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November 13, 2001

VIA FEDERAL EXPRESS

Bruce A. Berson, Esq.
Regional Counsel
U.S. Nuclear Regulatory Commission
801 Warrenville Road
Lisle, Illinois 60532

H. Brent Clayton
Enforcement Officer
U.S. Nuclear Regulatory Commission
801 Warrenville Road
Lisle, Illinois 60532

Re: Davis-Besse Nuclear Power Station
Investigation into C.R. 01-0091

Dear Mr. Berson and Mr. Clayton:

As a follow-up to my conversation with Mr. Berson, this letter is being sent to request enforcement discretion with regard to the investigation into the above-referenced matter and to request that the Region refrain from issuing a Notice of Violation in that matter, for the reasons described below. In doing so, reference in this submittal will be made to the "General Statement of Policy and Procedures for NRC Enforcement Actions", NUREG-1600 Rev. 1 (May 1998), and the most recently available version of NUREG-1600, dated May 1, 2000. Due in part, to the temporary unavailability of the NRC Website to the public, in the aftermath of the events of September 11, 2001, the above-cited references are the most updated versions that are available.

EA-01-261

Reference will also be made to the NRC Enforcement Manual, NUREG/BR-0195 Rev. 2 (August 1998, as amended Nov. 1998).

As your records will indicate, four management personnel were interviewed by the Office of Investigations at Davis-Besse on Thursday, July 12, 2001. Subsequent to these interviews, a copy of the Davis-Besse Ombudsman's file on this matter was requested by the OI investigator and was voluntarily provided. A copy of documents from that file with an internal memorandum, which documents are discussed below, is attached hereto for ready reference. As far as the Licensee is aware, the submittal of the requested Ombudsman documents concluded the fact-finding phase of this investigation as regards management personnel of the licensee.

Based upon the record developed and the documents submitted, it is respectfully requested, on behalf of the Licensee, that the NRC refrain from issuing a Notice of Violation, and exercise enforcement discretion in this matter, for the reasons described below. As noted at the outset, the reasons discussed below have been described with reference to Section VII B.5 of NUREG-1600 Rev. 1 (May 19, 1998), under the heading of "Mitigation of Enforcement Sanctions" and the subheading "Violations Involving Certain Discrimination Issues." As the first reason for requesting the exercise of enforcement discretion, the Licensee should receive substantial credit for **Self Identification.** As stated in NUREG-1600 Rev. 1, Section VII B.5.1:

> Enforcement discretion may be exercised for discrimination cases when a licensee, who without the need for government intervention, identifies an issue of discrimination and takes prompt, comprehensive and effective corrective action to address both a particular situation and the overall work environment for raising safety concerns.

As will be discussed below, that is precisely the case presented here.

As to "Self Identification", as the submitted documents from the Ombudsman's file indicate, an Ombudsman Concern Report ("OCR") No. 331 was filed on January 16, 2001 (Tab 1 attached hereto). The documents indicate that the Ombudsman initiated his investigation immediately upon receipt of the OCR from the concerned individual (Tab 2, attached hereto). Simultaneously, the Ombudsman notified the site Vice-President as well as the site Director-Support Services. In the Ombudsman's report (Tab 2), the Ombudsman promptly concluded that the action taken by the "responsible supervisor" in requesting an eight question fact finding (which fact finding was documented) was inappropriate (Tab 2). The Ombudsman promptly notified the concerned individual of that conclusion on January 17, 2001, the very next day after the OCR was filed (See Tab 2).

Second, the Licensee took **Prompt and Effective Corrective Action** to address both a particular situation and to clarify expectations regarding the preparation of Condition Reports.

(Tab 3 attached hereto, Memorandum of the Director-Support Services to the file). In particular, those prompt and voluntary corrective actions included the following:

1. The fact finding document was removed from the file. In that regard, it should be noted that the fact finding document was to be placed in only the personnel file of the concerned individual's immediate supervisor (who was also the "responsible supervisor"); it was not to be placed in the official personnel file at Davis-Besse;

2. The Director-Support Services met with all three shifts (of security personnel) to explain the expectation that there be an open environment for writing condition reports;

3. The Director-Support Services gave the responsible supervisor three days off to consider his actions and the importance of maintaining a Safety Conscious Work Environment at Davis-Besse;

4. The Director-Support Services met with the responsible supervisor to explain the importance of maintaining a Safety Conscious Work Environment ("SCWE") and why that supervisor's actions in this instance were not consistent with the Davis-Besse commitment to that policy.

In addition, the Ombudsman's investigation findings were promptly shared with the concerned individual, which individual indicated to the Ombudsman that his concerns had been satisfied and on that basis agreed to the Ombudsman's closure of this issue. (Tab 2). The Ombudsman also "discussed with all NSO's [nuclear security officers] what to expect from supervisors relative to CR initiation in the future, and opened the door for further discussions, issues as they perceived them." (Tab 2).

The actions described above demonstrate that the Licensee took prompt, comprehensive, and effective corrective action which included discipline for the specific supervisor involved and counseling on the importance of SCWE as well as training on the specific issue for all other relevant first line supervisors. The training also included explanation to all security officers to encourage the preparation of Condition Reports.

These prompt and effective corrective actions addressed not only the particular situation, but also the overall work environment for raising safety concerns throughout all three (the entire) shift of security officers. The Ombudsman's file also indicates that the Director-Support Services met and discussed this matter and the importance of maintaining a SCWE with the responsible supervisor, after which "the light came on and he accepted full responsibility for the situation, to his credit." (Tab 3). This has resulted in increased awareness of the responsible supervisor to SCWE issues.

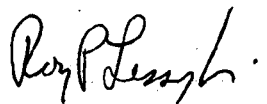
Finally, it should be noted that there appeared to be no precursor events to this situation that should have alerted management to this occurrence and that the record indicated that there have been numerous condition reports prepared by security officers during the tenure of the responsible supervisor involved, without incident. During the discussions between the Director-Support Services and the responsible supervisor, it was clear that the responsible supervisor clearly understood and accepted that his actions in this isolated instance were not conducive to a SCWE (Tab 3).

CONCLUSION

It is for all of the above reasons that it is respectively requested that enforcement discretion be exercised in this case where the licensee, without the need for NRC intervention, promptly identified an SCWE issue or potential issue; took prompt comprehensive and effective corrective action to address both a particular situation and the overall work environment for the security force in raising safety concerns, and provided counseling and discipline for the subject supervisor involved. The exercise of enforcement discretion in this matter is consistent with, and supported by, section 6.3.5, subparagraph "A" of the NRC Enforcement Manual, NUREG/BR-0195, Rev. 2, which supports the exercise of discretion in instances, such as this, "when a licensee who, without the need for government intervention, identifies an issue of discrimination it takes prompt, comprehensive, and effective corrective action to address both the particular situation and the overall work environment is helping to establish a safety-conscious workplace. Aggressive licensee follow-up also provides a message that retaliation is not acceptable within its workplace." For all of these reasons, it is respectively requested that the NRC refrain from issuing a Notice of Violation to Davis-Besse and exercise enforcement discretion for this matter.

If there are any questions related to the above, or if additional information is requested, please do not hesitate to contact me at (202) 887-4500.

Sincerely yours,



Roy P. Lessy, Jr.
Counsel for the Licensee

Enclosures: As Stated

Ombudsman

OMBUDSMAN CONCERN REPORT

ED 7725 (Use additional sheets as necessary)

No. 331 DATE 1/16/01

CONCERN DESCRIPTION

See attached discussion

LWW - This does not seem to meet our standards for maintaining SWE, specifically w/r to CR generation. [redacted] 1/16/1

PSM once CA taken.

☐ Continued

SYSTEM/EQUIPMENT NO. | PROCEDURE NO./REV.

LOCATION PPF

OTHER REFERENCES

ASSIGNED TO (Organization/Name) [redacted]

Please complete the investigation of this concern immediately upon receipt. Document your resolution below within 45 working days of its receipt.

See attachment

☐ Continued

COMPLETED BY [redacted] DATE 1/23/01

If another document was initiated to resolve this concern, identify the type and document number:

APPROVED BY (Division Director) | DATE

PLEASE RETURN THIS COMPLETED FORM TO THE OMBUDSMAN.

OCR 331

My resolution to the identified issue is as follows:

1. Perform investigation relative to fact finding with [redacted], who, why, and how we got to this point.

   My investigation revealed that the responsible supervisor [redacted] knew what was happening and directed the First Line Supervisor [redacted] to perform the fact finding with [redacted]. It is my opinion that [redacted] used poor judgement by pursuing the CR initiation, content and reason for initiation, through a fact finding, documenting the fact finding, and subsequently placing in [redacted] personnel file. Discipline has been administered relative to the incident for [redacted] (1/22/01).

2. I have informed [redacted] that our actions were inappropriate, and the reasons why, what he should expect in the future and that the fact finding documentation would be removed from his file and destroyed (1/17/01).

3. First Line Supervisors have had the situation described to them, and have received discussion relative to their participation in coaching [redacted] in writing CRs (1/22/01).

   - Safeguards
   - Understand the issue
   - Understand the facts
   - Understand audience

4. I have discussed with all [redacted] what to expect from supervisors relative to CR initiation in the future, and opened the door for further discussions, issues as they perceive them.

I discussed this response with the concerned party and they indicated they were satisfied and I could close the concern.

[redacted]

1/23/01

Ombudsman

OMBUDSMAN CONCERN NOTIFICATION

HAVE THE FOLLOWING CONCERN (Please Describe in Detail)

See attached discussion

8/16/07

PROCEDURE NO./REV

LOCATION PRF

[redacted]

[redacted]

TELEPHONE NUMBER

949 [redacted] 0324

My name may be used in resolving this concern. Yes

[redacted]

AUG-08 01 10:18 FROM:

TO:9-1-2029557763

PAGE:05

OCR 331
Date: 1/16/01

I [redacted] feel that [redacted] Supervision [redacted] others?) went beyond their responsibility for determining whether a Condition Report (CR) 01-0091 I wrote was accurate and complete when they conducted a Fact Finding Meeting with me on 1/12/01. They questioned my reason for writing the CR and whether I still wanted to pursue filing the CR. They questioned why I waited until 0500 (6 hours) to advise supervision of the CR. I indicated that I did not initiate the CR until after 0200 and was in [redacted] for the next two hours. I also indicated that this was my first CR initiated under the new computerized process. Under the old system, CRs where often held to the day shift for processing. They questioned why I needed to editorialize my thoughts in the CR. I indicated it was to draw attention that no training was given on how to handle intrusion alarms prior to initiating the new process. Guidance on how to handle the new Apollo system was later provided in the 1/14/01 turnover meeting (attached). Even though I agreed to remove the last two editorial sentences from the CR, I was informed that the Fact Finding Meeting (attached) would be documented in my personnel file. I believe the nature of the Fact Finding Meeting and the fact that it was placed in my personnel file is an act of retaliation which is not consistent with FENOC Policy and Senior Management expectations for employee concern resolution. Such actions can only serve to intimidate workers to not raise concerns that management might not like or there will be consequences.

[redacted]

NOP-LP-2001-01

CONDITION REPORT

CR Number 01-0091

TITLE: OWNER CONTROLLED AREA COMPUTER

ORIGINATION

DISCOVERY DATE	TIME	EVENT DATE	TIME	SYSTEM / ASSETS
1/11/2001	2248	ongoing	ongoing	

EQUIPMENT DESCRIPTION Owner Controlled Area Computer

DESCRIPTION OF CONDITION and PROBABLE CAUSE (If known) Summarize any attachments. Identify what, when, where, why, how.

Over the past several weeks, the owner controlled area buildings have been switched to a new system located in the the PPF. On 1/11/01, the panic alarm capabilities were switched to the new system. To this date, there has been no training of security personnell on this new system. [redacted] is responsible for the buildings in the owner controlled area, and need to respond to abnormal intrusion and or fire alarms. In light of the present striving for success from our employees, it saddens me to see the [redacted] set up for failure. This is not a good use of our event free tools.

SUPV COMMENTS / IMMEDIATE ACTIONS TAKEN (Discuss CORRECTIVE ACTIONS completed, basis for closure.)

QUALITY ORGANIZATION USE ONLY	IDENTIFIED BY (Check one)	ATTACHMENTS
Quality Org. Initiated ☐ Yes	☐ Individual/Work Group ☐ Supervision/Management	☐ Self-Revealed ☐ Internal Oversight ☐ External Oversight
Quality Org. Follow-up ☐ Yes ☐ No		☐ Yes ☑ No

ORIGINATOR	ORGANIZATION	DATE	SUPERVISOR	DATE	PHONE EXT.
[redacted]	NA				

PLANT OPERATIONS

SRO REVIEW	EQUIPMENT OPERABLE	EVALUATION REQUIRED	IMMEDIATE INVESTIGATION REQUIRED	ORGANIZATION NOTIFIED	MODE CHANGE RESTRAINT
☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

MODE	ASSOCIATED TECH SPEC NUMBER(S)	ASSOCIATED LCO ACTION STATEMENT(S)
		#2

DECLARED INOPERABLE (Date / Time)	REPORTABLE?	One Hour	APPLICABLE UNIT(S)
	☐ Yes ☐ No ☐ Eval Required	[redacted] Other	☐ U1 ☐ U2 ☐ Both

COMMENTS

Current Mode - Unit 1	Power Level - Unit 1	Current Mode - Unit 2	Power Level - Unit 2	
SRO - UNIT 1		SRO - UNIT 2		DATE

CRPA / SUPV / MRB

CATEGORY / EVAL	ASSIGNED ORGANIZATION	DUE DATE

TREND CODES

Process / Activity / Cause Code(s)	Comp Type / ID (If Cause T or W)	Resp Org

REGULATORY

REPORTABLE? ☐ Yes ☐ No ☐ LER No.

REPORTABILITY REVIEWER

DATE

INVESTIGATION OPTIONS ☐ Generic Implications ☐ Part 21 ☐ Maint.Rule ☐ OE Evaluation

CLOSED BY | DATE

[redacted] Items for January 14, 2001

2A exp. detector is O.O.S. ML filed. All other equip. is operational. Hand held metal detector tested sat.

495A is still taped off.

T-1 is checking the East P.A. walls of the Water Treatment and Intake Structure Hourly.

Post 4 in CM for LL area of concern on the west side of delay barriers Z-2 & 3. (During low light hours.)

Checking JT 3097 and the UPS J box once per shift in the PPF old I&C shop.

Dr. 426 is not pulling the strike. An 88 key is ty-wrapped to the door knob and call CAS signs are on the door.

Confidential: Discuss [redacted] voicemail message.

QA Audit to begin 1/22.

[redacted] is resting at home. Our thoughts are with him.

OCA Computer:
Fire alarms continue to report through the Honeywell computer and should be treated and responded to accordingly. The new Apollo system should be monitored for Panic Alarms ONLY and responded to accordingly. Notification should be made to the Supervisor of any problem, question or concern related to this new system. The System Engineer should be contacted by the Supervisor for guidance on any problem requiring input or change to the system. No system changes should be attempted or made without the approval of the Supervisor or System Engineer. The Apollo system computer workstation at SAS is not to be utilized to perform any activity other than Access Control and Alarm Monitoring functions. Prior to this system installation being completed and turned over to [redacted] for full use, training will be provided.

Good Catches. [redacted] identified a damaged .223 round in T-3 case (this was also identified by [redacted] Others were dented. The rounds were changed out. [redacted] identified a damaged FP header gauge that was damaged. MDT initiated by OPS. [redacted] discovered water seeping up from the ground in the area west of the DFS Pad and reported this to OPS.

On 1/22/01 [redacted] and the Human Performance Team will initiate a program to recognize and reward individuals who display Questioning Attitudes and [redacted] The prize will be a color TV with a BOSE Sound System which will be displayed at entrance. This program will work similar to the cruise giveaway.

[redacted]

Fact Finding Meeting with [redacted]

Date: January 12, 2001
Time: 2218
Subject: [redacted]
Attendees: [redacted]

This meeting is a fact finding meeting to determine the reason for writing Condition Report [redacted] and why he delayed informing the supervisor for over 6 hours after it was submitted.

1) What was the reason for writing the Condition Report?
Haven't had training

2) If you submitted the Condition Report at 2248 on January 11, 2001, why did you wait until approximately 0500 to report it to the supervisor? Filled out after 0200. Was in post 0200-0400.

3) Why did you feel you had to editorialize on the Condition Report i.e., put comments in other than what were required?
Draw attention that no training has been received

4) What information do you recall was given in turnover concerning the new Apollo system for the Owner Controlled Area after the system was put in SAS?
On going process of things being added to it

5) Do you recall the turnover notes saying training would be conducted on this new system prior to it being turned over to us?
No, I don't remember seeing that

6) Do you have any information concerning who might have accessed the South DBAB corridor exit door or the Computer room door at approximately 0400 on January 12, 2001?
Question deleted. Individual was previously identified.

7) Do you understand your obligation as a [redacted] to inform the supervisor immediately upon discovery of a problem or potential problem?
Yes

8) Do you still want to pursue filing [redacted]
Yes, but take out last few sentences.

OCR 331

My resolution to the identified issue is as follows:

1. Perform investigation relative to fact finding with [redacted] on, who, why, and how we got to this point.

   My investigation revealed that the responsible supervisor [redacted] knew what was happening and directed the First Line Supervisor [redacted] to perform the fact finding with [redacted] It is my opinion that [redacted] used poor judgement by pursuing the CR initiation, content and reason for initiation, through a fact finding, documenting the fact finding, and subsequently placing in [redacted] personnel file. Discipline has been administered relative to the incident for [redacted] (1/22/01).

2. I have informed [redacted] that our actions were inappropriate, and the reasons why, what he should expect in the future and that the fact finding documentation would be removed from his file and destroyed (1/17/01).

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   - Safeguards
   - Understand the issue
   - Understand the facts
   - Understand audience

4. I have discussed with all [redacted] what to expect from supervisors relative to CR initiation in the future, and opened the door for further discussions, issues as they perceive them.

I discussed this response with the concerned party and they indicated they were satisfied and I could close the concern.

[redacted]

1/23/01

COMPANY MEMORANDUM

FirstEnergy

TO File

DATE February 6, 2001

FROM [redacted]

MAIL STOP [redacted]

SUBJECT Ombusdman Investigation [redacted]

PHONE [redacted]

On January 16, 2001, I was informed by [redacted] of a concern submitted to the Ombudsman from [redacted] relative to writing Condition Reports (CRs).

I investigated the situation by interviewing the supervisors that directed the fact finding to be conducted/or conducted the actual fact finding. [redacted] respect. I found the following:

1. [redacted] directed [redacted] to conduct a fact finding to discover if [redacted] had any involvement in the entrance to the south DBAB corridor on [redacted] why it took so long to inform the supervisor of the issue the CR was written for; and to challenge [redacted] on several sentences that were written in the CR considered opinion.

2. [redacted] was aware of the fact finding being written down, it was discussed with him over the phone. He approved the questions that were asked by [redacted]

3. Questions were asked that challenged whether or not [redacted] wanted to proceed with the CR; why he didn't inform supervisor in a timely manner of the issue; what was meant by the two sentences that were considered opinions; if he wanted to remove those two sentences; etc.

4. [redacted] was left with the impression that this fact finding was discipline, and the fact finding documentation would be included in his personnel file. Thus, creating a negative SCWE in his opinion.

Based on the above, I took the following actions:

1. Ensured the fact finding documentation did not get put into [redacted] personnel file and had that conversation with [redacted]

2. Explained expectations for writing CRs to all three shifts, including what to expect from supervision relative to coaching, and their responsibilities.

3. Explained to the supervisors our expectations relative to writing CRs and handling our discussions with [redacted] "coaching, not challenging".

4. Gave [redacted] three days off.

My discussion with [redacted] led me to believe that the significance and impact on SCWE was not recognized by [redacted] until I pointed this out to him. After which, the light came on, and he accepted full responsibility for the situation, to his credit. It appeared to me that this situation happened on the eve of [redacted] vacation (one week) and he hurriedly handled the situation and did not think it through, or turn it over to this manager to handle, nor did he collaborate with his management.

[redacted]