UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

May 21, 2009

Mr. Barry Allen
Site Vice President
FirstEnergy Nuclear Operating Company
Davis-Besse Nuclear Power Station
5501 North State Route 2, Mail Stop A-DB-3080
Oak Harbor, OH 43449-9760

SUBJECT: DAVIS-BESSE NUCLEAR POWER STATION PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION 05000346/2009-006

Dear Mr. Allen:

On April 10, 2009, the U.S. Nuclear Regulatory Commission (NRC) completed a Biennial Problem Identification and Resolution inspection at your Davis-Besse Nuclear Power Station. The enclosed inspection report documents the inspection findings which were discussed on April 10, 2009, with you and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel. On the basis of the sample selected for review, the team concluded that implementation of the corrective action program (CAP) at Davis-Besse was generally good. The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies. During interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns.

Based on the results of this inspection, one NRC-identified finding of very low safety significance was identified. The finding involved a violation of NRC requirements. However, because of the very low safety significance, and because the issue was entered into your corrective action program, the NRC is treating the issue as a non-cited violation (NCV) in accordance with Section VI.A.1 of the NRC Enforcement Policy. If you contest any NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the Resident Inspector Office at the Davis-Besse Nuclear Power Station. In addition, if you disagree with the characterization of any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Davis-Besse Nuclear Power Station. The information you provide will be considered in accordance with Inspection Manual Chapter 0305.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be made 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/

Jamnes L. Cameron, Chief
Branch 6
Division of Reactor Projects

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

Enclosure: Inspection Report 05000346/2009-006
w/Attachment: Supplemental Information

cc w/encl: The Honorable Dennis Kucinich
J. Hagan, President and Chief
Nuclear Officer - FENOC
J. Lash, Senior Vice President of
Operations and Chief Operating Officer - FENOC
Manager - Site Regulatory Compliance - FENOC
D. Pace, Senior Vice President of
Fleet Engineering - FENOC
K. Fili, Vice President, Fleet Oversight - FENOC
P. Harden, Vice President, Nuclear Support
D. Jenkins, Attorney, FirstEnergy Corp.
Director, Fleet Regulatory Affairs - FENOC
Manager - Fleet Licensing - FENOC
C. O'Claire, State Liaison Officer, Ohio Emergency Management Agency
R. Owen, Administrator, Ohio Department of Health
Public Utilities Commission of Ohio
President, Lucas County Board of Commissioners
President, Ottawa County Board of Commissioners

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Letter to B. Allen from J. Cameron dated May 21, 2009

SUBJECT: DAVIS-BESSE NUCLEAR POWER STATION PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION 05000346/2009-006

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-346
License No:	NPF-3
Report No:	05000346/2009
Licensee:	FirstEnergy Nuclear Operating Company (FENOC)
Facility:	Davis-Besse Nuclear Power Station
Location:	Oak Harbor, OH
Dates:	March 23 through April 10, 2009
Inspectors:	R. Lerch, Project Engineer, DRP L. Jones, Reactor Inspector, DRS N. Feliz, Reactor Inspector, DRS F. Tran, Reactor Engineer, DRP P. Voss, Reactor Engineer, DRP A. Wilson, Resident Inspector
Approved by:	Jamnes L. Cameron, Chief Branch 6 Division of Reactor Projects

Enclosure

TABLE OF CONTENTS

SUMMARY OF FINDINGS

IR 05000346/2009-006; 03/23/2009 – 04/10/2009; Davis-Besse Nuclear Plant, Routine Biennial Problem Identification and Resolution Inspection. Identification and Resolution of Problems

This inspection was performed by five NRC regional inspectors and the Davis-Besse resident inspector. One Green finding was identified by the inspectors. The finding was considered a Non-Cited Violation of NRC regulations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Problem Identification and Resolution

On the basis of the sample selected for review, the team concluded that implementation of the corrective action program (CAP) was generally good. The licensee had a low threshold for identifying problems and entering them in the CAP. Items entered into the CAP were screened and prioritized in a timely manner using established criteria; were properly evaluated commensurate with their safety significance; and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. The team noted that the licensee applied operating experience to station activities. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies. On the basis of discussions and interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns.

A. NRC-Identified and Self-Revealed Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," for the failure to promptly identify and correct a condition adverse to quality regarding the expired qualification of molded case circuit breakers as safety-related components. Specifically, the licensee failed to identify that unqualified safety-related molded case circuit breakers were a condition adverse to quality and, as a result, the corrective actions were not prompt in that a 6 year replacement frequency was specified without an evaluation as to the acceptability of that frequency. The licensee entered this issue into its corrective action program.

  The inspectors determined that the finding was more than minor because the finding, if left uncorrected, would become a more significant safety concern. The finding screened as of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to have resulted in loss of operability or functionality in service. This finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee made a nonconservative determination that unqualified breakers were not a condition adverse to quality based on anecdotal history that suggested that no known problem existed at the time with any specific breaker. H.1(b)

B. Licensee-Identified Violations

No violations of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution (71152B)

The activities documented in Sections .1 through .4 constituted one biennial sample of problem identification and resolution as defined in IP 71152.

.1 Assessment of the Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's Corrective Action (CA) program implementing procedures and attended plant meetings to assess the implementation of the CA program by site personnel.

The inspectors reviewed risk and safety significant issues in the licensee's CA program since the last NRC Problem Identification and Resolution (PI&R) inspection in October 2006. The selection of issues ensured an adequate review of issues across NRC cornerstones. The inspectors used issues identified through NRC generic communications, department self assessment, licensee audits, operating experience reports, and NRC documented findings as sources to select issues. Additionally, the inspectors reviewed condition reports (CRs) generated as a result of facility personnel's performance in daily plant activities. In addition, the inspectors reviewed condition reports and a selection of completed investigations from the licensee's various investigation methods, which included root causes, apparent causes, and limited apparent causes.

The inspectors selected molded case circuit breakers to review in detail because they are associated with high risk systems. The inspectors' review was to determine whether the licensee staff were properly monitoring and evaluating the performance of these components through effective implementation of station monitoring programs. A 5 year review on the molded case circuit breakers was also undertaken to assess the licensee staff's efforts in monitoring for system degradation due to aging aspects. The inspectors reviewed a sample of work requests, condition reports, thermography results, and maintenance procedures. The inspectors also performed a walkdown through the plant to assess plant conditions.

During the reviews, the inspectors determined whether the licensee staff's actions were in compliance with the facility's corrective action program and 10 CFR Part 50, Appendix B requirements. Specifically, the inspectors evaluated whether licensee personnel were identifying plant issues at the proper threshold, entering the plant issues into the station's CA program in a timely manner, and assigning the appropriate prioritization for resolution of the issues. The inspectors also assessed whether the licensee staff assigned the appropriate investigation method to ensure the proper determination of root, apparent, and contributing causes. The inspectors evaluated the timeliness and effectiveness of corrective actions for selected condition reports, completed investigations, and NRC findings, including non-cited violations.

b. Assessment

(1) Effectiveness of Problem Identification

Based on the information reviewed, including initiation rates of CRs and interviews, the inspectors concluded that the threshold for initiating condition reports was appropriate. In addition, the inspectors noted that the licensee trends equipment and human performance on a regular basis.

Observations

Inspector Issues

During the plant walkdown, inspectors identified some minor deficiencies that the plant staff had not put into the CA program. One example was fire blankets missing from a cable tray. The licensee was not able to identify why it was removed or any mechanism to restore it. A CR was initiated for this issue.

In addition, inspectors identified that when operating experience that was not relevant to the work was included in work packages, this deficiency was not fed back to the package preparers.

Findings

No findings of significance were identified.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that in general the evaluations in apparent cause and root cause reports that were reviewed were adequate. However, the inspectors identified one finding for an inadequate evaluation and another example where the conclusion of a selected sample of licensee's past-operability determinations was inadequately supported (refer to the observations below).

Observations

Weakness in Searching Through the Corrective Action Tracking System

When performing the vertical slice on the molded case circuit breakers, the inspectors observed that the capability to perform searches through the corrective action tracking system is limited. Specifically, the inspectors noted that when performing a search for a specific topic multiple search entries are needed. The result is that different people may obtain different outcomes when performing the same search. The inspectors noted another example when the licensee provided a list of condition reports for a specific topic. The inspectors performed an independent search through the system that resulted in the identification of an additional condition report that met the criteria to be included in the list provided by the licensee. This is a weakness, for example, when relying on the corrective action tracking system to perform extent of conditions or attempting to understand the history of an issue.

Potential for missed opportunity during a past operability evaluation

The inspectors identified that a past operability evaluation of a mispositioned valve of the service water system only considered the thermal performance of the service water system's components and net positive suction head of the pumps. The past operability evaluation failed to consider the possibility that the water hammer analyses performed for any of the associated components could be affected by the mispositioned valve, as well as any other hydraulic effects. The licensee initiated CR 09-56907 to review and address this issue. By the end of the inspection the licensee was able to demonstrate that none of the associated components were significantly affected with respect to the hydraulic performance of the service water system with the mispositioned valve.

Discrepancy between plant procedures and vendor recommendations

The inspectors identified that the plant maintenance procedures for molded case circuit breakers do not list the torque values specified by the vendor of these components. The licensee relies in the skill of the craft to set these torque values. Industry operating experience documents the possibility of connectivity issues because of insufficient tightness as well as the development of longitudinal cracks in the connections due to excessive torque. However, there have been no known issues with this procedure in Davis Besse. The licensee initiated CR 09-56755 to review and address this issue.

The SAP database

The licensee has a database for tracking items determined to not be corrective actions using data entries called SAP Notifications. These are administered in accordance with procedure NOP-SS-8001, "FENOC Activity Tracking." Similar to the CA database, licensee staff were limited in their ability to do consistent data searches. The inspectors reviewed a sample of SAP notifications for issues that should have been in the CA program and did not find any examples.

Findings

Failure to evaluate molded case circuit breakers that exceed their qualified life

Introduction: A finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the failure to identify unqualified safety-related molded case circuit breakers as a condition adverse to quality and to promptly correct it.

Description: On April 8, 2009, the inspectors identified that the licensee failed to recognize that unqualified safety-related molded case circuit breakers were a condition adverse to quality and that, as a result, the licensee's corrective actions were not prompt.

Section 3.11.1, "Equipment Qualification Program," of the Updated Final Safety Analysis (UFSAR) states that safety-related electrical equipment and components are qualified to meet their performance requirements under normal, test, and accident operating conditions during which they need to function. Section 3.11.1.1, "Qualification Evaluation," states that electrical equipment is classified into two categories: (1) equipment with a satisfactory 40 year design life to Institute of Electrical

& Electronic Engineers (IEEE) 323-1974 by type test, or combination of type test/analysis; or (2) equipment requiring an on-going qualification and/or replacement program to continue its life for the design life of the plant. Furthermore, it states that a specified value of 40 years has been used for aging evaluation of all components and that the simulated aging conditions are reviewed against IEEE 323-1974 requirements.

IEEE 323-1974 defines equipment qualification as the generation and maintenance of evidence to assure that the equipment will operate on demand to meet the system performance requirements. Therefore, an unqualified safety-related molded case circuit breaker does not provide reasonable assurance that it will operate on demand to meet its performance requirements and, thus, is a condition adverse to quality.

In 2004, the licensee received the Westinghouse Electric technical bulletin TB-04-13 02, dated June 28, 2004, which was subsequently superseded by TB-06-02, dated March 23, 2006, alerting about molded case circuit breakers aging issues. Specifically, grease and red oil used in these breakers were found to be key limiting factors for continued operability within published specifications. As grease and red oil age beyond 20 years, their lubrication properties are reduced, resulting in slower trip times beyond the published time-current curves. The bulletin further concluded that the qualified life of molded case circuit breakers was reduced to 20 years.

The licensee captured the 2004 bulletin in their corrective action program as CR 04-04561. The corrective action was to replace the safety-related molded case circuit breakers that are greater than 20 years old during their regular 6 year preventative maintenance. This implied that for a period of at least 6 years after the receipt of this bulletin the licensee would continue to operate with a number of unqualified molded case circuit breakers. As of April 8, 2009, the licensee had not replaced all of the molded case circuit breakers that were older than 20 years in safety-related applications and had not performed an evaluation to generate evidence of assurance that these circuit breakers could perform their safety function until their replacement.

Analysis: The inspectors determined that the failure to evaluate the safety-related molded case circuit breakers that exceeded their qualified life in order to justify continuous operation of these components was a performance deficiency.

The performance deficiency was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, an unqualified safety-related molded case circuit breaker could lead to higher trip times that would result in the unnecessary loss of other safety-related systems or components associated with the bus when a circuit fault is present. The inspectors concluded that this finding was associated with the Mitigating System and Containment Barrier Cornerstones.

The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, “Significance Determination Process,” Attachment 0609.04, “Phase 1 - Initial Screening and Characterization of Findings,” Table 3b for the Mitigating System Cornerstone. Although the molded case circuit breakers associated with this performance deficiency affected systems and components in both the Mitigating System Cornerstone and the Containment Barrier Cornerstone, the number of mitigating systems affected was significantly higher than the systems associated with the

Containment Barrier Cornerstone. As an example, the failure to trip breaker BF1259, associated with one of the battery room vent fans, during a fault, would result in the trip of breaker BF115, which would result in the loss of power to nine components associated with: emergency diesel generator #2, including one air compressor and one fuel oil transfer pump; one spray valve of pressurizer #1; and the discharge of auxiliary feedwater pump #2 to steam generator #2. The finding screened as of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, a history review was conducted on molded case circuit breakers failures and no documented failures were determined to be associated with this performance deficiency.

This finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee did not use conservative assumptions in decision making and did not adopt a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. Specifically, the licensee did not recognize that unqualified breakers were a condition adverse to quality based on anecdotal history that suggested that no known problem existed at the time with any specific breaker. The finding is reflective of current performance because the licensee had multiple opportunities to recognize the condition adverse to quality until recently. Specifically, the 2004 bulletin was superseded in 2006, a CR referenced the bulletin in 2008, and a current maintenance procedure references and quotes the bulletin regarding the aging issue. [H.1(b)]

Enforcement: 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above, in 2004, the licensee failed to promptly identify and correct a condition adverse to quality regarding the expired qualification of molded case circuit breakers as safety-related components. Specifically, although the licensee captured the bulletin in their corrective action program as a CR, it failed to identify that unqualified safety-related molded case circuit breakers were a condition adverse to quality. Because the licensee failed to identify this, the corrective actions were not prompt, in that a 6 year replacement frequency was specified without an evaluation as to the acceptability of that frequency. Because this violation was of very low safety significance and it was entered into the licensee's corrective action program as CR 09-57013, this violation is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000346/2009006-01).

(3) Effectiveness of Corrective Actions

In general, the inspectors noted that the corrective actions addressed the cause of the identified problem, and appeared to have been effective. The inspectors also noted that the licensee recently identified that the corrective actions taken to address a licensee identified adverse trend in human performance were not effective and implemented more aggressive corrective actions.

Findings

No findings of significance were identified.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the facility's Operating Experience (OE) program. Specifically, the inspectors reviewed the implementation of operating experience program procedures, attended OE program meetings, and reviewed completed evaluations of OE issues and events identified through NRC generic communications and external OE in order to observe the use, disposition, and dissemination of OE information. In addition, the inspectors evaluated actions taken in response to reports made under 10 CFR Part 21, conducted interviews with licensee employees and examined work packages to assess OE use at the working levels, and reviewed selected monthly assessments of the OE composite performance indicators. The inspectors also reviewed corrective actions taken to address a 2007 incident where the failure to properly implement OE to address the presence of degraded hoses on the licensee's Emergency Diesel Generators (EDG) led to an air start failure during a monthly surveillance.

The inspectors' review was to determine whether the licensee was effectively integrating OE experience into the performance of daily activities, whether evaluations of issues were proper and conducted by qualified personnel, whether the licensee's program was sufficient to prevent future occurrences of previous industry events, and whether the licensee effectively used the information in developing departmental assessments and facility audits. The inspectors also assessed whether corrective actions, as a result of OE experience, were identified and effectively and timely implemented.

b. Assessment

The inspectors determined that the overall performance of the operating experience program was adequate. The licensee utilized a program that had established reasonable objectives and appeared to be making progress in meeting those objectives. The documents reviewed presented evidence that the licensee has committed to continually assess its program and take appropriate corrective actions when an objective is not being met. The independent and self assessments appeared to be effective in identifying negative trends and areas of improvement for the program. Additionally, the evaluations of external OE and NRC generic communications the inspectors reviewed seemed to appropriately address the issues identified in the OE. The inspectors did not have any observations of note that were not already being addressed by the licensee's corrective action program.

Observations

Relevance of Operating Experience in Work Packages

The inspectors noted multiple instances in which operating experience included in work packages during the planning stages of the work process was not relevant to the work being performed. This was noted in a few condition reports and duty team observations,

but the issue was highlighted during interviews with plant personnel and sampled work packages. The inspectors reviewed various work packages and noted that in multiple instances, where irrelevant OE was included in the package, there was no feedback documented on the work feedback form to ensure that planners were aware of the issue.

Personnel interviews confirmed that these deficiencies were not being documented. Some individuals commented that up to 50 percent of the work order OEs may be subject to this condition. To combat the issue, a work-around had been created, suggesting that test leaders, called test leads, should locate their own OE to be used in the pre-job brief. While in some cases this process has served as a short term remedy to the problem, the inspectors noted that this instruction may put unnecessary strain on the test leads. Additionally, interviews indicated that personal experience with past tests and work processes was frequently utilized as internal operating experience and discussed at pre-job briefs, but was not being documented for future use.

As a result of the licensee's Corporate Midcycle Assessment, many of these issues were noted, and CR 08-45509 was initiated to address this trend as an area for improvement. The corrective actions were mainly focused on procedural changes, and one corrective action implementing an effectiveness review remained open at the time of this inspection. Additionally, this issue was noted in the Operating Experience Program Self-Assessment.

Tracking of 10 CFR Part 21 Notifications

In addition, it was noted during this inspection that not all notifications issued under 10 CFR Part 21 are formally tracked by the licensee. Specifically, there is no formalized procedure guidance for the Vendor Information Coordinator (VIC) or other licensee personnel describing a process to track incoming 10 CFR Part 21 reports. The VIC noted that Part 21 listings are voluntarily checked every 3 to 4 weeks, but not at the direction of a procedure. While the inspectors did not find any Part 21 Notifications that had not been identified by the licensee, the lack of an organized tracking process creates a significant vulnerability that leaves open the potential for missing Part 21 Notifications. This could impair the ability of the licensee to verify that Part 21 procedural, evaluation, and timeliness expectations are being met, and hence could degrade the ability of the licensee to identify and correct conditions adverse to quality in a timely manner. The licensee has identified process tracking issues (documented in CR 09-54570) and was in the process of creating a new Vendor Technical Information procedure at the time of this inspection.

Documentation of Operating Experience Screening Conclusions

During their review of the external operating experience screening and evaluation process, the inspectors noted that, by procedure, incoming operating experience was systematically screened and then either evaluated or provided to others as information only. While the process was tracked through the SAP database, including the final outcome of the screening and the written evaluation of issues related to the Davis-Besse site if one was performed, the screening conclusions were not fully documented. Specifically, documentation of the screening process showed that screening occurred, and documented whether the OE would be evaluated, passed along as information only, or summarized and distributed in the weekly newsletter. The documentation did not describe the basis for passing the OE along under the lower, "information only"

thresholds rather than performing an evaluation. This could impair the licensee's ability to review OEs screened as "information only" and their screening bases, and ensure that evaluations are performed for those that are in need of them. Additionally, documenting these conclusions may be useful in performing effectiveness reviews of the screening process.

Findings

No findings of significance were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors assessed the licensee staff's ability to identify and enter issues into the CA program, prioritize and evaluate issues, and implement effective corrective actions, through efforts from departmental assessments and audits. Inspectors reviewed schedules, procedures, and completed audits and self-assessments.

b. Assessment

The team noted the effectiveness of the self-assessments and audits in their ability to identify, characterize, and correct performance issues and problems. Specifically, procedures for performing assessments were in place and implemented providing guidance and consistency. The site used their processes to evaluate and follow through on items that came out of the Audits and Assessments. The assessment and auditing assessment findings matched those of the team.

Findings

No findings of significance were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors assessed the licensee's safety conscious work environment through the reviews of the facility's employee concern program implementing procedures, discussions with the coordinator of the employee concern program, interviews with personnel from various departments, and reviews of issue reports. The inspectors also reviewed the results from a Safety Culture Survey.

Assessment

The inspectors concluded that the licensee was maintaining a safety conscious work environment while continuing efforts to reinforce a management message supporting the raising of safety issues.

All interviewees indicated that they would raise safety issues and were comfortable doing so. All individuals knew that, in addition to the CAP, they could raise issues to their management, the Employee Concerns Program, or the NRC. None of the

individuals interviewed indicated they had been retaliated against for raising issues nor were they aware of anyone who had been retaliated against. No negative issues relating to safety conscious work environment were raised by individuals interviewed by the inspectors.

Findings

No findings of significance were identified.

4OA6 Management Meetings

.1 Exit Meeting Summary

On April 10, the inspectors presented the inspection results to B. Allan and other members of the licensee's staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

C. Ackerman Staff Nuclear Specialist, Performance Improvement
B. Allen, Vice President, Davis-Besse Station
J. Barron, Manager, Site Projects
S. Brower, Nuclear Engineer, Plant Engineering
K. Byrd, Manager, Design Engineering
G. Wolf, Supervisor, Regulatory Compliance
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S. Cope, Senior Nuclear Specialist, Emergency Planning
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B. Hennesey, Supervisor, Performance Improvement
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V. Kaminskas, Director, Site Operations
G. Kendrick, Director, Work Management and Oversight Management
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D. Moul, Director, Site Engineering
S. Plymale, Manager, Plant Engineering
C. Price, Director, Site Performance Improvement
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P. Wadsworth, Senior Nuclear Specialist, Operations
D. Wahlers, Supervisor, Oversight
A. Wise, Manager, Technical Services Engineering
D. Wuokko, Acting Manager, Regulatory Compliance

Nuclear Regulatory Commission

J. Rutkowski, Senior Resident Inspector

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

2009006-01	NCV	Failure to evaluate molded case circuit breakers that exceed their qualified life

Closed

2009006-01	NCV	Failure to evaluate molded case circuit breakers that exceed their qualified life

LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety, but rather, that selected sections of portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

PLANT PROCEDURES

Number	Description or Title	Date or Revision
CLRTP	Containment Leakage Rate Testing Program	Rev. 06
DBBP-CHEM-1003	Shutdown Chemistry Guidelines	Rev. 1
DBBP-DES-1000	Administrative Control for Electrical System Analysis	Rev. 00
DB-ME-04100	Emergency Lighting System Test	Rev. 14
DB-ME-09100	Maintenance of Motor Control Centers	Rev. 09
DB-ME-09104	13.8KV and 4.16KV Westinghouse DHP Breakers	Rev. 09
DB-ME-09114	Molded Case Circuit Breaker Inspection and Test	Rev. 14
DB-MM-09186	Fuel Transfer Tubes Blind Flanges Removal and Reinstallation	Rev. 04
DB-MM-09186	Fuel Transfer Tubes Blind Flanges Removal and Reinstallation	Rev. 03
DB-MM-09186	Fuel Transfer Tubes Blind Flanges Removal and Reinstallation	Rev. 04
DB-MS-09137	Installation of Ceramic Fiber Fireproofing Materials	Rev. 23
DB-OP-01101	Containment Entry	Rev. 08
DB-OP-01101	Containment Entry	Rev. 08
DB-OP-01300	Switchyard Management	Rev. 5
DB-OP-02001	Electrical Distribution Alarm Panel 1 Annunciators	Rev. 20
DB-OP-02544	Security Events or Threats	Rev. 12
DB-OP-02546	Degraded Grid	Rev. 0
DB-OP-06911	Pre-Startup Checklist	Rev. 18
DB-PF-00205	Containment Leakage Test Program	Rev. 04
DB-PF-03008	Surveillance Test Procedure; Containment Local Leakage Rate Tests	Rev. 12
DB-SS-03710	Functional Test for Control Room Emergency Ventilation System Train 1	Rev. 6
DB-SS-03711	Functional Test for Control Room Emergency Ventilation System Train 2	Rev. 6

PLANT PROCEDURES

Number	Description or Title	Date or Revision
EN-DP-01040	Vendor Technical Information (VTI) Processing	Rev. 07
MRPM 25	Maintenance Rule Program Manual	Rev. 25
NG-EN-00333	Vendor Manual Control	Rev. 09
NOBP-LP-1104	Control of Keys, Locks and Combinations	Rev. 02
NOBP-LP-1107	Security Operating Experience (SOE) Guideline	Rev. 00
NOBP-LP-2001	FENOC Self-Assessment/Benchmarking	Rev. 12
NOBP-LP-2008	FENOC Corrective Action Review Board	Rev. 8
NOBP-LP-2010	CREST Trending Codes	Rev. 08
NOBP-LP-2018	Integrated Performance Assessment/Trending	Rev. 03
NOBP-LP-2023	Performance Assessment	Rev. 04
NOBP-LP-2100	FENOC Operating Experience Reference Guide	Rev. 3
NOBP-OP-0012	Operator Work Arounds, Burdens & Control Room Deficiencies	Rev. 00
NOPB-LP-2011	FENOC Cause Analysis	Rev. 07
NOPB-LP-2602	Human Performance Success Clocks and Quick Human Error Response	Rev. 06
NOP-CC-1003	Vendor Manuals and Vendor Technical Information	Rev. 00 Draft B
NOP-ER-3004	FENOC Maintenance Rule Program	Rev. 01
NOPL-LP-2001	Policy – QA Program	Rev. 02
NOPL-LP-2006	Policy—Use of OE	Rev. 00
NOP-LP-1202	Vehicle and Material Access Control	Rev. 01
NOP-LP-2001	Corrective Action Program	Rev. 19
NOP-LP-2004	Internal Assessment Process	Rev. 06
NOP-LP-2100	Operating Experience	Rev. 3
NOP-LP-4007	Regulatory Agency Communications	Rev. 03
NOP-LP-4101	Access Controls for Radiologically Controlled Areas	Rev. 01
NOP-OP-1002	Conduct of Operations	Rev. 5
NOP-OP-1003	Grid Reliability Protocol	Rev. 2
NOP-SS-3300	FirstEnergy Enterprise Records Management Program	Rev. 02
NOP-SS-8001	FENOC Activity Tracking	Rev. 01
NOP-WM-1001	Order Planning Process	Rev. 10
NOP-WM-4300	Order Execution Process	Rev. 6
NORM-ER-3103	FENOC Low and Medium Voltage Switchgear and Motor Control Centers	Rev. 04
PAP-1107	Plant Administrative Procedure: Temporary Instruction Control	Rev. 7

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

CR Number	Description or Title	Date or Revision
01-3331	Timely Evaluation of Part 21s and capture of Part 21s on CRs	12/11/01
04-01443	Breaker HAAE4 Failed to Close from Control Room	2/23/2004
04-02511	Failure of ABDD2 to Open	4/05/2004
04-03980	BF1203 Failed as found testing	6/14/04
04-04561	Westinghouse Technical Bulletin TB-04-13	7/15/04
04-06755	Missing relay mounting screws	11/3/04
04-07685	Breaker fails testing for BF1140	12/16/04
05-02556	Post Maintenance test on breaker removed from BF1195 failed resistance test	5/4/05
05-02876	Timeliness of Implementing a Definition for Declaring a Release in Progress	5/19/05
06-03375	BF1274 for Service Water Pump 2 Strainer Thermal Overloads Tripped	9/02/2006
06-10550	OE23676 SAF-T-CLIMB notched-rail fall protection syst defect	11/27/06
06-10840	VITAL AREA SECURITY KEYS TAKEN OFFSITE	12/3/2006
06-11623	OE23816 Respirator Sample point not IAW Reg Guide 8.15	12/19/06
06-7261	SAP OE operations incorrectly closed/documented	10/4/06
06-7798	2006 DB Safety Culture Assessment 7c.1 addressing operating experience	10/11/06
06-9759	Failed Test – DB-SC-04109	11/10/2006
06-9765	Test Deficiency DB-SC-04109	11/10/2006
07-12066	Unsecured Vehicle In The Protected Area	1/2/2007
07-12365	Vital Area Keys Uncontrolled	1/8/2007
07-12602	Incorrect Motor Data for MP173A(B) in C-EE-015.03-008 and E-1042/E-1043	1/12/2007
07-14520	Decay Heat Pump #1 Vibrations in Alert Range on Minimum Recirc Flow	2/13/2007
07-16753	EDG #1 Fuel Oil Transfer Pump Failed to Start	3/22/2007
07-16829	Qual matrix does not reflect current course number for tagging OE and NOP	3/23/07
07-17562	OE 24431- Exposure to personnel in trailers/buildings near rad storage facility	04/04/07
07-17595	Emergency Battery Lighting, BP314N, did not pass 8 hr test	4/1/07
07-18003	Disabling Seismic Monitoring System Impacted Emergency Assessment Capability	4/9/07
07-18074	HPI Train 1 discharge piping – potential air intrusion	4/10/07
07-18215	Failure of Acceptance Criteria for DB-SC-04108	4/12/2007
07-18438	SAC-1 Performance Check Failed	4/14/2007
07-19301	DB-FP-04017 Procedure Deficiency – Steps Out of	4/25/07

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

CR Number	Description or Title	Date or Revision
	Sequence for Deluge Valve Reset	
07-19773	ZONE 2 KEYS LOST	5/1/2007
07-21644	DB-OP-6261 May Place Service Water in an Unidentified Inoperable Condition	6/5/07
07-22745	UNCONTROLLED KEYS IN THE PROTECTED AREA	6/28/2007
07-22854	Failed SAC 2 Performance Test DB-SS-04013	6/30/2007
07-23438	Snapshot self-assessment results for DB-SA-07-069	7/16/07
07-24261	SAC 2 Failed Periodic Test DB-SS-04013	7/27/2007
07-24605	OE25154: Past ES377 inspections may not meet NEIL requirements	08/03/07
07-25427	ADVERSE TREND IN SITE PROTECTION VEHICLE SAFETY	8/20/2007
07-25988	DB-SA-07-043 AFI—using operating experience effectively to prevent events	8/31/07
07-25993	Inadequate SW flow through CCW heat exchanger #1	8/31/07
07-26300	HAAE4 Failed to Close During Functional Test	9/09/2007
07-26739	DB-OP-00002 Needs Revising Re: Reporting of Tech Spec Safety Limit Violations	9/14/07
07-27415	VEHICLE FOUND WITH KEYS IN IGNITION/RUNNING UNATTENDED IN PROTECTED AREA	9/28/2007
07-28362	VEHICLE LEFT WITH KEYS IN THE IGNITION/RUNNING INSIDE PROTECTED AREA	10/10/2007
07-28749	OE25629 - NSAL 07-02 - A200 starter/contactor evaluation increased EOC	10/17/07
07-29963	CREVS Train 2 Compressor Tripped During DB-SS-03042 Monthly Test	11/09/2007
07-30072	CREVS 2 Required Manual Reset of Pressure Trip Following Maintenance	11/12/2007
07-30241	EDG #2 starting issues	11/15/07
07-30261	Failed Breaker at BF4123	11/16/2007
07-31128	Replacement of old EDG Flex hoses: CR 07-30241 Extent of condition	12/6/07
07-31128	Replacement of old EDG flex hoses: CR 30241 Extent of Condition	12/6/07
07-32090	VITAL SECURITY KEYS REMOVED FROM SITE	12/30/2007
07-32112	Pressurizer Level Decrease While Placing DH Train 1 in Standby	12/30/07
08-32521	Pressure boundary leak found during decay	1/4/08

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

CR Number	Description or Title	Date or Revision
	heat drop line weld overlay	
08-32655	DB-PA-08-01: ADVERSE TREND IN OPERATIONS KEY CONTROL	1/5/2008
08-33392	DR2012A (Penetration #13) Failed Its As Found Local Leak Rate Test	1/14/2008
08-33412	CV5011B Failed PMT LLRT	1/14/2008
08-33454	SW271 Closure and Leak Test Failed	1/15/2008
08-33818	MU38 failed to Travel to Its Fail Position During Operational Testing	1/19/2008
08-33865	Missed Surveillance For Train 1 Station Batteries 1N and 1P	1/19/08
08-33948	Concern over use of 20 year old molded case breakers	1/21/08
08-34311	DB-PA-08-01 BE1159 Tripping	1/24/2008
08-34328	Two Auxiliary Boiler Trips When Applying Steam Loads	1/25/08
08-34411	EVS Train 1 Failed to Provide Expected Drawdown During DB-SS-03250	1/28/2008
08-34644	Increase trend in number of maintenance related human performance issues	1/30/08
08-36020	ES 370 Has an Air Leak	2/28/08
08-36684	CREVS 1 Compressor Trip During Monthly Test DB-SS-03041	3/12/2008
08-37171	EMPLOYEE LEFT SITE WITH NON-VITAL SECURITY KEYS	3/21/08
08-37179	OE26443 Incorrect weld rods issued for prefab work (Kewaunee)	3/22/08
08-37282	KEYS LEFT UNATTENDED	3/26/2008
08-37376	Lucas County Sirens 001 Through 005 Did Not Activate on First Attempt	3/26/08
08-37410	Lack of recent/relevant operating experience in EDG PM work order packages	3/28/08
08-38334	Decay Heat Pump 1 D-Axial Vibes are in the Alert Range	4/15/2008
08-38559	Adverse Plant Status Control Trend	4/16/08
08-39129	Order operating experience not relevant for CCW Ventilation work	4/25/08
08-39178	An Unexpected Drop in MSR 2nd Stage Pressure was Observed	4/26/08
08-39738	SAC 2 Failed Periodic Test DB-SS-04013	5/04/2008
08-40896	VEHICLE KEYS DISCOVERED LEFT INSIDE VEHICLE WHILE INSIDE THE PROTECTED AREA	5/27/2008
08-40947	OE Potential issue with DEP opportunity from 4/24/08 drill	5/28/08
08-41222	Emergency Instrument Air Compressor Oil Leak	6/4/08
08-41285	CREVS Train 1 Make-up Air Flow Exceeds Upper	6/04/2008

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

CR Number	Description or Title	Date or Revision
	Limit	
08-41517	Two Breakers Not Positioned to Normal Position After Clearance Removal	6/6/08
08-42002	EP Drill – Missed Drill Objective for Emergency Classification	6/17/08
08-42408	OE not discussed at pre-job brief	6/26/08
08-42506	Inadvertent Start of the Electric Fire Pump	6/27/08
08-43160	VEHICLES PARKED WITHIN 25 FEET OF HOSE HOUSE 24	7/13/08
08-43336	EDG Air Compressor 1 Failed Post Maintenance Test DB-SC-04108	7/16/2008
08-43340	CC130 Failed Closure Test	7/17/2008
08-43479	Work order content of operating experience marginally relevant	7/19/08
08-43946	IPA Trend – Increased Number of EPZ Siren Failures During 1st Half 2008	7/29/08
08-44209	Procedure Need for Response to Grid Disturbances	8/4/08
08-44756	MS-C-08-08-02 Finding: Mode Change W/O Chemistry Surveillance Tests	8/13/08
08-45509	SA#FL-SA-08-004 OE Program AFI—OE in work packages	8/28/08
08-45569	Negative trend in maintenance mispositioning events requires aggregate review	8/29/08
08-45663	IQR Comments, NOP-LP-2100, Operating Experience Program, rev 3	9/2/08
08-46287	DB-PA-08-03: VEHICLE INSPECTION FACILITY (VIF) VEHICLE LOG DEFICIENCY	9/15/2008
08-46788	4 EA EDG/SBODG Air motors in DB warehouse are of an unreliable design	9/23/08
08-47050	CA-SA-08-052 AFI: Inconsistent use of human performance tools within maintenance	9/30/08
08-47050	CA-SA-08-052 AFI: Inconsistent use of human performance tools within maint.	9/30/08
08-47171	INDIVIDUAL INADVERTANTLY ENTERED CONTAMINATION AREA WITHOUT PROPER CLOTHING	10/1/2008
08-47525	CC130 Failed Closure Test	10/08/2008
08-48549	SW Vacuum Breaker Leakage Has Significantly Increased	10/27/2008
08-49044	MS-C-08-10-19, UNSECURE MAINTENANCE VEHICLE WITHING THE PROTECTED AREA	11/6/2008
08-49046	VIOLATION OF NOP-LP-1202, VEHICLE AND MATERIAL CONTROL, SECTION 4.10.1-1.B	11/6/2008
08-49452	OE 27264 Evaluation - desirable actions	11/13/08
08-49619	NRC NCV: Improperly transmitted safeguards information	11/17/08

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

CR Number	Description or Title	Date or Revision
08-50228	Effectiveness review determines CA's for CR 08-34644 were ineffective	12/2/08
08-50346	CONTRACTOR OPERATING COMPANY VEHICLE, UN-ESCORTED IN P/A	12/3/2008
08-50746	EXPOSURE FOR THE CT ENTRY EXCEEDED ESTIMATE	12/11/2008
08-51028	VEHICLE ESCORT REQUIREMENTS NOT MET FOR A VEHICLE ENTERING THE PROTECTED AREA	12/17/2008
08-51437	Op Ex training material not updated to reflect procedure RQMTS	12/30/08
09-51496	BACC- Boric Acid Deposits, Valve DH2736	01/01/09
09-51753	Individual ruptures tendon while blousing their BDU pants	1/8/2009
09-52062	Cold Weather: CTRM chillers tripped	1/16/09
09-52256	OE27676 - Common cause/common mode failure of SCI inverter	01/20/09
09-52384	OE27758 - ICS relay cards susceptible to tin whiskers	01/22/09
09-52539	Enhancement to DB-SC-04132, Section 4.2.4 Check Source Testing	1/25/09
09-52750	Westinghouse Technical bulletin breaker life shorter than in EQ program	1/29/09
09-53070	INDIVIDUAL REMOVED VITAL AREA KEYS FROM SITE	2/5/2009
09-53083	OE review identifies actions from DB-SA-07-069 and CR 07- 23438 not effective	02/05/09
09-53530	Decay Heat Pump 1 C-Horizontal Vibrations are in the Alert Range	2/13/2009
09-53841	Breaker ACD2 Trips Free When Attempting to Close	2/19/2009
09-54570	Initiation of CRs for 10CFR Part 21 Notifications	3/3/09
09-54629	VIOLATION OF NOBP-LP-1104, CONTROL OF KEYS, LOCKS AND COMBINATIONS	3/4/2009
09-55170	OE-crimping of non-seismic AFW recirculation piping not evaluated	03/11/09
09-55578	Decay Heat Pump #1 Vibrations	3/17/2009
09-55865	Inconsistent Interpretation of Reference Material Regarding Release in Progress	3/22/09
N/A	All CRs initiated in 2007-2008 for 10 CFR Part 21 Notifications	Rec. 3/27/09

CONDITION REPORTS GENERATED DURING INSPECTION

CR Number	Description or Title	Date
CR-09-55982	NRC PI&R 2009: Flexible Conduit Pulled Away From SV225A	3/24/2009
CR-09-55988	NRC PI&R 2009: Kaowool Missing From Tray ACJH21 IN #4 MPR (RM 314)	3/24/2009
CR-09-56211	NRC PI&R 2009: CR 08-34537 (Door 495C Left Unsecured) Did Not Receive SRO Review	3/27/2009
CR-09-56723	NRC PI&R 2009:CR 05-05731 maintenance deficiency tag not removed fROm DH2736	3/25/2009
CR-09-56755	NRC PI&R 2009; DB-ME-09114 does not implement recommended torque values	4/6/2009
CR-09-56868	NRC PI&R 2009: document with confidential information transmitted to NRC	4/07/2009
CR-09-56907	NRC PI&R 2009 (NO. 0073): Waterhammer not considered by past operability eval	4/8/2009
CR-09-57013	NRC PI&R 2009: CR 04-04561, Westinghouse TB-04-13 circuit BRKR Eval & Actions	4/8/2009

OPERATING EXPERIENCE

Number	Description or Title	Date or Revision
10CFR21-0095	Engine Systems, Inc. Ingersoll-Rand Series 89 Air Start Motors, P/N 8367694-ESI	10/21/08
200319126	DB Evaluation of IN 2008-6 Instrument Air System Failure Resulting in Manual Reactor Scram	4/10/08
200324924	DB Evaluation of IN 2008-9 Turbine-Driven Auxiliary Feedwater Pump Bearing Issues	5/22/08
600459096	DB Evaluation of IN 2008-5 Fires involving EDG Exhaust Manifolds	7/20/08
N/A	OEs discussed during 3/25/09 Fleet OE Conference Call	3/25/09
OE24868	Rad Protection Program Implementation Failure—Fleet evaluation	5/24/07
OE26401	General Employee training examinations at remote location were not administered in accordance with station requirements (Browns Ferry)	3/7/08
OE26713	Turkey Point—Invalid form of identification used for escorted visitor access	4/30/08
OE27263	Fire in Turbine Hall Light	9/18/08
OE27676	Vital inverters transfer to alternate source due to voltage transient	9/24/08
OE27758	ICS relay cards susceptible to tin whiskers	1/22/09

OPERATING EXPERIENCE

Number	Description or Title	Date or Revision
SER 2008-S02	Fitness for Duty (FFD) Testing results in reinstated access authorization being revoked	1/26/09

AUDITS, ASSESSMENTS AND SELF-ASSESSMENTS

Number	Description or Title	Date or Revision
2004-0020	Ongoing Self-Assessment: Air Operated Valve Program	07/16/2004
CA-SA-08-044	Corporate Assessment Team Report	3/31-4/4 2008
CA-SA-08-052	Davis-Besse Nuclear Power Station Mid-Cycle Assessment	9/15-9/19 2008
DB-C-06-01	First Quarter 2006 Audit Report	1/3/2006
DB-C-06-02	Second Quarter 2006 Audit Report	4/1-6/30 2006
DB-C-06-03	Third Quarter 2006 Audit Report	7/1-9/11 2006
DB-PA-06-03	Radioactive Material Shipment to Beta Lab; scrap steel bin outside the weld shop door	8/22-8/25 2006
DB-PA-07-01	Fleet Oversight Quarterly Performance Report – Davis-Besse	1/1-3/31 2007
DB-PA-07-02	NRC Inspection of Radiation detecting instrumentation; Area Monitors and Portable Instruments	6/18/2007
DB-PA-07-02	Fleet Oversight Quarterly Performance Report – Davis-Besse	4/1-6/30 2007
DB-PA-07-03	Station ALARA Committee Meeting	7/23/2007
DB-PA-07-03	Fleet Oversight Quarterly Performance Report – Davis-Besse	6/1-9/30 2007
DB-PA-07-04	Station ALARA Committee Meeting	10/19/2007
DB-PA-07-04	NRC Entrance and Exit Meetings	12/10/2007
DB-PA-07-04	Fleet Oversight Quarterly Performance Report – Davis-Besse	10/1-12/29 2007
DB-PA-08-01	Fleet Oversight Quarterly Performance Report-Davis-Besse	4/23/2008
DB-PA-08-01	Fleet Oversight Quarterly Performance Report – Davis-Besse	12/30-3/31 2008
DB-PA-08-02	Fleet Oversight Quarterly Performance Report – Davis-Besse	4/1-6/30 2008
DB-PA-08-03	NRC Exit Meeting	8/29/2008
DB-PA-08-03	Fleet Oversight Quarterly Performance Report – Davis-Besse	7/1-9/30 2008
DB-PA-08-04	FENOC Fleet Performance Summary Executive Summary	2/6/2009

AUDITS, ASSESSMENTS AND SELF-ASSESSMENTS

Number	Description or Title	Date or Revision
DB-PA-08-04	Briefings for routine containment buildings tour at full reactor power	12/10/2008
DB-PA-08-04	Fleet Oversight Quarterly Performance Report – Davis-Besse	10/1-12/31 2008
DB-SA-07-035	FENOC Air Operated Valve Program	07/24/2007
DB-SA-07-074	Alert and Notification System	10/3-10/5 2007
DB-SA-07-09	Integrated Performance Assessment; Radiation Protection	5/1-12/31 2006
DB-SA-08-006R2	Integrated Performance Assessment; Emergency Response	3/6/2008
DB-SA-08-014	Integrated Performance Assessment; Radiation Protection	Rev. 07
DB-SA-08-044	Davis-Besse 2008 Pre-INPO EP Visit Self-Assessment Report	7/22/2008
DB-SA-08-048	15 RFO Outage Execution Assessment Final Report	Rev. 01
DB-SA-08-048	15 RFO Outage Execution Assessment Appendix 6.1; ALARA Report	Rev. 0
DB-SA-08-056	Emergency Response Integrated Performance Assessment, 1st half 2008	Rev. 1
DB-SA-08-056 R1	Integrated Performance Assessment; Emergency Response	8/6/2008
DB-SA-08-059	Operations Integrated Performance Assessment, 1st half 2008	Rev. 1
DB-SA-08-083	Staff Augmentation Drill	8/11/2008
DB-SA-08-107	Emergency Preparedness Industry Focused	1/12/2009
DB-SA-08-84	Emergency Public Information Assessment	9/16/2008
DB-SA-09-009	Emergency Response Integrated Performance Assessment, 2nd half 2008	Rev. 2
DB-SA-09-012	Operations Integrated Performance Assessment, 2nd half 2008	Rev. 1
DB-SS-05-04	Davis-Besse Vendor Control Program Snapshot Self-Assessment Plan	July 2005
DB-SS-05-04	Davis-Besse Vendor Control Program Snapshot Self-Assessment Plan	July 2005
DB-SS-06-23	Align the Motor Operated Valve (MOV) Program with the INPO MOV Engineering Program Guide EPG-03	07/27/2006
February 2009 Report	Operating Experience Status Report for Davis-Besse—Program Performance Assessment	Monthly frequency
FENOC Fleet	Monthly Operating Experience Screening/Evaluation Program	February 2009

AUDITS, ASSESSMENTS AND SELF-ASSESSMENTS

Number	Description or Title	Date or Revision
	Performance Indicator	
First Quarter 2008	Fleet Performance Summary	6/23/2008
FL-SA-07-054	RP Integrated Performance Assessment Fleet Rollup January 2007 to June 2007	8/31/2007
FL-SA-08-004	FENOC Fleet Focused Self-Assessment Operating Experience Program	8/14/08
FL-SA-08-096	Unplanned Radiation Exposure FENOC Response Effectiveness	
FL-SA-08-100	Effectiveness Review – Common Cause for High Radiation Area Events	9/12/2008
MS-C-06-12-24	Emergenct Preparedness Audit Report	12/18 – 1/24 2007
MS-C-07-02-25	Quality Assurance Audit Report – Regulatory Affairs	2/26/07-4/4/07
MS-C-07-02-25	Quality Assurance Audit Report; Regulatory Affairs Program	2/26-4/4 2007
MS-C-07-02-25 (checklist)	PLAN CHECKLIST--Davis Besse - Regulatory Affairs	2/26/07-4/4/07
MS-C-07-12-24	Emergency Preparedness Audit Report	12/3 – 1/30 2008
MS-C-08-07-16 (checklist)	Fleet Oversight Audit Checklist—Procurement	7/28/08-9/29/08
MS-C-08-07-16	Procurement QFO FLT1200857 (DB)	7/28-9/29 2008
RAOG 06-0052	Assessment of Davis-Besse Nuclear Power Station Interface with State and Local Governments	12/21/2006
RAOG-07-0042	Assessment of Davis-Besse Nuclear Power Station Interface with State and Local Governments	12/20/2007
MS-C-07-08-03	Quality Assurance Audit Report	8/20-9/28 2007

MISCELLANEOUS

Number	Description or Title	Date or Revision
C-NSA-060.05-013	Past Operability Analysis of SW036 Mispositioning	Rev. 0
CR 08-41525 CA-1	CREVS Maintenance Rule (a)(1) Evaluation Form	6/6/08
CR 08-42275 CA-2	Chilled Water Maintenance Rule (a)(1) Evaluation Form	6/24/08
DB-Serial Number 3245	Response to NRC Generic Letter 2006-02	4/3/2006
Drawing 22040-3	Transfer Tube Assy.	5/21/2008
N/A	Basic Operating Experience Program Flowchart	Rec. 3/24/09
N/A	FENOC Operating Experience Summary Report—Week of March 9, 2009	3/9/09
N/A	OE Departmental Coordinators Contact List	Rec. 3/24/09

MISCELLANEOUS

Number	Description or Title	Date or Revision
N/A	List of Open OE Evaluations/Confirmatory Screenings/Follow-up Actions	3/13/09
NOTIFICATION 600445692	DB-MM-09186 Procedure Revision	2/15/2008
Notification 600380993	DB-FP-04017	4/25/2007
Notification 600396004	DB-OP-06261	7/3/2007
Notification 600419263	DB-OP-00002	10/16/2007
Notification 600438869	Inspect #1 Auxiliary Boiler Feed Pump Internal	1/25/2008
Notification 600439514	DB-OP-06241	1/27/2008
Notification 600449358	ES 370 Has an Air Leak	2/28/2008
Notification 600449487	STAR Training Aid	2/28/2008
Notification 600461393	MS 338 Not Controlling Properly	4/26/2008
Notification 600474242	DB-OP-06251	6/24/2008
Notification 600475701	DB-FP-04050	6/27/2008
Notification 600491905	MS-C-08-02-02 Chemistry Surveillances	9/11/2008
Notification 600517540	DB-SC-04132	1/27/2009
Order 200164862	BE1298 Preventative Maintenance Data Sheet	1/22/07
Order 200171383	BF1255, 1256, 1258, 1261, 1263, 1289, Preventative Maintenance Data Sheet	1/4/06
Order 200225450	BF1230 Preventative Maintenance Data Sheet	3/28/08
Order 200225481	BE1289, 1261, 1255, 1256, 1259, 1289, 1258 Preventative Maintenance Data Sheet	11/08
OS-021, Sheet 1	Operational Schematic Component Cooling Water System	Rev. 33
OS-021, Sheet 2	Operational Schematic Component Cooling Water System	Rev. 25
PM 4989	Preventative Maintenance—K5-1 Check & Replace—EDG #1	12 yr Frequency
PM 4993	Preventative Maintenance—K5-2 Check—EDG #2	12 yr Frequency
WO 2002298890	Install/Remove T'FER Tube Flngs	1/23/2008
WO 200252461	EVS PM 1233—Inspect EVS fan #1-2	4/1/09

MISCELLANEOUS

Number	Description or Title	Date or Revision
WO 200258200	EVS Train 2 Work & Monthly test	4/1/09
WO 200329435	Relay lights, A bus out (P5-605 & P5-607)	3/16/09
WO 200356233	F59-1 Contingent filter change	4/1/09

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access Management System
CA	Corrective Action
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CR	Condition Report
EDG	Emergency Diesel Generator
IEEE	Institute of Electrical & Electronic Engineers
NCV	Non-Cited Violation
OE	Operating Experience
PI&R	Problem Identification and Resolution
SDP	Significance Determination Process
UFSAR	Updated Final Safety Analysis Report
VIC	Vendor Information Coordinator