

Exit Meeting Notes

- I. Introduction (may be unnecessary if Bruce goes first)
 - A. NRC
 1. Self
 2. Jack
 3. Bruce
 4. Resident
 - B. Licensee
 - C. Request for attendance list
- II. Administrative
 - A. Exit meeting for a portion of the System Health Assurance Implementation inspection
 - B. Inspection report is 02-13 for docket 346
 - C. Inspection began on September 3rd and covered the weeks of September 16th, September 23rd, October 7th, October 21st, and November 4th
 - C. I was assisted during the week of September 16th by John Jacobson
 - D. I was assisted during the week of November 4th by George Hausman.
 - E. Before I begin to discuss the inspection, it is important that I take the time to express my appreciation to a number of Davis-Besse staff for inspection support.
 1. Terry Mountain
 2. Terry Cribbe
 3. Gene Metranga
 4. Eric Grindahl
- III. Objectives - there were three objectives
 - A. To evaluate the licensee's implementation of the System Health Assurance (SHA) Building Block in their Return to Service Plan.
 - B. To verify that the design bases have been correctly implemented for selected risk-significant systems to ensure that the systems can be relied upon to meet their functional requirements.
 - C. To accomplish applicable inspection requirements from Inspection Procedures 95002 and 95003 (These are special NRC inspection procedures used when a plants performance has deteriorated)
- IV. There were six components to the inspection
 - 1) Review and evaluate the licensee's "Building Block" program plan and applicable parts of the licensee's Return to Service Plan, Restart Action Plan, and Restart Action Plan Process.
 - 2) Observe and evaluate a risk-informed sample of the licensee's implementation efforts for the program.
 - 3) Assess the licensee's independent oversight effectiveness for the program.

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- 4) Evaluate the adequacy of the licensee's Performance Indicators for the area of inspection, review the insights provided by implementation of those performance indicators, and review the actions taken in response to performance indicator data.
- 5) Perform independent inspection to verify licensee's results.
- 6) Classify and evaluate, in accordance with licensee's restart action plan process, a sampling of the issues which emerged from the discovery portion of the system health assurance plan.

V Overview

A. We have completed four of the six components

- 1) Review and evaluate the licensee's "Building Block" program plan and applicable parts of the licensee's Return to Service Plan, Restart Action Plan, and Restart Action Plan Process.
- 2) Assess the licensee's independent oversight effectiveness for the program.
- 3) Evaluate the adequacy of the licensee's Performance Indicators for the area of inspection, review the insights provided by implementation of those performance indicators, and review the actions taken in response to performance indicator data.
- 4) Perform Independent inspection to verify licensee's results.

B. We have not completed the evaluation of a risk-informed sample of the implementation efforts for the program because only a few of the review reports have been completed and approved.

C. We have not completed the final component which directs us to classify and evaluate, in accordance with licensee's restart action plan process, a sampling of the issues which emerged from the discovery portion of the system health assurance plan because the issues are still being assessed, and for the most part corrective actions have yet to be prescribed, evaluated or implemented.

VI Inspection Activities

- Examine procedures used for the review program
- Reviewer training and qualification
- Licensee performance indicators relative to SHA
- Walk down two of the 31 SHRR systems
- walkdown of latent issues review system (auxiliary feedwater)
- Monitor Latent Issues Review team activities in-process
- interview team leaders and team members
- Monitor System Health Readiness Review team activities in-process
- interview a system health review team leader
- Monitor Engineering Assessment Board activities in-process

- NQA oversight plans specific to SHA
- Monitor NQA oversight activities in-process
- review the QA reports for the three systems they examined
- review the independent self-assessments prepared for the three systems our team inspected
- Monitor licensee evaluation of progress compared to performance indicators

VII Findings

- A. There were no formal findings from this inspection.
1. It was an inspection of processes put in place by you to examine the condition of plants systems necessary for safe reactor operation.
 2. As such, unless there was a significant flaw in the process or a breakdown in implementation, findings were unexpected.

VIII Observations

- A. I had a wide variety of observations, many were directly related to the System Health Assurance effort but some of them were outgrowths from the inspection.
- B. System Health Assurance observations
1. The processes for the latent issues and system health readiness reviews were adequate for the task.
 2. There were a couple minor loopholes related to ensuring that oversight organizations such as EAB and the validation teams comments and instructions were fed back into the final products. These were resolved by procedure reviews
 3. EAB is a significant strength by the nature of its in-depth, probing, and comprehensive examinations of system health products that it reviewed.
 4. At the start of the effort QA had not completely thought through how their oversight effort would be reported.
 5. Performance indicators for completed reports needed to be adjusted to allow for validation. Reports were being considered completed after EAB had approved them but in fact significant validation team effort was still part of the process.
 6. 125/250 VDC SHRR report was properly prepared and adequately supported its conclusion that the system was not ready to support restart
 7. The self-assessments of SW, 4160VAC, and HPI, done in advance of our team inspection were thorough and revealed design basis discrepancies which were factored into your decisions on expanding the system health assurance program.
 8. Latent Issues Reviews identified that there were significant problems in calculations and design basis information, but did not identify the number of specific problems that our team inspection did.
 9. System Health Readiness Reviews were not intended to identify design basis issues ... our examination of 4160 and HPI did reveal these kinds of problems which indicates the need for some sort of design basis examination for SHRR systems.
 10. the collective significance effort underway has the capability to address design basis issues from both LIR and SHRR systems. In the realm of System Health Assurance, I believe the most important task you have

before you is the development and implementation of the expansion action plans, most importantly, those dealing with design basis.

C. Additional observations

1. System engineers seemed to be focused on TS and acceptance criteria for testing under their cognizance but unfamiliar with the design basis information that is the foundation for these setpoints
2. Questions on greasing of manual valves and struts, preventive maintenance on molded case circuit breakers led to questions on component oriented maintenance programs and identification of a three-year old self-assessment on that topic for which there had been no follow-up
3. Inquiries into inconsistencies in greasing of support struts revealed that the struts were supplied as dry-film lubricated and weren't supposed to be greased. Since greased struts were identified, the extent of the condition has to be determined and operability of greased struts must be assessed.
4. Review of 125/250 VDC SHRR report revealed a need to determine extent of condition for an incomplete fuse replacement program initiated in 1992
5. As a result of my inquiries an old commitment related to deadheading of HPI during a small-break LOCA was closed. The closure based on the current HPI operating procedure; however, that procedure did not address or control deadheading of HPI during a small-break.
6. Resolution of deficiencies identified by the Design Basis Validation Program was flawed. I identified an improperly closed high-significance issue in the service water report that was improperly closed. You have confirmed this observation in you own examination of these reports.
7. The Design Basis Validation Program was initiated in response to the 10CFR 50.54(f) letter of 1996. The letter was spawned by concerns with accuracy problems with FSARs and USARs throughout the industry. Based on my review of the Davis-Besse validation program and the service water design validation report prepared by Sargent and Lundy, the program used the USAR as baseline, primarily focused on the System Descriptions, and attempted to validate them as design basis documents rather than verify the accuracy of information in the SAR.

IX Summary

- A. There are no violations or findings
- B. The second group of observations ... those that emerged from the inspection, are issues which you need to pursue
- C. The System Health Assurance program was appropriate to the circumstances
- D. Although the Latent Issues Review was not intended to dig deeply into calculations, the process did identify programmatic problems with calculations
- E. Our team inspection identified design basis and calculation issues in systems not subjected to Latent Issues Review

- F. How you chose to expand System Health and the depth to which you go must be carefully considered and technically justified.**

- X. Licensee questions or comments**

- XI. NRC management comments**

- XII. Proprietary statement**
 - A. I am unaware of any proprietary information being examined during this inspection. If anybody does know of proprietary information reviewed during this effort, please let me know.**

- X. Adjourn**