Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002) NRG-PreDecisional

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Using modified IAEA approach: Fact Level; Conclusion Level; Root Cause. Conclusions are in bold and underlined; supporting facts are assigned beneath the conclusion. Other individual facts that require fact verification are shown as bold. Root Causes are designated by rc with associated conclusions mapped to each root cause.

			WHY: NRC and industry failed to understand operating experience relevant to nozzle cracking and boric acid corrosion
		<u>rc1</u>	NRC and industry failed to assess operating experience relevant to nozzle cracking and boric acid corrosion
	b	RC1	NRC failed to follow-up on Generic Communications.
59	В	RC1	62001 not used for DB (precursor events)
61	В	RC1	62001 used 15 reactors (all RIV PWRs)
62	В	RC1	No insp followup of GL97-01
66	В	RC1	NRC followup for 88-05 audited 10 plants; DB acceptable
84	В	RC1	RIII factored BU2001-01 commitments as part of Baseline prog.
129	В	RC1	TI on BU2001-01 didn't address BA issues
132	В	RC1	2515 IP do not look at BA/GC followup
133	В	RC1	The old inspection program (9000 series) looked at OE issues
154	В	RC1	# of Generic Comm (NRC) not corrected with # of events
156	В	RC1	MD8.5 can't be followed because it hasn't been updated



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160	В	RC1	No NRC programmatic guidance for effectiveness review of generic comm.
161	В	RC1	Sample/shotgun method for verification of generic comm implementation
164	В	RC1	IP62001 deleted w/o considering why it existed
165	В	RC1	NRC generated 17 boric acid generic communication
187	В	RC1	11/93 SER recommended inspection (visual) or leak detection system
189	В	RC1	11/93 SER recognized circumferential cracking, but didn't make recommendations
201	В	RC1	GL97-01 closeout for DB based on generic info
202	В	RC1	DB was the only B&W licensee that didn't do inspections (ref GL97-01) NRC
232	В	RC1	1972 requested enhanced ISI for BA corrosion
304	В	RC1	1991 Action Plan - no evidence that it was done
310	В	RC1	50.71e and Reg Guide changes to BA analysis not required in FSAR update
	ci	RC1	NRC failed to implement procedures/programs failed to address implications of BA corrosion
14	CI	RC1	Licensee stated that NRR knew about BA on head
15	CI	RC1	SRI saw CR on BA on head
28	CI	RC1	BA CRs not selected for PIR
29	CI	RC1	Abbreviated version (issue) of BA CRs not represented
33	CI	RC1	No apparent NRC followup of 96, 98 PCAQs
42	CI	RC1	Aware of BA on RPV head and didn't inspect
43	CI	RC1	SRI knew of flange leaks
49	CI	RC1	DRP BC and former SRI (only) knew of flange leaks

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45	СР	RC1	Corrosion Neither of Residents received training on BA
	ср	RC1	NRC procedures/programs failed to address implications of BA
295	CI	RC1	Licensee asserted that NRC questioned how the licensee was able to do a visual insp. given that boron was left on the head, but never followed up
233	CI	RC1	1993 2.206 Greenpeace response - cracking issues
229	CI · ·	RC1	NUMARC 1993 and NEI 1995 letters - GL88-05 will let the industry locate leaks before a real problem is identified
227	CI	RC1	Industry and NRC were managing BA issue by leakage
222	CI	RC1	NRC staff believed dry boric acid not corrosive
169	CI	RC1	NRC 1993 SER addressed RVH nozzle cracks as not immed. safety issue
130a	CI	RC1	BA buildup not a safety issue by NRC
128	CI	RC1	RI reviewed CR/equivalent in some manner
116	CI	RC1	BC/SRI/RI didn't observe RPV head videos
95	CI	RC1	RIII saw RC-2 as a material control problem -vs- boric acid prog prob
65	CI	RC1	1992 precursor insp no perf issues/no F/U of BA control prog
<u> </u>	CI	RC1	Flange leaks not pursued

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157	Н	RC1	OE review in NRC not performed by independent or long review
163	Н	RC1	NRR is reactive for short-term/current event
166	Н	RC1	NRC generic issue program takes too long/too harduse bulletins instead
170	Н	RC1	Foreign OE was reviewed by NRC
171	Н	RC1	70 LERs about Boric Acid leaks
172	Н	RC1	Axial cracks known from early 1970s, Circumferential from 1980s
173	Н	RC1	LIC-503 references some wrong procedures in RES
183	Н	RC1	No clear process for using foreign experience
184	Н	RC1	French corrective actions were documented but never used
185	Н	RC1	Mind set that French CA was an over reaction from NRC perspective; aggressive inspection was reponse
186	Н	RC1	NRC never asked the French why they were replacing their RPV heads
188	Н	RC1	Swedish, Spanish, Japanese, French have replaced heads
193	Н	RC1	NRR staff not aware BA leakage OE
196	Н	RC1	Conclusion in the EPRI guidebook not supported
209	Н	RC1	RES procedure 2i not used/not known by staff
210	Н	RC1	Cracking/BA corrosion not considered by either NRR or RES to be a GI (MD 6.4)
221	Н	RC1	License Renewal report (GALL) addresses acceptability of GL88-05 for aging management to be updated to reflect lessons learned
230	Н	RC1	GI program relies on user needs before taking action
231	Н	RC1	Preferred process flow for OE: nothing; IN; BU; GL; GI (all else fails)
242a	Н	RC1	MNSA and roll expansion- repair of joints, boric acid issues NRC

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303	Н	RC1	NRR did not review the French experience
312	Н	RC1	NUREG 5576 events RE: TP4 & Salem 2 not known within NRC
313	Н	RC1	Circumferential cracks not picked up by GIP screening program
314	Н	RC1	All B&W plants experienced circ cracks (except 1)
315	Н	RC1	Tracking of foreign experience cost
316	Н	RC1	NUREG 6245 CRDM experience not known within NRC/Industry
	j	RC1	Licensee failed to understand implications of BA corrosion.
32	J	RC1	BA on head was a "routine" CR
36	J	RC1	1996 CR on BA stayed open for ~2 years
130	J	RC1	BA buildup not a safety issue by DB
155a	J	RC1	NUREG 6245 (CRDM crack) Industry not aware of B&W content
178	J .	RC1	BACC person also had many other duties as a system engineer
194	J	RC1	BWOG rep didn't know the significance of Brown/red tinted BA buildup
197	J	RC1	Risk significance of BA on RPV head is low LIC
217	J	RC1	BA procedure not "QA" until 5/02
234	J	RC1	Mod on service structure delays
239	J	RC1	Ombudsman & cleaning statements
274	J	RC1	PRG staff didn't viewed head tapes
275	J	RC1	Former VP viewed as-found, not after tape until Fall2001
282	J	RC1	Only staff involved in head cleaning
296	J	RC1	PCAQ 96-0551 was one of ten oldest CRs before it was resolved
298	J	RC1	Multiple people involved in head cleaning w/o raising issues
302	J	RC1	ISI summary only included outside CRDMs

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325	J	RC1	1993 topical report is same issue as Davis-Besse
339	J	RC1	DB banking on another 5-years beyond Oconee cracking experience
342	Ј	RC1	DB and ANO late in implementing service structure port mod
347	J	RC1	Former VP didn't see BA on head as important
	m	RC1	Licensee failed to learned from internal/external OE.
68	M	RC1	DB's BACC didn't include Rx head/instr until 5/02
151	M	RC1	Oconee OE not evaluated at DB until 5/2002
152	М	RC1	OE in USBoric acid leaks. #1 area was CRDM, DB considered not significant
153	M	RC1	100% B&W units had RCS PB leakage
162	M	RC1	DB OE procedure doesn't require NRC LER review
168	M	RC1	100% CE had RCS pressure boundary leakage
174	М	RC1	45% of Oconee cracking (CRDM) appears in the same quadrant as DB leakage problems
175	М	RC1	CE plants dominated RCS instrumentation nozzle leakage (10 of 13 leaks)
176	М	RC1	Average # of operating years prior to CRDM leakage ~22 years
179	М	RC1	Foreign experience would indicate that the "crack" model is flawed
191	М	RC1	NUREG/CR 6245 recommended enhanced online leakage detection systems (NRC?)
192	М	RC1	Calvert Cliffs LER indicated wet boron vs dry
198	М	RC1	Annealing nozzle temps were different than required
200	M	RC1	3 LERS involved pzr material wastage
242	М	RC1	MNSA and roll expansion- repair of joints, boric acid issues LIC
276	М	RC1	Two precursor BA eventsRC2, SG line

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308	М	RC1	1998 DB had a resin intrusion
314	М	RC1	All B&W plants experienced circ cracks (except 1)
316	М	RC1	NUREG 6245 CRDM experience not known within NRC/Industry
327	M	RC1	D-B should have been industry leader following the RC-2 event
345	M	RC1	Many CRs on BAC but no evidence of tracking
346	М	RC1	RCS system engineer not aware of 1996 PCAQ

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		<u>rc2</u>	Industry failed ensure that previously identified BA leakage issues were resolved and corrective actions were effectively implemented
:	i	RC2	Licensee failed to implement owners group guidance.
202a	I	RC2	DB was the only B&W licensee that didn't do inspections (ref GL97-01) LIC
236	I	RC2	No BWOG verification for implementation of GL97-01
237	I	RC2	No BWOG verification for implementation of GL88-05
247	I	RC2	No tracking system to ensure that industry guidance was included in site guidance/ processes.
261	I	RC2	93 B&W report flange leaks need to be eval first
289	I	RC2	BA corr handbook shows CAC/RM as evidence of RCS leak
322	I	RC2	Former RCS system engineer not aware of 1993 B&W guidance
329	I	RC2	Licensee did not view enhanced visual inspection to be commitment
341	I	RC2	B&W topical assumed that BA leakage was found and repaired
	k	RC2	Licensee failed to resolve chronic RCS leakage.
24	K	RC2	Routine CAC cleaning
108	K	RC2	CAC/RM fouling may have been the impetus for TS change in #107
109	K	RC2	HEPA filter for RM may defeat the purpose of the RM workarounds -vs- fix the problem
119	K	RC2	Licensee not rigorous in finding RCS leaks
120	K	RC2	Licensee deleted Mode 3 walkdown for BA
235	K	RC2	CAC fouling and ALARA
244	K .	RC2	DB entered a 6-hour shutdown TS situation because of RM Problems with BA
248	K	RC2	Ability to differentiate between flange leakage/ head penetration leakage

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255	K	RC2	Until RFO13 lic had flange leaks
262	K	RC2	Heavy boron buildup on CACs
268	K	RC2	No systematic leak search for 12RFO
269	K	RC2	Deleted mode 3 walkdown
273	K	RC2	Long history of thermowell leaks
280	K	RC2	Triage plan for flange leak / didn't fix all flange leaks
287	K	RC2	100% NDE 5.7Rem estimate <past cleaning<="" head="" td=""></past>
300	K	RC2	Relief valve mod masking other leaks in 1998-99 time frame
330	K	RC2	Containment >120F on several occasions
331	K	RC2	CAC cleanings occurred as early as 1997
332	K	RC2	Lic root cause didn't identify CAC cleaning in 1997
334	K	RC2	CAC cleaning being tracked as a high dose job
335	K	RC2	CAC/RM not identified as a workaround
338	K	RC2	SV temp mod failed to assess leakage
343	K	RC2	Ops lack of ownership of plant material problems
344	K	RC2	BACC program manager couldn't find all components in BACC program
	1	RC2	Licensee failed to properly implement an adequate BACC program.
34	L	RC2	1996 CR explicit on the BA concern
35	L	RC2	~50% of RPV head cleaned in 1996
70	L	RC2	BAC checklists not kept/tracked/trended
123	L	RC2	None of the RPV head cleanings were 100%
124	L	RC2	Lost control of video tapes
144	L	RC2	BAC procedure wasn't followed

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251	L	RC2	Appropriate cleaning methods for RPV head (water-vs-vacuum)
254	L	RC2	#4, 5 nozzles still had boron on them following cleaning
260	L	RC2	Couldn't complete head cleaning due to schedule pressure
263	L	RC2	Potential CRDM G9 leak was crack, not dispositioned
266	L	RC2	RCS sys engr: scaffold was removed without permission
267	L	RC2	RP considered head cleaning as decon, so no procedure
279	L	RC2	No deviations from RFO12 WO to clean RPV head
281	L	RC2	RCS sys engineer upset that they head wouldn't be totally cleaned
283	L	RC2	Index of head tapes incomplete
284	L	RC2	4/17/00 head mislabeled as as-left
285	L	RC2	Head inspection tape not documented as to what was actually inspected - QA zip
301	L	RC2	Molpus slides show that licensee understood BAC in 1999 [RC-2 event]
	n	RC2	Licensee staff resources & experience
159	N	RC2	40-50% DB staff decrease over 10 years
238	N	RC2	O&M/capital budget and actuals have decreased over last 10-years
246	N	RC2	Multiple job assignments depending on cycle (outage, ops, EP)
256	N	RC2	VP - No NDE tools by 12/31
277	N	RC2	Lack of system engineer continuity
317	N	RC2	Region I few resources/staff with materials backgrounds (NRC/DB)
333	N	RC2	Inflation adjusted O&M decreased over period 1991-2001
	ġ	RC2	Licensing program guidance and implementation failed
31	Q	RC2	We rely on lic to give NRC correct info
115	Q	RC2	NRR PM limited visits to DB

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182	Q	RC2	After the RPV head videos were shown to the NRC, a vote was taken: 3 for shutdown; remaining (10-13) voted to allow continued operation
204	Q	RC2	No process for verifying licensee info for continued operation
207	Q	RC2	Some PM haven't visited plants
208	Q	RC2	PM didn't review commitment change reports
211	Q	RC2	NRR not implementing procedures
212	Q	RC2	LA/SE for RM for RCS leakage didn't consider DB OE
213	Q	RC2	NRR perception was that DB was a good performer
297	Q	RC2	No NRC review of submittals/reports (ISI)

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re3 NRC failed to accurately assess DB safety performance a RC3 NRC failed to adequately assess symptoms of RCS leakage. 12 A RC3 CAC/Rad Monitor cleaning known by NRC through BC level 13 A RC3 BA on head known by SRI during RFO12 16 A RC3 RIII (Grant) knowledge of Rad Monitor 18 A RC3 BCs logs on CAC/RMs & discussed in morning meetings 19 A RC3 CAC cleaning observed by inspectors (DRS) 20 A RC3 PM knew about CACs 22 A RC3 DRP BC listed CAC cleaning (2001) 23 A RC3 RIII didn't see CAC/RM cleaning as important 37 A RC3 RIII didn't see CAC/RM cleaning as important 38 A RC3 Inspection reports discussing RMs without conclusions 41 A RC3 Sinspection reports discussing RMs without conclusions 52 A RC3 RIII didn't view leakage as a problem 58 A RC3 Multiple cleaning of CACs				· · · · · · · · · · · · · · · · · · ·
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97 À RC3 CR for CAC/RM not seen as safety-sig would be screened out 98 A RC3 NRC Briefing package for Merrified didn't include BA problems	87	A	RC3	
98 A RC3 NRC Briefing package for Merrified didn't include BA problems	88	Α	RC3	Assumed Pzr safety valve leakage was reason for CAC fouling
	97	À	RC3	CR for CAC/RM not seen as safety-sig would be screened out
107 A RC3 TS requirements for CAC/RM were relaxed	98	A	RC3	NRC Briefing package for Merrified didn't include BA problems
	107	A	RC3	TS requirements for CAC/RM were relaxed

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRG-PreDecisional

118	A	RC3	BC didn't tell RI to pursue BA issues
125	Α	RC3	RA knew of CAC issues
	eia	RC3	NRC failure to adequately integrate Davis-Besse safety performance data
1	EIA	RC3	Region viewed Davis-Besse as good performer.
21	EIA	RC3	One PPR summary listed CAC cleaning
46	EIA	RC3	Inspection on RM didn't provide any performance issues
54	EIA	RC3	CCW event (10/98) resulted in Spec Insp
55	EIA	RC3	NRC prompted Lic regarding RCS leak on MUIA described as positive in IR
56	EIA	RC3	DB PIR viewed as the best by RIII
121	EIA	RC3	NRC thought that the licensee was rigorous in their leak hunt
138	EIA	RC3	Range of opinions on whether an AIT/IIT/SI
	eii	RC3	NRC failure to adequately inspect Davis-Besse safety performance
25	EII	RC3	PI&R/40500 did not review area
27	EII	RC3	Gap of 2 ½ years between CA inspections (missed events)
39	EII	RC3	Inspection reports don't list all docs reviewed (6 years of reports)
44	EII	RC3	RC-2 escalated enforcement didn't require closeout inspection
51	EII	RC3	Former SRI did not perform any followup on leak hunt plan RFO12
72	EII	RC3	Verbatim comp. W/insp procedures (not there/can't do)
78	EII	RC3	1997 NOP/NOT walkdown by NRC found no leaks
96	EJI	RC3	RIII had differing views for RC-2 violation followup
122	EII	RC3	RI thought the RPV head was 100% cleaned
127	EII	RC3	ALARA insp didn't show that CAC cleaning was largest dose

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRC.PreDecisional

181	EII	RC3	(Other than SRI) NRC not told about red/brown BA buildup until after the DB event
223	EII	RC3	Extending the inspection for DB was largely based on the belief that a "strong" VT-2 inspection was done at DB
270	EII	RC3	Kerosene burner not eval'd for ctmt
271	EII	RC3	No oper eval for the clogging of CACs
272	EII	RC3	Non-conservative assumption of LOCA steam clean CACs
278	EII	RC3	Lic didn't complete all RC2 CAs
290	EII	RC3	No doc'd eval of CAC clogging
294	EII	RC3	Inadequate temp mod safety eval on code safety seat leakage
309	EII	RC3	Region III 1998 ISI inspection reviewed flange bolts, housing but didn't indicate BAcorresponded with timing for BA on head and cleaning
340	EII	RC3	96, 98, 00 CRs indicate brown colored boronno record of NRC review of two
	f	RC3	NRC staff resources & experience
2	F	RC3	NRC staffing level not filled for all positions
3	F	RC3	One year period (1999), only one Resident on site.
4	F	RC3	Project Engineer - two 8-month gaps.
5	F	RC3	Resident inspectors not certified.
6	F	RC3	SRI position delayed in filling.
7	F	RC3	High Project Manager turnover rate (9 PMs in 10-years)
9	F	RC3	Limited commercial nuclear experience RI
10	F-	RC3	Resident inspector had a materials background
11	F	RC3	SRI experience with only DB containment

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> **Description of the image of the

40	F	RC3	Low number of inspection hours compared to other RIII sites (½ in 1999)
53	F	RC3	1998 events diverted inspection efforts re:BA issues
57	F	RC3	Resident not aware of OOS logs
63	F	RC3	PE little time at DB (1997&1999)
92	F	RC3	Between PE coverage gaps, 8 months/3months coverage/8 months
93	F	RC3	BC had Clinton 0350 plant coincident w/DB
110	F	RC3	RIII resources decreasing
111	F	RC3	RIII insp contractor support poor
112	F	RC3	RIII too many competing priorities which detract from insp.
131	F	RC3	No 1245 cert requirements for BA corrosion
158	F	RC3	Contract support after '98 report dried up (staff decreased/# reports decreased)
215	F	RC3	No guidance for background training for PM
317	F	RC3	Region I few resources/staff with materials backgrounds (NRC/DB)
318	F	RC3	ASME Code knowledge/representation
	g	RC3	NRC failed to communicate critical information regarding Davis-Besse safety performance
17	G	RC3	Other than DD-DRP; limited recollection of CAC/RM issues by RIII SES managers
94	G	RC3	NRR inspection branch has no feedback form on Plant status time as addressed by RI interview
101	G	RC3	Procedure for RIII morning meeting isn't followed
102	G	RC3	RIII not conducive to info exchange
103	G	RC3	Senior RIII Managers not the audience for the morning meeting
117	G	RC3	RI not aware of FeO on CAC



<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRC-PreDecisional^a

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126	G	RC3	RA didn't know about BA on head
136	G	RC3	IRO didn't participate to follow MD8.3 for AIT determination
137	G	RC3	NRR/RIII didn't follow MD8.3
180	G	RC3	Story differences between what DB told NRC -vs- what NRC thought they were told about BA by DB
203	G	RC3	Deferral of DB shutdown not well documented
216	G	RC3	Interviews indicate that NRR and RIII communications poor/nonexistent
291	G	RC3	Late arrival of calcs for crack propagation
	o	RC3	Licensee failed to communicate critical information
150	0	RC3	Lic Response to BU2001-01 contained many inaccurate info /response
177	0	RC3	Many licensee (DB) staff thought that a whole head inspection/cleaning was done
180	0	RC3	Story differences between what DB told NRC -vs- what NRC thought they were told about BA by DB
181	0	RC3	(Other than SRI) NRC not told about red/brown BA buildup until after the DB event
240	0	RC3	BU2001-01 documentation responses by DB not accurate
241	0	RC3	12-16 people at DB reviewed DB response to BU2001-01
257	О	RC3	VP -Ops last know
264	0	RC3	Lic Managers / staff knew of head cleaning %, lower staff thought that head was 100% cleaned
265	0	RC3	Lic managers said they showed NRC the as-found video tapes of the head
321	О	RC3	Current VP said that engineering would know before Ops
326	О	RC3	E-mail makes D-B look bad for RPV head cleaning



<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> <u>NRC-PreDecisional-</u>

328	0	RC3	Unclear as to who viewed the post cleaning video tape (DB)
336	0	RC3	12RFO QA audit of head cleaning was positive
337	0	RC3	Discrepancies with internal documents on whether head cleaned or not
348	0	RC3	Ops didn't view video tapes

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<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRC-PreDecisional*

		<u>rc4</u>	NRC and industry failed to establish adequate requirements and guidance
1	d	RC4	NRC failed to establish adequate requirements.
139	D	RC4	Enforcement history doesn't equate with OE
140	D	RC4	Lack of enforcement for RCS leakage
141	D	RC4	Enforcement/NRR trying to figure out what should be done for RCS leakage
142	D	RC4	1997 SONGS nozzle cracking cited Maintenance Rule
143	D	RC4	NRC response (policy) not consistent - SONGS/Oconee
145	D	RC4	No ASME Code requirement (of inspections/RCS leakage)
146	D	RC4	Code didn't require insulation to be removed for inspections
147	D	RC4	VC Summer had RCS leakage and didn't report it
149	D	RC4	Enf discretion issued for VCSummer and Oconee; no enf discretion or enforcement on ANO
205	D	RC4	12/31/2001 was an arbitrary date for shutdown; basis question
219	D	RC4	Code did not require insulation removal (VT-2)
243	D	RC4	Enhanced visual meant for circ, not axial cracking (vol NDE)
245	D	RC4	ANO a through wall CRDM crack is a statistical certainty
253	D	RC4	Several CRDM nozzles cracked, some through wall NRC
305	D	RC4	Nov 2001, NRC indicated that they did not like ASME code (VT-2)
307	D	RC4	ASME code allows plant to start up from outage with known code class 1 flange leaks
319	D	RC4	Age related risk from passive components not captured in PRA
	ер	RC4	NRC failed to provide adequate Reactor Oversight Process (ROP) guidance.
26	EP	RC4	PI&R samples began 1999 for 3/01 (gap issue)

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRG-PreDecisional

60	EP	RC4	62001 cancelled in 10/01
64	EP	RC4	Limited entries into containment by NRC
67	EP	RC4	NRC audit (GL88-05) of BAC didn't include Rx head/instr
TY	EP	RC4	Two people felt that there were not enough hours in ROP for (BA) inspections didn't allow some inspection
73	EP	RC4	Can't go outside of the baseline unless you have a >green finding
74	EP	RC4	Baseline inspection doesn't include structures or passive components
75	EP	RC4	Some good practices ceased following ROP implementation (ex. containment closeout insp)
82	EP	RC4	ISI didn't have inspection guidance to look at A600 nozzles
85	EP	RC4	RIII issued SL3 for RC-2; would be a green finding today
89	EP	RC4	RIII invoked MC0350 w/o DB having met criteria
96	EP	RC4	DB event risk not completed yet
191	EP	RC4	SDP has taken 5 months
106	EP	RC4	MC2515 AppD doesn't provide thorough guidance for review of CR
113	EP	RC4	Only 1 SES manager inside containment since 1996
114	EP	RC4	Limited senior manager visits to DB
134	EP	RC4	No NRC requirement to review employee concerns
225	EP	RC4	Over-reliance on a risk information -vs- deterministic
282	EP	RC4	62001 intended for 16 hours every other outage
293	EP	RC4	All PI's green prior to event
311	EP -	RC4	Lessons learned weren't learned from previous lessons learned reviews (South Texas, Millstone, IP2)
	p	RC4	Industry failed to provide adequate guidance and oversight relevant to nozzle cracking and boric acid leakage control.
196	P	RC4	Conclusion in the EPRI guidebook not supported

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> <u>NRG-PreDecisional</u>

199	P	RC4	"Boric acid on the head is good."
214	P	RC4	INPO ratings declined from 1 to 2 within the last few years
218	P	RC4	B&W didn't recommend the service structure mod
220	P	RC4	DB experienced no insulation deflections caused by BA buildup on the head
259	P	RC4	Lic did not eval use of power washer on head
306	P	RC4	BWOG/Framatome indicated that they made no recommendations for service structure mods
323	P	RC4	INPO noted chronic RCS leaks, but not BA on head
324	P	RC4	INPO noted ALARA positive for CAC cleaning by power washer
350	P	RC4	Vendor testing not representative of actual installation

<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> **RE-PreDecisional**

	w	RC6	Awaiting additional review
345	w	RC6	Many CRs on BAC but no evidence of tracking
	x	RC6	<u>Deleted</u>
8	Х	RC6	PM inspection approach changing.
30	X	RC6	CRs reviewed for PI&R ~7000
47	X	RC6	Neither the old/new insp programs found/discussed RM issues
48	X	RC6	SSDI insp in 2000 indicated performance was worse than expected
69	x	RC6	40500 insp in '98 indicated that commitment tracking NG
79	x	RC6	SRI 97-98 no recollection of flange leaks
80	х	RC6	Former SRI works for FENOC
81	X	RC6	1992 uptake event insp closeout, then 1998 uptake occurred
86	X	RC6	RC-2 event would have not gone beyond baseline
99	x	RC6	PI&R doesn't allow independent look by inspectors
100	Х	RC6	Some interviews indicated RI/SRI not as visible in ctmt and CR post ROP
104	Х	RC6	PI&R team leader thought that the short form description of CR was adequate
135	х	RC6	RIII inspector was told that DB was SALP 1 didn't take findings seriously (arrogant)
138	Х	RC6	Range of opinions on whether an AIT/IIT/SI
148	X	RC6	Nothing in allegation area was relevant to BA/cracking issues
190	х	RC6	Staff action plan GL97-01 can't be found
195	X	RC6	BACC person indicated that the next major nuclear accident will be caused by BAC
197a	х	RC6	Risk significance of BA on RPV head is low NRC
206	x	RC6	PMs don't conduct site visits



<u>Davis-Besse Lessons Learned Task Force Meeting (8/5-8/2002)</u> NRG-PreDecisional

224	X	RC6	Risk informed process didn't alert the NRC to a potential risk
249	X	RC6	Bonus correlation with operations
250	Х	RC6	Basis for dose estimates for RPV head inspections
258	X	RC6	Eng received closed door talking to for CR initiation
286	X	RC6	Lic is doing an assessment of BU2001-01 submittal
288	X	RC6	No VT-2 insp during RFO12 per RCS sys eng
292	X	RC6	QA group didn't have a problem with BAC RFO12 report shows positive finding
299	х	RC6	Same job done by Framatome at other plants?
320	X	RC6	Too much focus on PRA vs deterministic
349	Х	RC6	High turnover on BWOG positions from DB staff