions to individuals responsible for locating equipment have been revised.
The strengthening of the Engineering organization is being implemented as discussed in the PEP and the COA.

86012-01c

As stated in the Notice of Violation for Report 86012, "the inspection showed that action had been taken to correct the identified violation and to prevent recurrence. Consequently, no reply to the violation is required . . .."

Based on the above, Toledo Edison considers this portion of Violation 86012-01 closed.

Violation: 86012-03

10CFR50.73(a)(1) states in part, "The . . . (licensee) shall submit a Licensee Event Report (LER) for any event of the type described . . . within 30 days of the discovery of the event."

Contrary to the above, following an event of the type described in 10CFR50.73, the licensee did not submit LER 86-15 until April 18, 1986, 68 days after the discovery of the event.

Response:

Acceptance or Denial of the Alledged Violation

Toledo Edison (TED) acknowledges that the lines were not seismically qualified and in the event of a rupture could have caused the failure of the battery chargers. Toledo Edison believes that LER 86-015 was submitted in a timely manner and therefore does not consider the LER submittal in question to be in violation of 10CFR50.73(d).

Also, as noted in the body of Inspection Report 86012, Toledo Edison acknowledges that the engineering analysis of this event was inadequate and supplemental information will be provided.

Reason for Denial of the Alleged Violation

10CFR50.73(d), Submission of Reports, states in part that Licensee Event Reports must be ". . . submitted within 30 days of discovery of a reportable event or situation to the Nuclear Regulatory Commission . . .".

NUREG 1022, Supplement 1, provides further guidance concerning the actual discovery date and therefore the beginning of the actual "30 day clock" and determination of the due date.

NUREG 1022, Supplement 1, states: "The discovery date (which starts the 30-day clock) is the date that the technician sees a problem. Therefore, for a single event or condition it is possible to have as many as four applicable dates:

1. The Event Date when the event actually occurred.

2. The Discovery Date when someone in the plant recognizes that the event has occurred (starts the 30-day clock).

3. The "Reportability" Date when someone decides or "discovers" that the event is reportable.

4. The Report Date when the LER is submitted".

For the item of concern, domestic water lines near the battery chargers and the effect they could have on the chargers during a seismic event, Toledo Edison feels that the discovery date is March 21, 1986 rather than February 19, 1986, as stated in Inspection Report (IR) 86012. As stated in the guidance given in NUREG 1022, Supplement 1, the discovery date is when someone in the plant recognizes that the event has occurred. In this specific case, Toledo Edison believes that the "Discovery" date and the "Reportability" date are the same. Toledo Edison feels that the "Discovery" date is the day on which it was recognized that the domestic water lines were not seismically qualified and that a rupture of these lines could cause the failure of the battery chargers. This date was March 21, 1986.

As documented in IR 86005, on February 19, 1986, the NRC Resident Inspector questioned the effect a rupture of the domestic water lines would have on the battery chargers. The Updated Safety Analysis Report (USAR) states that no domestic water lines will affect safety related equipment. This concern was noted and Deviation Report (DVR) 86-142 was initiated. Analyses were begun to determine whether the lines were seismically qualified and the consequences of a possible line rupture. During the investigation, it was found that the A/E's assistance was required to resolve these questions.

On March 21, 1986, the A/E notified Toledo Edison that the lines were not seismically qualified and that a problem (rupture of these lines could affect the battery chargers) existed. Based on the determination (discovery) that the lines were not seismic and a failure of the lines could affect the safety-related battery chargers, a report due date of April 20, 1986 was established.

Toledo Edison feels that the determination of whether a problem existed was made as expeditiously as possible. Of importance also is the fact that Toledo Edison, upon initially hearing the Resident Inspector's concern, isolated and drained the lines in question. This action was effective in eliminating any potential hazard which may have existed until the final determination could be made of whether an actual problem existed.

Toledo Edison feels that the submittal of LER 86-015 was timely and in accordance with the guidance set forth in NUREG 1022, Supplement 1. For these reasons, Toledo Edison requests that this violation be withdrawn.

Acknowledged Enhancements Which Can Be Made

Toledo Edison acknowledges that the engineering analysis of this event was inadequate. The LER should have discussed the effect the battery charger failures would have had on the station batteries. Closer attention will be given to 10CFR50.73(b) contents when preparing and reviewing LERs to ensure adequate information is provided.

Toledo Edison also acknowledges that the NRC Resident Inspectors should have been kept informed of the status of the evaluation and schedule for the LER submittal. The LER also should have contained a discussion of the reason for the event date, discovery date, and the report date as outlined in NUREG 1022, Supplement 1.

In an attempt to simplify and to provide for a timely review process on potentially reportable items, Toledo Edison has established a review board which evaluates Potential Conditions Adverse to Quality (PCAQ). This committee reviews potential conditions which may be adverse to quality to determine if a problem in fact exists. For complex items, the review board may assign responsibility for determination of whether an actual problem exists. This also includes prioritization, scheduling, and tracking of assigned items to ensure timely responses and subsequent reporting, if necessary.

The above noted improvements should ensure improved LER content, improved internal plant communications, improved communications between the plant and the NRC, and continued and improved timeliness in submittal of reportable events.

Very truly yours,

JW:JS

cc: DB-1 NRC Resident Inspector

DD C/301