

October 4, 2006

EA 03-214

Mr. Mark B. Bezilla
Site Vice President
FirstEnergy Nuclear Operating Company
Davis-Besse Nuclear Power Station
5501 North State Route 2
Oak Harbor, OH 43449-9760

SUBJECT: DAVIS-BESSE NUCLEAR POWER STATION
NRC SPECIAL INSPECTION - MANAGEMENT AND HUMAN
PERFORMANCE CORRECTIVE ACTION EFFECTIVENESS -
REPORT NO. 05000346/2006011(DRP)

Dear Mr. Bezilla:

On August 24, 2006, the NRC completed a Special Inspection at FirstEnergy Nuclear Operating Company's (FENOC) Davis-Besse Nuclear Power Station. The inspection was to assess the effectiveness of FENOC's corrective actions in response to deficiencies identified through its October 2005 Safety Conscious Work Environment (SCWE) survey and its subsequent 2005 independent Safety Culture (SC)/SCWE assessment, which the NRC's March 2004 Confirmatory Order required.

Following the identification of organizational effectiveness and human performance as one of the principal causes of the reactor pressure vessel head degradation in 2002, the NRC conducted a series of special inspections in the management and human performance area. These inspections were designed to evaluate the effectiveness of FENOC's corrective actions in this area. The overall inspection plan was designed to assure that an appropriate root cause analysis had been completed (Inspection Report 05000346/2002015, dated February 6, 2003), that appropriate corrective actions had been identified and implemented (Inspection Report 05000346/2002018, dated July 24, 2003), and that the effectiveness of those corrective actions was assessed (Inspection Report 05000346/2003012, dated February 27, 2004).

During the final stages of the effectiveness inspection, FENOC provided the NRC with detailed results from its November 2003 SCWE survey. Because several key departments had responded more negatively to some questions than in the March 2003 survey, a follow-up inspection (Inspection Report 05000346/2004003, dated March 31, 2004) was conducted to understand the cause(s) for the increase in negative responses. Additional follow-up inspections (Inspection Report 05000346/2004013, dated October 17, 2004; and Inspection Report 05000346/2005016, dated December 2, 2005) were conducted to assess the effectiveness of your corrective actions for the identified deficiencies.

In contrast to the SC/SCWE assessment conducted in 2003 and 2004, your 2005 internal SCWE survey and the 2005 independent SC/SCWE assessment noted modest improvements in most organizations. The previous inspection results in this area, documented in Inspection Report 05000346/2005016, noted these improvements and identified that your corrective actions appeared to have the most significant impact during the mid-cycle outage in January 2005. While improvements were noted during and following the mid-cycle outage, it was important to assess the long term effectiveness of the corrective actions and determine whether the effectiveness of the corrective actions would be sustained during the first refueling outage following the extended shutdown. To that end, we conducted focused group interviews in June 2006, to assess the SC/SCWE at the site following the January 2006 refueling outage.

The NRC concluded that the corrective actions implemented at Davis-Besse to improve its SC and SCWE following the 2004 and 2005 SCWE survey and independent SC/SCWE assessment have had an overall positive effect. The team noted that while some departments exhibited more negative responses than other departments, overall responses from all organizations, in general, were more positive, indicating that corrective actions implemented following the 2005 survey and assessment were effective.

Based on the results of this inspection, we have concluded that the SC and SCWE at Davis-Besse are improving and acceptable to support continued facility operation.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Eric R. Duncan, Chief
Projects Branch 6
Division of Reactor Projects

Docket No. 50-346
License No. NPF-3

Enclosure:
Inspection Report 05000346/2006011(DRP)

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Sincerely,

Eric R. Duncan, Chief
Projects Branch 6
Division of Reactor Projects

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cc w/encl: The Honorable Dennis Kucinich
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Nuclear Officer - FENOC
J. Hagan, Senior Vice President of
Operations and Chief Operating Officer
Richard Anderson, Vice President
Director, Plant Operations
Manager - Site Regulatory Compliance
D. Pace, Senior Vice President of
of Fleet Engineering
J. Rinckel, Vice President, Fleet Oversight
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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-346

License No: NPF-3

Report No: 05000346/2006011

Licensee: FirstEnergy Nuclear Operating Company

Facility: Davis-Besse Nuclear Power Station

Location: 5501 North State Route 2
Oak Harbor, OH 43449-9760

Dates: June 26 through August 24, 2006

Inspectors: G. Wright, Lead Inspector, Region III

Team Members: J. Persensky, RES
M. Keefe, RES

Observer: T. Ghosh, NMSS

Approved by: E. Duncan, Chief
Projects Branch 6
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000346/2006011, FirstEnergy Nuclear Operating Company, on June 26 - August 24, 2006, Davis-Besse Nuclear Power Station, Special Inspection.

This report covers a special inspection continuing the NRC's review of the long-term effectiveness of the licensee's corrective actions (CA) associated with the deficiencies identified through the 2004 and 2005 Safety Conscious Work Environment (SCWE) surveys and independent Safety Culture (SC)/Safety Conscious Work Environment assessments. The inspection was conducted by NRC inspectors and specialists (team). The inspection concluded that, overall, the CAs were effective.

The results of the inspection indicated that for the first time, Davis-Besse staff exhibited a sustained improvement in both SC and SCWE. Specifically, changes in behavior relative to work management during the January 2005 mid-cycle outage, continued through the January 2006 refueling outage and continued to have a positive effect. The team concluded that, overall, actions by the licensee have resulted in improvements in the SC/SCWE at Davis-Besse.

Summaries of the five areas assessed during this inspection are provided below.

Willingness to Raise Concerns (Management Support - Worker Confidence - Raise Concerns Without Fear of Retaliation)

Site-wide, individuals felt free to raise concerns and management encouraged workers to raise nuclear safety concerns. Further, licensee staff had no concerns about documenting issues, though they did have problems with the new system for documenting concerns. The staff also indicated that they had no concerns about challenging management regarding non-conservative decision making.

Effective Normal Problem Resolution Processes (Effectiveness of Corrective Action Program)

The staff continued to document issues even though there appeared to be wide-spread confusion related to the SAP system. The SAP system was recently implemented to separate issues which were less significant than conditions adverse to quality from the more traditional condition report system. This would allow for improved focus on higher priority issues. SAP system training to date appeared not to have been fully effective in improving the staff's ability to use the system. While improvements in the corrective action program were realized, three organizations expressed concerns with the timeliness and priority of responses to their concerns. Overall, the team concluded that staff confidence in the corrective action program had improved.

Effective Alternate Problem Resolution Processes (Employee Concerns Program)

Improvements in Employee Concerns Program visibility and training were made. Previous confidentially concerns were not apparent during the interviews.

Safety Conscious Work Environment Review Team (Ability to Detect and Prevent Retaliation)

There was no evidence of retaliation and no one interviewed indicated that they were aware of any retaliation. The team concluded that the licensee's actions to identify potential issues regarding retaliation and to take appropriate actions where questions exist had been effective.

Staff Feedback on 14th Refueling Outage

Management actively sought input from the staff on areas for improvement for future outages. The management team's critique of the 14th refueling outage (RFO 14) captured the same issues that the inspection team heard from the staff during focused group interviews. Despite the issues identified during RFO 14, there was no degradation of safety culture. In addition, despite RFO 14 being extended beyond its original end date, the staff indicated that there was no undue production pressure on individual site workers.

The team's interviews, following RFO 14, confirmed that the staff believed that RFO 14 was managed with a safety first attitude. The team heard a number of comments with respect to the outage, best summed up by one staff member's statement: "We scheduled the outage but we didn't plan it." However, these issues appeared not to result in negative perceptions regarding management actions and behaviors. The team also heard from staff, in several organizations, that even under stressful conditions, in general, management recognized when they were exhibiting behaviors that could be perceived in a negative way, and took actions to correct them.

REPORT DETAILS

I. Scope

The inspection was accomplished by a special inspection team consisting of an NRC inspector and specialists (team). The inspection was designed to assess the licensee's compliance with 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," by evaluating the effectiveness of the management and human performance corrective actions (CAs) developed by the licensee from its assessment of the 2004 and 2005 Safety Conscious Work Environment (SCWE) surveys and Confirmatory Order required independent Safety Culture/Safety Conscious Work Environment assessments.

II. Objective

The inspection was designed to independently assess the effectiveness of the licensee's CAs related to the 2005 SCWE survey and independent outside SC/SCWE assessment.

III. Assessment Process

.A Inspection Basis

The inspection consisted of a review of the corrective actions (CAs) identified by the licensee, an independent assessment of the effectiveness of the CAs, a review of the licensee's assessment method and report, and observations and discussions with individuals from ten licensee departments.

The team used focus group interviews along with document review as input to its assessment. The team also reviewed related documents listed in Attachment 1.

.B Inspection Approach

The team used the following techniques to perform the inspection:

- .1 Independent review of documents, e.g.;
 - .a Employee Concerns Program (ECP) survey data
 - .b Monthly Safety Culture (SC) Performance Indicators (PIs)
 - .c Results from the independent outside SC/SCWE assessment
- .2 Focus group interviews were conducted with staff from:
 - .a Operations
 - .b Maintenance
 - .c Chemistry
 - .d Radiation Protection
 - .e Training
 - .f Engineering
 - .g Site Projects

- .h Security
- .i Supervisors, all departments

IV. Assessment, Observations, and Conclusions

.A Corrective Action Effectiveness for Management & Human Performance Issues

1. Scope

The team used the focus group interview approach to assess the effectiveness of the licensee's corrective actions to address issues identified during the 2005 Independent Safety Culture/Safety Conscious Work Environment Assessment. To effectively assess the interview results against the results from the licensee's assessment tools, the focus group interview protocol was organized around the four licensee defined pillars of SCWE: Willingness to Raise Concerns, Normal Problem Resolution Process, Effective Alternate Problem Resolution Processes (Employee Concerns Program), and Preventing and Detecting Retaliation, as the basis for its interviews.

2. Observations

Observations are presented by SCWE Pillar.

.a Pillar 1: Willingness to Raise Concerns (Management Support - Worker Confidence - Raise Concerns Without Fear of Retaliation)

.1) Observations

During all of the focus group interviews, participants responded that they would raise safety concerns and that management encouraged workers to raise safety concerns. Further, those interviewed said they could freely raise issues or document issues without fear of retaliation. They also indicated that they had no concerns about challenging management regarding non-conservative decision making. There was a prevailing opinion amongst the staff interviewed, that the improved willingness to raise issues was due to concerns being addressed more expeditiously because management had made this a priority. Some licensee staff even expressed the opinion that management now exhibited an attitude that they would not shy away from fixing problems and would address issues, even if it negatively impacted the schedule. Those interviewed also indicated that management had been doing a better job explaining their actions so there was a clearer understanding of how and why actions were taken. The staff indicated that this has led to greater staff confidence, even if they did not necessarily agree with the actions taken.

The previous NRC inspection report on this topic (IR 05000346/2005016 (DRP)), noted that a pivotal event appeared to be the January 2005 mid-cycle outage. Most staff viewed the management behaviors exhibited during the mid-cycle outage positively. The staff also indicated that they believed that continuation of the behaviors would allow for significant improvements in the future and would remove additional barriers to raising concerns. The staff indicated that management performance during refueling outage 14 (RFO 14) would be a critical test. Even though all licensee personnel the team

talked to agreed RFO 14 was problematic, they also indicated that management maintained its positive behaviors regarding acceptance of staff raising concerns, even if the issue impacted the schedule. While some staff continued to have a perception that there was a production over safety attitude, actual management behaviors and actions did not support this perception. When asked for examples, the same staff agreed that work would be stopped if there was a safety issue. The conflict between perception and actual conditions indicated that communications had not been fully effective in this area.

Only a few individuals in the Security and Radiation Protection groups indicated that they might be hesitant to raise a concern because it might not be addressed. On further probing, those individuals indicated that there had been improvement in this area and that part of the issue was the priority and timing of corrective actions. In the Security area, comments also indicated that supervisors were more available and visible, and that staff was more willing to challenge safety and security issues.

The most frequently mentioned concern regarding raising issues was the difficulty and confusion surrounding entering items into the newly implemented SAP program. This is described below.

.2) Conclusions

Site-wide, individuals felt free to raise concerns and management encouraged workers to do so. Further, the staff had no concerns about documenting issues, though they did have problems with the new system for reporting (see following section). The staff also indicated that they had no concerns about challenging management regarding non-conservative decision making. Overall, Pillar 1 improved from earlier assessments.

.b Pillar 2: Effective Normal Problem Resolution Processes (Effectiveness of Corrective Action Program)

.1) Observations

Though no issues related to raising concerns were identified, there was wide-spread confusion related to the recently implemented SAP system for tracking issues that did not rise to the level of a condition adverse to quality. While a few staff indicated that they were comfortable using SAP, most indicated that they would submit a condition report to document the concern, or go to a supervisor or colleague who understood the system to input the issue. The supervisors who were interviewed indicated that while some individuals were reluctant to use SAP, based on the number of issues in the system, everyone's issues appeared to be getting entered in some manner. The supervisors also indicated that many staff relied on a couple of individuals in each organization to enter notifications. Most staff also indicated that supervisors were willing to help input concerns into the system. All individuals contacted during the inspection indicated SAP was not user friendly and training had not been effective.

On the positive side, some of those interviewed believed that using SAP to remove less significant issues from the corrective action program helped focus resources on more significant issues. The staff also indicated that the Corrective Action Review Board (CARB) had done a good job of prioritizing issues.

Most individuals interviewed, indicated that they were more confident about raising issues because they had seen a change in the way issues were addressed. Individuals also said that there had been a reduction in the maintenance backlog. They also observed an improvement in management's willingness to address concerns, which had a direct impact on the amount of work in the backlog. Further, the Duty Teams, which consisted of employees from across the disciplines who were able to quickly resolve concerns without having to raise concerns through multiple layers of management, had improved the timeliness of issue resolution. The Duty Teams were seen by employees as very effective in resolving issues in a safe manner and with staff input.

Not all of the feedback during the focus group sessions was positive. Three organization raised concerns related to the timeliness of actions to resolve issues. One organization continued to be concerned about the time required to correct some of their industrial safety issues. The same individuals indicated they had a positive reaction to the posting of action items and status for their review. The Chemistry staff indicated that their work was considered lower priority and therefore took longer to resolve. Nuclear safety issues were considered to be longer term for chemistry, therefore, they were given a low priority. Chemistry was concerned that they were routinely told they were one of the top five most important areas of the plant, but prioritization of their equipment and maintenance needs did not reflect that importance level. An example given related to the failure to repair a skid mounted cleanup system in a timely manner resulting in increased workload. Chemistry staff also indicated that because maintenance on chemistry equipment was considered low priority, if parts were not available when the job was scheduled, the job would be immediately rescheduled to a time much farther in the future. This resulted in the need to devise work-arounds for back-logged maintenance issues. In Radiation Protection, some individuals indicated that there had been a loss of confidence in the condition report process because of the lack of action follow thru. Some staff believed that SAP provided an opportunity for a "band-aid" fix, so that real problems were not always addressed and the items were not tracked.

Another issue discussed was lack of feedback in the SAP program. Because some personnel had trouble finding items in SAP, they were sometimes unsure of the status of items they identified. Feedback to the originator of SAP notifications was not required, though the staff desired it to better understand the status of the equipment for which they were responsible. This lack of feedback had resulted in some individuals using condition reports (CRs) for lower significance items, which increased the burden on the daily review of CRs and SAP notifications to ensure proper classification. The team was told that there was a feedback provision in SAP; however, it had not been implemented.

.2) Conclusions

The staff continued to document issues even though there appeared to be wide-spread confusion related to SAP. The SAP system was not user friendly and training to date appeared not to have been fully effective in improving the staff's ability to use the system. In the meantime, supervisors and some staff members have compensated for the knowledge gap by assisting with data entry. The lack of feedback from the SAP was a concern for many. While improvements in the corrective action program had been

realized, three organizations expressed concerns with the timeliness and priority of responses to their concerns. Overall, the team concluded that staff confidence in the corrective action program had improved.

c. Pillar 3: Effective Alternate Problem Resolution Processes (Employee Concerns Program)

.1) Observations

Based on information gathered by the team during focus group interviews, improvement had been made with regard to individuals' perceptions of Employee Concerns Program (ECP) effectiveness. Most of the staff interviewed were aware of the ECP and the process to raise a concern through the ECP. Further, most staff interviewed were also familiar with the new ECP manager, were aware of recent efforts to re-familiarize the staff with the ECP, and believed that the ECP was generally confidential and effective. The new ECP manager had made a concerted effort to increase his visibility in the plant; many individuals indicated that they had seen and interacted with him. The staff also indicated that they had received recent training on methods of problem resolution, including the ECP, CAP, normal management chain, and the NRC. While the issue of confidentiality had been a concern in the past, individuals interviewed indicated that they believed the ECP program would keep their identity as confidential as the process allowed. Though they were aware of the program, most individuals indicated that they preferred to go to their management or used the CAP to express concerns.

At least one group believed the improvements in SCWE survey results were because all non-represented employees bonuses were tied to SCWE survey results. The team verified that managers and above had a safety culture component in their performance appraisals which used some information from the SCWE survey; however, no direct connections between SCWE survey results and bonuses were identified. This issue appeared to be the result of mis-communication.

.2) Conclusions

Improvements in ECP visibility and training have been made. Previous confidentially concerns were not re-identified during the interviews. Most people indicated they would use the normal management chain or the corrective action program rather than ECP. The team concluded that corrective actions implemented to improve ECP visibility had been effective.

d. Pillar IV: Ability to Detect and Prevent Retaliation (Safety Conscious Work Environment Review Team)

.1) Observations

The majority of individuals interviewed believed they were free to raise concerns without fear of retaliation. Further, none were aware of any retaliatory actions having been taken against others for raising safety issues. However, the team noted that the perception remained among some individuals that the 2005 re-organization was used as an opportunity to target some more vocal employees.

Though no concerns were raised with regard to overt retaliation, some concerns were raised in the Maintenance organization related to schedule pressures. For instance, there was a perception that journeyman did not want to move into supervisory positions because the supervisors were treated poorly by management if schedules were not adhered to. This may have been the result of a lack of understanding between management holding supervisors accountable for their group's performance and actual incidents of retaliation. Some individuals indicated that they were encouraged to adhere to the schedule, even if they complete a task early, potentially leading to less than optimal use of resources.

.2) Conclusions

There was no evidence of retaliation and no one interviewed indicated that they were aware of any retaliation issues. The team concluded that the licensee's actions to identify potential issues regarding retaliation and to take appropriate actions where questions existed had been effective.

B. Staff Feedback on 14th Refueling Outage

.1 Scope

During the interviews, the staff raised numerous concerns regarding the conduct of RFO 14. The team reviewed the licensee's refueling outage self-assessment/critique to observe the extent to which the licensee included the staff's concerns, i.e., the extent to which the licensee exhibited traits of a learning organization.

.2 Observations

The staff's concerns associated with RFO 14 fell into three areas: work control and outage coordination, contractor oversight, and communications. The team's roll up of comments made by focus group members is provided below by area.

.a Work Control and Outage Coordination

Staff from several work groups expressed concerns about work control and coordination during the outage. For example, staff described work-arounds that had to be devised to deal with emergent equipment problems. There was a perception among some staff that management's focus in dealing with problems was to fix the symptoms rather than the actual problem. Staff also expressed the concern that too much management involvement in day-to-day activities affected their ability to work effectively.

Another area of concern was As Low As Reasonably Achievable (ALARA) planning. Some of the staff indicated that the ALARA planning goals revised by FENOC corporate were unrealistic. In addition, the team heard that some personnel incurred higher radiation doses because the cleanup of the primary coolant system was postponed due to schedule pressures. The team also heard that maintenance personnel incurred higher radiation doses because of administrative burden.

There were perceptions of poor planning and coordination among work activities across several organizations. Some staff provided the example of systems being only partially restored before subsequent work activities took place; which led to disruptions, including water spills, and caused additional unnecessary work. Some staff were also concerned about whether appropriate reviews were conducted before partial restorations were approved. Another example of poor coordination provided by the staff, was that security personnel were pulled into trimester training during RFO 14.

B. Contractor Oversight

Several organizations identified contractor oversight as a concern. One of the issues expressed was that FENOC did not provide direct oversight of contractors; rather, oversight was conducted by the contractor organizations. There was a perception that the plant could not bring contractors on site early enough for adequate outage preparation. The overall perception was that contractor resources were not effectively utilized and oversight was poor.

C. Communications

Communications continued to be an issue at Davis-Besse. For example, individuals across multiple organizations perceived that schedule and production pressure on site management was coming from FENOC corporate. Staff from several work groups shared the view that unrealistic goals during the RFO 14 outage did not align with the work scope, and some believed that the site had been “set up for failure.” The team was not made aware of any communications addressing these concerns.

The staff also pointed out that prior to the outage, FENOC, as one of its “common process” reviews, revised the cleanliness/foreign material exclusion closeout inspection process at Davis-Besse. The change removed Chemistry as the primary organization responsible for cleanliness/foreign material closeout inspections on the main condenser. During RFO 14, chemistry personnel identified foreign material in the water boxes after the boxes had been cleared for closure. It appeared that either the change management process and/or communications of expectations were not effective at ensuring that the condition of the water boxes was satisfactory prior to being designated for closure.

The Davis Besse leadership team had recognized past worker concerns of production over safety and negative management behaviors, and had taken actions to improve performance in those areas. The numerous issues identified by the staff during RFO 14 could best be summed up by one statement that, “we scheduled the outage but we didn’t plan it.” Feedback from the staff, during focused group interviews, indicated that despite the issues identified during RFO 14, there was no degradation of safety culture. In addition, even though the outage was extended beyond its original completion date, the staff did not perceive that there was any undue production pressure placed on individual site workers. Following RFO 14, management sought input on areas for improvement that could be made for future outages. The team’s brief review of the RFO 14 critique identified that it captured the same issues that the inspection team heard from the staff during focused group interviews. The results of the critique were shared with the staff during an all hands meeting.

3. Conclusions

In the previous inspection in this area, the team observed that Davis-Besse staff had a “wait and see” attitude regarding RFO 14 and future outages. The team’s interviews following RFO 14, identified that Davis-Besse staff believed that RFO 14 was managed with a safety first attitude. Staff and supervisors interviewed indicated that the message from upper management was that supervisors should set the right tone and reinforce positive behaviors in dealing with staff. This appeared to have been effective as individuals from several organizations stated that even under stressful conditions, in general, management recognized when they were exhibiting behaviors that could be perceived in a negative way, and took actions to correct them.

Even though the staff identified numerous areas for improvement, they did not note any undue pressure to meet schedules and the issues did not appear to result in negative perceptions regarding management actions and behaviors. The team concluded that the licensee critique had captured all the issues that the staff had brought to the team’s attention, thereby exhibiting the characteristics of a learning organization.

V. Exit Meeting

The Lead Inspector met with Mr. R. Schrauder and members of your staff on August 24, 2006, to discuss the results of this inspection. Mr. Schrauder acknowledged the team’s conclusions. The licensee confirmed that no proprietary information was discussed during the exit meeting.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

FirstEnergy Personnel

J. Dominy	Superintendent, Maintenance P&S
R. Drew	Manager, Supply Chain
G. Fidurski	Supervisor, Security Operation
L. Griffith	Manager, Site Human Resources
R. Hruby, Jr.	Manager, Fleet Oversight
R. Jarosi	ECP Representative
M. Leisure	Supervisor, Regulatory Compliance
C. Mincheff	Supervisor, Security Training
R. Schrauder	Director Performance Improvement
J. Vetter	Manager, Emergency Response

State of Ohio

E. Edwards	Ohio Emergency Management Agency
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DOCUMENTS REVIEWED

Tabulated results from the licensee's supplemental summer 2005 and fall 2005 SCWE surveys

Licensee's March 4, 2005, letter resubmitting its 2004 Organizational Safety Culture and Safety Conscious Work Environment Independent Assessment Report and Actions Plans for the Davis-Besse Nuclear Power Station

Oversight and Process Improvement Nuclear Quality Assessment, Safety Culture and Safety Conscious Work Environment Interviews/Survey performed October 10 - 21, 2005

Licensee's January 27, 2006, letter submitting its 2005 Organizational Safety Culture and Safety Conscious Work Environment Independent Assessment Report and Actions Plans for the Davis-Besse Nuclear Power Station

LIST OF ACRONYMS

ALARA	As Low As Reasonably Achievable
CA	Corrective Action
CARB	Corrective Action Review Board
CFR	Code of Federal Regulations
ECP	Employee Concerns Program
FENOC	FirstEnergy Nuclear Operating Company
IR	Inspection Report
NRC	Nuclear Regulatory Commission
PI	Performance Indicator
RFO	Refueling Outage
SC	Safety Culture
SCWE	Safety Conscious Work Environment