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April 11, 2003

Docket Number 50-346
License Number NPF-3
Serial Number 2951

Mr. Samuel J. Collins, Director
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

Subject: Response to Supplement to 10 CFR § 2.206 Petition Filed by Congressman Kucinich

Dear Mr. Collins:

On March 27, 2003, Congressman Dennis J. Kucinich ("Petitioner") filed a Supplement to the 10 CFR § 2.206 Petition, dated February 2, 2003 ("original Petition"), which requested the NRC to revoke FirstEnergy Nuclear Operating Company's ("FENOC") license to operate the Davis-Besse Nuclear Power Station ("Davis-Besse"). According to Petitioner, the basis for this Supplement is to apprise the Nuclear Regulatory Commission ("NRC") of "new information" that has allegedly arisen since the filing of the original Petition.¹

FENOC hereby responds and requests the NRC to deny the Supplement in its entirety. As more fully set forth in FENOC's Response to the original Petition, dated February 27, 2003 ("initial Response"), NRC's own guidance requires NRC to deny a § 2.206 petition where the issues raised are already the subject of NRC staff review and evaluation and the petition presents no significant new information.² As with the original Petition in this case, the Supplement does not raise any new issues or present any new facts that are not already known to, and already reviewed by or under review by, the NRC. Therefore, the Supplement should be denied. FENOC will specifically address each of Petitioner's seven assigned reasons for license revocation.

A. Condition of Electrical Systems and Cable Trays

¹ Supplement, pp. 1-2.

² Initial Response, pp. 1-2 (citing Management Directive 8.11, Part III, Section C(2)(b)).

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Petitioner first alleges that the electrical systems and cable trays in the containment building may have been subjected to, and adversely affected by, boric acid particulates suspended in the atmosphere, and that the NRC is not performing “full inspections” to address this condition.³ Petitioner’s allegation ignores the actions of FENOC and misconstrues the nature of the NRC inspection regime.

The potential for adverse effects of boric acid on electrical systems, structures, and components (“SSC”) has already been addressed by FENOC in the Containment Health Assurance Building Block, which is part of FENOC’s overall Return to Service Plan.⁴ Inspections and evaluation of containment SSCs, including the electrical SSCs, are part of FENOC’s Containment Health Assurance Plan.⁵ The Plan’s stated purpose is to inspect and evaluate containment SSCs, and to assure completion of required remediation activities prior to restart.⁶ The scope of such inspections includes identifying any damage that may have resulted from boric acid leakage and dispersion in the containment. These are comprehensive inspections of potentially affected components.

As is well known to NRC, under its inspection programs, NRC does not conduct 100% inspections of all activities performed by a licensee, but instead conducts selected inspections of a representative sample of licensee activities. Based upon the representative sample, NRC draws conclusions on the overall adequacy of the licensee’s activities. In accordance with its well-established, long-standing inspection practices, the NRC has inspected the Davis-Besse Containment Health Assurance Plan and a sample of its implementation. Based upon its inspections, NRC has concluded that:

Your inspection staff were appropriately trained, equipped with adequate equipment/tools, and followed procedures with adequate quality standards and guidance. The net result was that boric acid and corrosion deposits observed by the NRC inspectors on components (e.g. reactor vessel, hot-leg dissimilar metal welds, and electrical components) within containment were in each case appropriately identified and documented by your staff. Therefore, we concluded

³ Supplement, pp. 2-3.

⁴ The Return to Service Plan contains seven Building Blocks covering the following areas: Restart Action, Containment Health Assurance, Reactor Head Resolution, Program Compliance, System Health Assurance, Restart Test, and Management and Human Performance Excellence. The Return to Service Plan was originally provided to the NRC on May 21, 2002, and has been revised several times. The Plan is available on NRC’s web page.

⁵ Return to Service Plan, Section IV.B.

⁶ Return to Service Plan, Section IV.B.

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that the “Davis-Besse Containment Health Assurance Plan” was effectively implemented.⁷

In summary, Davis-Besse has established and implemented a plan for inspecting electrical equipment to verify their acceptability in light of the release of boric acid in the containment. NRC has inspected both this plan and its implementation, and has concluded that they have been effective. Therefore, the Petitioner’s allegation regarding electrical systems and cable trays provides no new information, as stated is inaccurate, and provides no basis for revocation of the license for Davis-Besse.

B. Safety Systems Match the Design Basis

Petitioner next alleges that Davis-Besse’s safety systems may not match the design basis for the plant, and that FENOC and the NRC are not addressing this issue.⁸ Contrary to this allegation, FENOC is taking comprehensive and decisive action to ensure that Davis-Besse’s safety systems match the design and licensing bases for the plant. In fact, this objective was an integral part of the Latent Issues Review already performed by FENOC pursuant to another one of the Return to Service Plan Building Blocks – the System Health Assurance Plan.⁹

The System Health Assurance Plan’s stated purpose is to assure that plant systems can perform their safety functions.¹⁰ This assurance is being attained through the implementation of a three-tiered review process, including 1) reviews of systems important to safety (Operational Readiness Reviews); 2) reviews of systems that perform risk-significant functions (System Health Readiness Reviews); and 3) reviews of systems that perform safety and accident-mitigating functions (Latent Issues Reviews).¹¹

The NRC has conducted inspections of the System Health Assurance Plan and its implementation. In a recent Inspection Report, the NRC specifically concluded that “the System Health Assurance Plan was well-designed, plans and procedures were appropriate to the circumstances, the program was rigorously implemented, and quality assurance review by the Nuclear Oversight Department was adequate.”¹² More specifically, the inspectors concluded that

⁷ NRC letter dated Nov. 29, 2002, p. 1 (enclosing NRC Inspection Report 50-346/02-12).

⁸ Supplement, pp. 3-4.

⁹ Return to Service Plan, Section IV.C.

¹⁰ Return to Service Plan, Section IV.C.

¹¹ Return to Service Plan, Section IV.C.

¹² NRC Letter dated Feb. 26, 2003, p. 1 (enclosing NRC Special Inspection – System Health Assurance – Reports No. 50-346/02-13 and 50-346/02-14).

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“the system walkdowns conducted by the licensee . . . were thorough and appropriate to the circumstances.”¹³

In addition, FENOC has prepared an overall plan for resolving design issues identified during the Latent Issues Reviews and the System Health Readiness Reviews. This plan is called the “Resolution of System Health Assurance Plan Design Issues,” and has three major components: resolution of individual design issues through the Corrective Action Program, the Safety Function Validation Project (“SFVP”) to validate that plant systems can perform their necessary safety functions, and reviews to determine the extent of condition of five topical design issues. This plan was discussed in detail with the NRC at a public meeting on December 23, 2002.

In particular, the purpose of the SFVP is to provide additional assurance of the adequacy of the design for those plant safety functions that provide a significant contribution to core damage frequency (“CDF”) as determined by the Probabilistic Safety Assessment (“PSA”). The overall approach consists of confirming that design basis calculations demonstrate safety function capability or that applicable tests are performed which demonstrate safety function capability. This approach consists of a review of the safety functions, performed on a system-by-system basis. The systems reviewed under the SFVP were those systems with safety related functions that contribute greater than 1% of the total baseline CDF. The SFVP has been completed and corrective actions are currently in progress.

In summary, contrary to Petitioner’s allegation, FENOC has established and is implementing plans for verifying that Davis-Besse’s systems can perform their design basis functions. NRC has inspected these plans and their implementation. Although implementation of the plans and associated corrective action is still in progress, the results to date have shown the plans to be sufficient to achieve their goals. Therefore, the Petitioner’s allegation regarding the match of safety systems to the design basis of Davis-Besse presents no new information, as stated is inaccurate, and provides no basis for revocation of the license for Davis-Besse.

C. Leak Monitoring

Petitioner alleges that Davis-Besse’s reactor coolant pressure boundary (“RCPB”) leak detection system “will not be able to detect leaks as required by the NRC,” and that FENOC and the NRC are not addressing this issue.¹⁴ Petitioner bases this allegation on a flawed understanding of Davis-Besse’s leak detection and monitoring capabilities. The Petitioner incorrectly assumes that Davis-Besse’s new FLÜS system,¹⁵ coupled with the containment radiation monitors, are the

¹³ NRC Special Inspection Report No. 50-346/02-13, p. 5.

¹⁴ Supplement, pp. 4-5.

¹⁵ FLÜS is an acronym for the German leak detection system, Feuchtigkeit Leakage Überwachungs System. FLÜS is a state-of-the-art leak monitoring system, which operates on the principle of (continued).

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only methods of detecting RCPB leakage, and that these methods will be insufficient to detect leaks of 1 gpm within one hour as specified in NRC Regulatory Guide 1.45.

Contrary to Petitioner's assumption and this allegation, the FLÜS system and containment radiation monitors are not the only methods for detecting RCPB leakage. Davis-Besse has a RCPB Leak Detection System, and the containment radiation monitors comprise only part of this system. The RCPB Leak Detection System is described in Section 5.2.4 of the Updated Safety Analysis Report ("USAR") for Davis-Besse, which has been provided to the NRC and is a publicly available document. As stated in this section of the USAR, the RCPB Leak Detection System is composed of three separate, and complementary, leak detection and monitoring systems, including 1) the containment atmosphere particulate radioactivity monitoring system; 2) the containment atmosphere gaseous radioactivity monitoring system; and 3) the containment sump level and flow monitoring system.

Both the containment atmosphere particulate radioactivity monitoring system and the containment atmosphere gaseous radioactivity monitoring system have two separate and redundant monitors that provide control room indication of RCPB leakage. The containment sump level and flow monitoring system includes normal, narrow and wide range sump level indicators, which also provide control room indication of RCPB leakage. In addition, monitoring and trending of changes in makeup tank water levels and water inventory balances also serve to detect RCPB leakage.

The Petitioner completely ignores the containment sump monitoring system. As stated in Regulatory Guide 1.45:

Industry practice has shown that water flow rate changes of from 0.5 to 1.0 gpm can readily be detected in containment sumps by monitoring changes in sump water level, in flow rate, or in the operating frequency of pumps. Sumps and tanks used to collect unidentified leakage and air cooler condensate should be instrumented to alarm for increases of from 0.5 to 1.0 gpm in the normal flow rates. This sensitivity would provide an acceptable performance for detecting increases in unidentified liquid leakage by this method.

Furthermore, the Petitioner's allegation regarding the containment radiation monitors is incorrect. As stated in Section 5.2.4.3 of the USAR, Davis-Besse has replaced its original monitors. As reported in the USAR, the existing containment airborne particulate monitor and

humidity detection. This system is intended to augment Davis-Besse's existing capabilities. In particular, it will be utilized to detect leakage from the lower reactor pressure vessel head. Installation of the FLÜS system is not a requirement, but rather a FENOC initiative and enhancement, and will be the first such installation in the United States.

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the containment radioactive gas monitor are each capable of detecting a 1 gpm leak within one hour assuming 0.1% failed fuel.

Thus, Davis Besse's RCPB Leak Detection System is a redundant and overlapping network of leak detection and monitoring systems and capabilities. This system conforms to the leak rate detection criteria in NRC Regulatory Guide 1.45. Therefore, Petitioner's allegation regarding Davis-Besse's leak detection capability presents no new information, as stated is inaccurate, and provides no basis for revocation of the license for Davis-Besse.

D. NRC Oversight

Petitioner alleges that the NRC Lessons Learned Task Force ("LLTF") made certain recommendations relative to the Reactor Oversight Process ("ROP"), and that there is no mechanism for ensuring those recommendations are implemented before the 0350 Panel ends.¹⁶

Contrary to Petitioner's allegation, the LLTF's recommendations do not identify any fundamental flaw in the ROP. Instead, the recommendations are intended to selectively enhance the ROP in light of lessons learned from Davis-Besse. Therefore, the Petitioner does not provide any basis for questioning the adequacy of the overall ROP to provide sufficient oversight of Davis-Besse after restart of the plant and prior to NRC's full implementation of the LLTF's recommendations.

The LLTF's objective was to "independently evaluate the NRC's regulatory processes related to assuring [reactor pressure vessel (RPV)] head integrity in order to identify and recommend areas for improvement."¹⁷ Although the LLTF did identify specified weaknesses in NRC inspection, enforcement and assessment guidance, as well as inadequate vessel head penetration nozzle and RPV head inspection requirements, these findings do not represent a fundamental flaw of the ROP. Such findings pertain, in large part, to NRC requirements and guidance regarding stress corrosion cracking, operating experience, correction of long-standing problems, and boric acid leakage and corrosion. As part of its Building Block plans, FENOC has taken and is taking programmatic and hardware corrective actions for these areas prior to restart, and these actions are part of NRC's 0350 restart checklist.¹⁸ The 0350 Panel will ensure the adequacy of FENOC's corrective actions in these areas prior to restart. Therefore, the Petitioner's allegation regarding the Davis-Besse lessons learned presents no new information, as stated is inaccurate, and provides no basis for revocation of the license for Davis-Besse.

¹⁶ Supplement, pp. 5-6.

¹⁷ Degradation of the Davis-Besse Nuclear Power Station Reactor Pressure Vessel Head Lessons Learned Report, p. 1 (Sept. 30, 2002).

¹⁸ NRC letter dated Oct. 30, 2002 (attaching Davis-Besse Oversight Panel Restart Checklist, Rev. 1). Relevant items from the Checklist include 2.a, 2.c, 2.d, 3.b, and 3.d.

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E. Public Participation

Petitioner alleges that the NRC's existing oversight processes do not provide an adequate forum for public participation.¹⁹ This allegation is wholly without merit. The NRC's 0350 Panel holds meetings with FENOC on a monthly basis, all of which are open to the public. Not only are members of the public invited to attend, they are also invited to make statements and ask questions of the NRC. In addition, the 0350 Panel holds a separate meeting each month for the express purpose of briefing the public on the status of the Panel's activities and receiving public comments and responding to public questions on Davis-Besse. Since its inception, the 0350 Panel has held ten sets of monthly public meetings, with each set of monthly meetings lasting roughly six hours in duration. In addition, the NRC has convened numerous other public meetings regarding the Davis-Besse RPV head degradation as well as restart-related activities in Rockville, Maryland; in Ohio; and in Lisle, Illinois. The presentation materials from these meetings are publicly available, as well as the transcripts of the monthly 0350 Panel meetings, which are posted on a special page of NRC's website.

In summary, NRC has gone to extraordinary lengths to provide a more than adequate forum for public participation as part of its 0350 oversight activities and Davis-Besse restart actions. Therefore, the Petitioner's allegation regarding the adequacy of public participation is unfounded, inaccurate, and provides no basis for revocation of the license for Davis-Besse.

F. Wrongdoing Investigation

Petitioner asserts the position that the NRC must await the outcome of the wrongdoing investigation being conducted by the Office of Investigations ("OI") before ruling on the original Petition and allowing Davis-Besse to return to service.²⁰ This position is without merit. First, neither this Supplement nor the original Petition provide new information relevant to the current OI investigations. Second, NRC's procedures and practices assure that OI will advise the NRC staff of any developed information which may be relevant to a restart decision. Third, on its own initiative, since discovery of the Davis-Besse RPV head wastage, FENOC has undertaken several probing and self-critical investigations or reviews in an effort to self-identify and evaluate the circumstances that led to this condition. In each of its reviews, FENOC attempted to assess candidly past performance—including the performance of individuals—and comprehensively correct identified deficiencies. Based upon its several reviews, FENOC concluded that no single person or group is solely responsible for the RPV head wastage. Rather, FENOC concluded that the Davis-Besse organization must bear collective responsibility for missed opportunities to prevent or earlier detect RPV head wastage.

¹⁹ Supplement, p. 6.

²⁰ Supplement, pp. 6-7.

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Even if OI ultimately substantiates wrongdoing on the part of one or more individuals relative to the events leading to identification of the RPV head wastage, as part of its corrective action, FENOC already has taken comprehensive measures to address the programmatic and management weaknesses identified during the course of its several reviews. These measures included replacing senior and mid-level managers in a position of responsibility prior to February 2002, and adding new management positions. Specifically, FENOC created new Company-level leadership positions, including a Chief Operating Officer, a Vice President of Oversight, and an Executive Vice President of Engineering and Services. Additionally, Davis-Besse has a new senior leadership team in place, including a new Site Vice President, new Directors, and new Managers in all key functional areas, *e.g.*, Engineering, Maintenance, Corrective Action Program, and Quality Assessment. The new management team has, in turn, initiated a Management and Human Performance Excellence Plan, as well as a more detailed Management and Human Performance Improvement Plan, designed to upgrade management and performance at all levels of the Davis-Besse organization. These actions have been described in detail in numerous public meetings with NRC's 0350 Panel.

In sum, FENOC has replaced virtually all of the top three levels of management at Davis-Besse. None of the current management team at Davis-Besse had any involvement in the events that led to the degradation of the RPV head or, insofar as known to FENOC, the matters being investigated by OI. Thus, the investigation currently being conducted by OI is not an assessment of, and does not reflect upon, FENOC's current ability or willingness to meet NRC requirements and to safely operate the plant. As such, its outcome should not impact restart. As in the other areas cited by Petitioner, no new allegations not previously known to NRC and assumedly already under OI review have been presented; NRC procedures already require OI to advise the NRC staff of developed information relevant to restart; and FENOC's corrective actions have already assured that individuals who played any significant role in earlier opportunities to identify or prevent RPV head wastage will not play a significant role involving restart. Therefore, Petitioner's assertions provide no basis for NRC delaying restart or revoking the license for Davis-Besse.

G. The Siemaszko Allegations

Finally, Petitioner repeats allegations contained in a discrimination complaint, which was filed by a former FENOC employee, Mr. Andrew Siemaszko, against FENOC with the Department of Labor ("DOL") under Section 211 of the Energy Reorganization Act.²¹ Petitioner merely adopts the unsupported allegations in Mr. Siemaszko's complaint as true and then makes sweeping

²¹ See Supplement, pp. 8-11 (citing Complaint dated Feb. 15, 2003).

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generalizations regarding the implications thereof for the safety culture at Davis-Besse.²² This reliance is misplaced.

Rather than reflecting negatively on the current safety culture, FENOC's dismissal of Mr. Siemaszko reflects positively on FENOC's willingness to hold people accountable for poor performance. Mr. Siemaszko was the System Engineer responsible for the reactor coolant system and the RPV head inspections during the twelfth refueling outage ("12 RFO") and he was principally responsible for the technical input to portions of FENOC's responses to NRC Bulletin 2001-01. Mr. Siemaszko was terminated for his involvement in the missed opportunities to earlier prevent or detect the RPV head wastage at Davis-Besse, and for his involvement in the responses to the Bulletin.

Mr. Siemaszko's Section 211 allegations are appropriately before DOL, as well as NRC OI, and FENOC is cooperating with each agency. As will be convincingly established in those two forums, Mr. Siemaszko's claim of retaliation is baseless, and his complaint contains numerous inaccuracies and false statements, which provide compelling corroboration of FENOC's initial decision to terminate him.

For purposes of responding to Petitioner's Supplement, however, FENOC wants to be clear that protected activity played no role in its decision to terminate Mr. Siemaszko. Rather, the decision to separate him was based solely on legitimate business reasons. Mr. Siemaszko's failure to perform his assigned job responsibilities to even minimal Company standards significantly contributed to the failure to identify earlier degradation of the RPV head at Davis-Besse. Further, his inattention to detail and failure to inform FENOC managers, as described below—over the course of several months—significantly contributed to inaccurate and incomplete information being provided to the NRC. Specifically, Mr. Siemaszko's failure to inform FENOC managers about deficiencies with his own RPV head inspection in April 2000, and those previously conducted by others in 1996 and 1998, resulted in substantial misunderstandings, at Davis-Besse and at the NRC, about the condition of the Davis-Besse RPV head. That these failures contributed to significant consequences for FENOC understates the case.

These performance failures were the only reasons FENOC executives decided to separate Mr. Siemaszko from the Company—and they are compelling.

Petitioner adopts and advances certain of the allegations contained in Mr. Siemaszko's complaint, and therefore FENOC will address them briefly here. First, Petitioner asserts—with no supporting factual basis—that Davis-Besse management "thwarted" Mr. Siemaszko's efforts to inspect or clean the RPV head. This assertion is contrary to fact. Specifically, during 12 RFO, Mr. Siemaszko advocated cleaning the RPV head using pressurized water and,

²²

See id.

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following 12 RFO, he advocated the purchase of a robotic crawler. Both of his recommendations were approved and fully funded by management. As for the head cleaning performed during 12 RFO, Mr. Siemaszko did not raise any objection or reservation to restart, nor did he write a Condition Report ("CR") documenting any concern with regard to the results of the head cleaning. In fact, Mr. Siemaszko's own close-out of the relevant CR and associated Work Order reflect his satisfaction with the results of the head cleaning. Contrary to what all now know the facts to be, at the close of 12 RFO, Mr. Siemaszko wrote that "[a]ccumulated boron . . . was removed," and that "work [was] performed without deviations." Contrary to the allegations, Mr. Siemaszko also was not an advocate of the referenced modification to install larger access holes in the service structure. Rather, Mr. Siemaszko and others were of the view that other techniques would suffice until the entire service structure would be replaced during 14 RFO.

The Petitioner's characterization of Mr. Siemaszko's role regarding the dispositioning of the RCP gasket leakage is also factually incorrect. Contrary to Petitioner's account, records reflect that Mr. Siemaszko did not raise issues regarding RCP gasket leakage, and did not advocate gasket replacements. Other FENOC personnel identified that leakage and saw to its resolution. Because of observed weaknesses in Mr. Siemaszko's performance, in June 2002, FENOC hired another engineer to support reactor coolant system issues. The additional engineer identified several issues regarding the RCPs, including some evidence of a history of inner gasket leakage, and recommended replacing gaskets on all four RCPs during 13RFO.

In parallel, FENOC senior management approved and funded a project, requested by a mid-level FENOC manager, to manage RCP maintenance issues during the outage. On July 12, 2002, this mid-level manager reported to Davis-Besse senior managers that it would be necessary to replace gaskets on one pump during this outage, and requested additional approval to replace gaskets on all four RCPs, as a conservative measure. Senior management gave approval to replace gaskets on two of the pumps, and funding to test the condition of the gaskets on the other two. When this same mid-level manager, and others, suggested gasket replacement on all four RCPs during 13RFO, senior managers suggested contacting the pump vendor to hear its expert recommendations on the subject.

In stark contrast to Mr. Siemaszko's allegations, the pump vendor never recommended gasket replacement on all four RCPs during 13 RFO. On July 2, 2002, the pump vendor recommended adopting an integrated approach to RCP maintenance, including gasket replacement. The pump vendor, however, did not recommend attempting that work on all four RCPs during the same outage, let alone the current outage. Quite the contrary, in a meeting at Davis-Besse on September 10, 2002, the pump vendor representative recommended replacing gaskets on two RCPs during the current outage, as planned, and testing the other two, at full system pressure and temperature, to ensure no external leakage. In fact, the pump vendor technical representative at that meeting had concerns about attempting such a broad scope effort on four RCPs during the same outage. The pump vendor's September 16, 2002, letter documented their

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recommendations. At the September 10, 2002, meeting, the participants developed a common understanding of FENOC's planned approach. This group included senior managers, the pump vendor representative, the mid-level manager, the additional engineer, Mr. Siemaszko, and others. No one voiced disagreement with the planned approach.

And FENOC did not refuse to test or repair the RCPs as alleged in the Supplement. Quite to the contrary, and consistent with the pump vendor's recommendations, FENOC instituted a comprehensive RCP refurbishment project, pursuant to which, during 13 RFO, FENOC replaced the gaskets and motors on two of the four pumps, performed air-drop tests on the remaining two pumps, and will test all four pumps with water at full pressure and temperature before restart.

In sum, FENOC has acknowledged that programmatic deficiencies, as well as missed opportunities by a number of Davis-Besse personnel, resulted in undetected wastage of the RPV head. In response to the numerous reviews of the circumstances that allowed this event to occur, FENOC management initiated a number of corrective actions to prevent reoccurrence of similar events in the future. Those corrective actions include holding people, as in the case of Mr. Siemaszko, accountable for their actions or inactions as they related to the RPV head wastage and the communication of inaccurate and incomplete information about the condition of the head to the NRC. These corrective actions enhance and reflect favorably on the site's safety culture, and do not detract from it.

Petitioner's wholesale adoption of Mr. Siemaszko's complaint is misguided. No new information is asserted in this Supplement. The allegations adopted are already actively being investigated by and are squarely before both DOL and the NRC. The evidence will disprove Mr. Siemaszko's alleged retaliation, as well as his alleged advocacy about both the RPV head and the RCPs. The allegations of protected activity are patently false and will be proved so by the evidence, including Mr. Siemaszko's own contemporaneous documents. Significantly, there is no evidence, whatsoever, that the executives who decided to terminate Mr. Siemaszko had any knowledge of his role in the alleged protected activities. As such, Petitioner's allegations in this regard provide no basis to delay NRC approval of restart or to revoke the license for Davis-Besse.

CONCLUSION

In sum, the Supplement presents no significant new information that would warrant a change of position on the part of the NRC. The Supplement merely repeats issues and facts already known to and already reviewed or under review by the NRC or DOL. Moreover, the Supplement disregards the numerous actions by both FENOC and the NRC, which operate collectively to ensure regulatory compliance and the continued safe operation of the plant after restart. FENOC has consistently demonstrated its ability and willingness to comply with all applicable NRC requirements, and, pursuant to the extensive 0350 process, Davis-Besse will not be permitted to restart until the plant has demonstrated its readiness to operate safely. Accordingly, the

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Supplement does not articulate a sufficient basis to warrant the extreme remedy requested by the Petitioner. Therefore, the original Petition, as supplemented, should be denied in its entirety.

Very truly yours,



Robert F. Saunders
President and Chief Nuclear Officer
FirstEnergy Nuclear Operating Company

Enclosure

cc: Mr. William D. Travers, NRC Executive Director for Operations
Mr. J. E. Dyer, Regional Administrator, NRC Region III
Mr. J. B. Hopkins, DB-1 NRC/NRR Senior Project Manager
Mr. C. S. Thomas, DB-1 NRC Senior Resident Inspector
U.S. Document Control Desk
Congressman Dennis J. Kucinich
Utility Radiological Safety Board

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COMMITMENT LIST

The following list identifies those actions committed to by the Davis-Besse Nuclear Power Station (DBNPS) in this document. Any other actions discussed in the submittal represent intended or planned actions by the DBNPS. They are described only for information and are not regulatory commitments. Please notify the Manager – Regulatory Affairs (419-321-8450) at the DBNPS of any questions regarding this document or any associated regulatory commitments.

COMMITMENTS

DUE DATE

None