

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/90020(DRP)

Docket No. 50-346

Operating License No. NPF-3

Licensee: Toledo Edison Company
Edison Plaza, 300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse 1

Inspection At: Oak Harbor, Ohio

Inspection Conducted: October 10, 1990 through November 26, 1990

Inspectors: P. M. Byron
R. K. Walton

Approved By: *AC Knapp*
I. N. Jackiw, Chief
Reactor Projects Section 3A

12-10-90
Date

Inspection Summary

Inspection on October 10 through November 26, 1990
(Report No. 50-346/90020(DRP))

Areas Inspected: A routine safety inspection by resident inspectors of licensee actions on previous inspection findings, licensee event reports, plant operations, radiological controls, maintenance/surveillance, emergency preparedness, security, engineering and technical support, and safety assessment/quality verification was performed.

Results: Airborne contamination generated from the preparation of radioactive waste material for shipment resulted in both internal and external contamination of the workers. The licensee is still reviewing the circumstances and corrective actions for this event (Paragraph 5). The licensee is performing a Safety System Functional Inspection of the electrical distribution portion of the Emergency Diesel Generator (Paragraph 9). Compensatory measures have been taken by the licensee to prevent the release of chlorine gas from the water treatment building until a chlorination system modification is completed (Paragraph 5). The licensee assembled a team to assess its corrective action program effectiveness. The team has concluded that lack of management support was one area that needed attention (Paragraph 10).

DETAILS

1. Persons Contacted

a. Toledo Edison Company

- D. Shelton, Vice President, Nuclear
- G. Gibbs, Director, Quality Assurance
- *L. Storz, Plant Manager
- M. Heffley, Maintenance Manager
- K. Brandt, Plant Operations Manager (Acting)
- M. Bezilla, Superintendent, Operations
- *D. Ricci, Supervisor, Operations
- *E. Salowitz, Director, Planning and Support
- S. Jain, Director, DB Engineering
- *R. Zyduck, Nuclear Engineering Manager
- G. Grime, Industrial Security Director
- *D. Timms, Systems Engineering Manager
- R. Uebbing, Maintenance Coordinator
- J. Polyak, Radiological Control Manager
- *R. Coad, Radiological Protection Supervisor
- *J. Lash, Independent Safety Engineering Manager
- T. O'Dou, Radiological Assessor
- *J. Moyers, Manager Quality Verification
- T. Anderson, Manager Maintenance Planning and Outage Mgmt.
- *G. Honma, Compliance Supervisor
- *R. Gaston, Licensing Technologist
- R. Schrauder, Manager, Licensing

b. USNRC

- *P. Byron, Senior Resident Inspector
- R. Walton, Resident Inspector

*Denotes those personnel attending the November 26, 1990, exit meeting.

2. Licensee Action on Previous Inspection Findings (92701)

(CLOSED) Unresolved Item (346/36005-13(DRP)): A licensee deviation report written in 1985, documented that an auxiliary feedwater (AFW) valve (AF3872) was opened from its normally closed position by a Facility Change Request (FCR). The licensee did not perform a proper safety analysis as it did not adequately address the single failure criteria. The plant operated in this condition from January 9, 1985, until April 10, 1985, when AF3872 was returned to its normally closed position. The inspectors believed that the licensee should have written a Licensee Event Report (LER) to document this event. FCR 85-065, Rev 0, Supp. 5 dated October 10, 1988, performed a safety evaluation which concluded that the proposed change to the AFW system does not involve an unreviewed safety question and that an LER is not required. The licensee has given safety evaluation training

to selected individuals and only trained personnel are authorized to perform safety evaluations. The licensee's actions satisfied the inspectors' concern and this item is closed.

(CLOSED) Unresolved Item (346/88007-02(DRP)): The licensee made two administrative errors in the implementation of its Control of Locked Valves program. The affected procedures have been revised. The inspectors have reviewed the revised procedures and have observed that the licensee's control of locked valves has significantly improved. This item is closed.

(CLOSED) Open Item (346/88007-03(DRP)): The licensee historically has problems operating the service water (SW) valves to the component cooling water heat exchangers. The valves would not remain in their safety positions after a loss of air requiring the licensee to change its emergency procedures to lock the valves open after a safety features actuation signal. The licensee concluded that the installed valves were a misapplication for the design requirements. A FCR was issued to replace the valves with a design that would meet the requirements. Throttleable ball valves were purchased to replace the installed butterfly valves. The licensee installed one ball valve (SW1424) during the last refueling outage and the remaining two valves will be replaced by the end of the next refueling outage. The replacement valve has functioned satisfactorily and this item is closed.

(CLOSED) Open Item (346/88007-04(DRP)): During the performance of a Safety Features Actuation System (SFAS) test, the licensee noted the following: valve DR 2012A failed to open, the motor driven feedwater pump (MDFP) would not start and two diesel generator (DG) sequencer relays failed. The valve was disassembled and found to have a corroded stem and packing gland which was replaced and tested satisfactorily. The failure of the MDFP to start was due to a high starting current resulting from the pumps discharge valve being open and discharging to a tank at atmospheric pressure coupled with a lower motor torque available to start the pump from a loaded DG. Since the acceleration period of the pump exceeded the time allowed by the protective relays, the MDFP breaker opened. The licensee's design basis for starting the MDFP is bounded by the following conditions: Starting with normal power and one steam generator depressurized or starting on either DG (which is loaded to normal loss of off site power loads) and both steam generators pressurized. Analysis and plant testing confirm that the MDFP will start under these conditions and that the MDFP was tested by the SFAS test for a condition not explicitly analyzed. The DG relay failure was due to internal corrosion of the relay as a result of a gradual loss of sealing nitrogen. A monthly preventive maintenance procedure checks the integrity of these relays to verify that the SFAS sequencer is operable. Additionally, the licensee has a modification pending to evaluate the application of these types of relays and install arc suppression where it is required. The inspectors consider the licensee's actions to be adequate and this item is closed.

(CLOSED) Open Item (346/88010-01(DRP)): All three component cooling water (CCW) heat exchangers were opened on the service water side for the first time since initial construction and were found to have a

significant amount of silt and corrosion products. Additionally, the licensee discovered significant local corrosion of heat exchanger shell welds due to microbiological attack. The licensee believes that the microbiologically influenced corrosion was due to the synergistic effects of low service water flow during the winter months and the lack of effective chlorination due to an unreliable temporary chlorination system. The licensee has removed the sludge from the coolers and has required a weekly flush of the service water sides of the coolers to minimize sludge buildup. Ultrasonic testing of areas in the heat exchanger requiring weld build up was completed and wall thicknesses verified. Additionally, a preventive maintenance program was established to periodically open, clean and inspect the interior of the CCW heat exchangers. A reliable chlorination system has replaced the temporary system and the licensee has included these heat exchangers in its corrosion and erosion monitoring and analysis program. Service water piping inspections performed during the refueling outage indicate potentially severe piping degradation including flow restrictions and pin hole pipe leaks. The licensee has implemented a program to systematically monitor and replace degraded piping. The inspectors will continue to monitor the licensee's program to address the concerns of NRC Generic Letter 89-13, "Service Water System Problems Affecting Safety Related Equipment". This item is closed.

(Closed) Unresolved Item (346/88015-02(DRP)): The results of testing the heat transfer capabilities of the Decay Heat Removal heat exchangers revealed that the coolers had a lower heat transfer capability than stated in the Updated Safety Analysis Report (USAR) Accident Analysis. Licensee inspection of the internals of both the coolers did not show any signs of degradation or significant fouling. The licensee performed a safety evaluation and determined that the coolers were capable of performing their safety function even with a lower heat transfer coefficient. The USAR was changed to reflect the new heat transfer coefficient. The inspectors reviewed the USAR change. This item is closed.

(CLOSED) Unresolved Item (346/89014-01(DRP)): On April 25, 1989, the Emergency Core Cooling System (ECCS) room 3 sump overflowed when equipment operators were draining decay heat removal piping. An equipment operator entered the room and discovered about 3 inches of water on the floor of the room and neither sump pump operating. The level switch was mechanically agitated and the pumps started. An investigation of the event revealed that a high sump level alarm was received in the control room with both sump pumps not operating for at least an hour and a half prior to the equipment operator entering the room. The control room operators did not respond since they believed this was a normal condition due to the draining in progress and that the sump high level alarm came in before the sump pumps energized. The pump start level set point and high level alarm set point for the ECCS room 3 sump differ from the other ECCS room sumps in that the pump start set points and the high level alarm set points were reversed which is not in accordance with the USAR. The USAR requires that the relationship between the pump start and alarm set point be the same for all three ECCS rooms. The licensee has changed

the ECCS room 3 sump set point and the USAR so that the USAR reflects actual plant set points. The pumps now start first and the high level set point is at a higher level. The licensee has added to its preventive maintenance program the cleaning of the ECCS room sump level indicators. This item is closed.

(Closed) Violation (346/89016-01(DRP)): On February 16, 1989, the inspectors informed the licensee that contrary to the USAR, there was a hole in the wall between the condenser pit and the service water (SW) tunnel and that there was no procedural guidance for operators to isolate the SW tunnel from the SW pump room in the event of flooding in the SW tunnel. This meant that the safety-related SW pumps were not protected from flooding by a break in the non-safety-related circulating water system. On February 10, 1989, the licensee issued a standing order instructing operators to plug the floor drains in the SW pump room in the unlikely event of a SW tunnel flooding event. LER 89-004 was issued to document this condition. The inspectors noted on August 31, 1989, that the hole in the wall had been plugged. This item is closed.

(Closed) Unresolved Item (346/89016-03(DRP)): On June 5, 1989, at 12:10 p.m., the licensee added fluid to core flood tank (CFT) 1-2. Technical Specification 4.5.1.b requires verification of boron concentration in the CFT within 6 hours after an addition of at least 80 gallons. The shift supervisor did not review the sample results until 9:15 p.m. The licensee's investigation revealed that communications between chemistry personnel was incomplete. Chemistry personnel have reviewed this event and have revised log keeping practices. This item is closed.

(Closed) Violation (346/89016-05): On June 5, 1989, the licensee started control room emergency ventilation system (CREVS) No. 1 and secured it less than an hour later at 5:40 a.m.. During its operation, CREVS No. 1 had switched from its normal water cooled mode to an abnormal air cooled mode. Operation of CREVS in the air cooled mode requires the opening of manually operated valves or the compressor will trip on high pressure. These valves were not opened. The CREVS No. 1 compressor had apparently tripped on high pressure during its short operation in the air cooled mode. Since the high pressure trip does not give a control room or local alarm, operators were not aware of the high pressure trip condition. The licensee attempted to perform its monthly surveillance test on CREVS No. 1 on June 26, 1989, but the compressor would not start. In addition, the licensee determined that CREVS No. 2 was inoperable for maintenance from June 8, 1989, until 2:55 p.m. on June 12, 1989. This meant that both CREVS units were inoperable for about 9 hours and 15 minutes. The licensee was not aware of the CREVS condition and hence did not realize that Technical Specification 3.0.3. was applicable. The licensee has since revised the CREVS operating procedure, (DB-OP-06505), to require opening the air cooled condenser isolation valves prior to starting CREVS in case an automatic switch over occurs. All operations shift personnel have received training on the procedure changes and this event. The pressure switch set point for automatic switch over was raised to prevent

premature switch over due to the initial pressure surge during system start up. This item is closed.

(Closed) Violation (346/89016-08(DRP)): On July 14, 1989, the licensee discharged 1700 gallons of water from Clean Waste Monitor Tank (CWMT) 1-1 instead of from CWMT 1-2 as planned. CWMT 1-1 was not sampled prior to the release in violation of the Technical Specifications. The inspectors concluded that the procedure had a typographical error which lead the operator to select the incorrect CWMT for discharge. Additionally, the inspectors were concerned that a procedure referenced by the discharge procedure was confusing. The licensee has revised the procedure to make it more clear. The inspectors have reviewed the revised procedure and consider the changes to be adequate. This item is closed.

No violations or deviations were identified in this area.

3. Licensee Event Reports Follow up (92700)

Through direct observation, discussions with licensee personnel, and review of records, the following licensee event reports (LERs) were reviewed to determine that reportability requirements were fulfilled, that immediate corrective actions to prevent recurrence was accomplished in accordance with Technical Specifications (TS). The LERs listed below are considered closed:

(CLOSED) LER 86006: Environmental Qualification Program Not Adequately Established. This LER was discussed in Inspection Report 50-346/88038(DRP). This item is closed.

(CLOSED) LER 88006: Software Error in Kaman Radiation Monitors. On February 12, 1988, the licensee was notified by the Kaman Instrumentation Corporation that a possible software defect existed on four station vent radiation monitors supplied by the vendor. The software error causes indicated particulate and iodine activity to read less than the actual activity if the instrument is not reset every 48 hours. On February 22, 1988, the vendor confirmed that the defect existed. Since the instrument was installed in 1984 and the licensee has not reset it every 48 hours, it provided inaccurate information prior to February 12, 1988. The licensee states that the noble gas monitoring abilities of the instrument which are normally associated with a particulate or an iodine release were not affected and any release through the station vent would be detected. The licensee reset the instrument every 48 hours since February 12, 1988, while in modes 1 through 4 until the fifth refueling outage when new software was installed in the instruments and the equipment was satisfactorily tested. This item is closed.

(Closed) LER 88015: Loose Parts Discovered in the Reactor Vessel. On July 2, 1988, during an inspection of the interior of the reactor vessel, the licensee discovered an apparent paint chip, a rag, and two pieces of metal later identified as part of a high pressure injection thermal sleeve. The cause of the rag and the paint chip being in the vessel was

poor cleanliness controls. The licensee has since modified its Cleanliness and Housekeeping procedure. The inspectors have noted improved housekeeping practices during the past refueling outage. The thermal sleeve and the rag were retrieved.

The probable cause of the failure of the thermal sleeve is high cycle thermal fatigue. The thermal sleeve did not pass into the active core area nor did it circulate through the reactor coolant system hence no safety hazard due to loose parts in the system occurred. The licensee discovered cracks in the cladding in the vicinity of the failed thermal sleeve but confirmed that no cracks penetrated into the carbon steel pressure boundary. The licensee replaced the failed thermal sleeve and modified system flow conditions to minimize thermal fatigue of the nozzle. NRR is reviewing the licensee's efforts for analysis and projected potential replacement of the high pressure injection thermal sleeves. This LER is closed.

(CLOSED) LER 90014: Incomplete Daily Heat Balance Calibration Test of One of Four Power Range Nuclear Instruments. On October 3, 1990, an engineer reviewing the Daily Heat Balance Calibration (DB-PF-03230) performed on September 26, 1990, recognized that the calibration was incomplete. One of the four power range instruments used for the calibration was unavailable due to the performance of a quarterly test. Since the Daily Heat Balance Calibration was not completed for September 26, 1990, the licensee did not meet the requirements of TS Table 4.3-1, item 2. The licensee plans to add a note to DB-PF-03230 to clarify the acceptance criteria. This item is closed.

No violations or deviations were identified.

4. Plant Operations (42700, 71707, 93702 71714)

a. Operational Safety Verification

Inspections were routinely performed to ensure that the licensee conducts activities at the facility safely and in conformance with regulatory requirements. The inspections focused on the implementation and overall effectiveness of the licensee's control of operating activities, and on the performance of licensed and non-licensed operators and shift managers. The inspections included direct observation of activities, tours of the facility, interviews and discussions with licensee personnel, independent verification of safety system status and limiting conditions of operation (LCO), and reviews of facility procedures, records, and reports. The following items were considered during these inspections:

- Adequacy of plant staffing and supervision.
- Control room professionalism, including procedure adherence, operator attentiveness, and response to alarms, events, and off normal conditions.

- Operability of selected safety related systems, including attendant alarms, instrumentation, and controls.
- Maintenance of quality records and reports.

The inspectors observed that control room shift supervisors, shift managers, and operators were attentive to plant conditions, performed frequent panel walk downs and were responsive to off normal alarms and conditions.

b. Off-Shift Inspection of Control Rooms

The inspectors performed routine inspections of the control room during off-shift and weekend periods; these included inspections between the hours of 10:00 p.m. and 5:00 a.m. The inspections were conducted to assess overall crew performance and, specifically, control room operator attentiveness during night shifts. The inspectors determined that both licensed and non-licensed operators were alert and attentive to their duties, and that the administrative controls relating to the conduct of operation were being adhered to.

c. Operator Requalification

From November 13 to November 19, 1990, Region III operator licensing examiners administered initial qualification examinations to 8 reactor operators and 10 senior reactor operator candidates. The examinations included both written and walk through tests.

d. ESF System Walkdown

The operability of selected engineered safety features was confirmed by the inspectors during walk-downs of the accessible portions of several systems. The following items were included: verification that procedures match the plant drawings, that equipment, instrumentation, valve and electrical breaker line up status is in agreement with procedure checklists, and verification that locks, tags, jumpers, etc., are properly attached and identifiable. The following systems were walked down during this inspection period:

- 480 Volt AC Electrical Distribution System
- Component Cooling Water System
- Emergency Diesel Generator System
- DC Electric Distribution System
- Service Water System

e. Plant Material Conditions/Housekeeping

The inspectors performed routine plant tours to assess material conditions within the plant, ongoing quality activities and plant wide housekeeping. Housekeeping was adequate. Plant deficiencies were appropriately tagged for deficiency correction.

No violations or deviations were identified.

5. Radiological Controls (71707, 86750)

The licensee's radiological controls and practices were routinely observed by the inspectors during plant tours and during the inspection of selected work activities. The inspection included direct observations of health physics (HP) activities relating to radiological surveys and monitoring, maintenance of radiological control signs and barriers, contamination, and radioactive waste controls. The inspection also included a routine review of the licensee's radiological and water chemistry control records and reports.

Health physics controls and practices were satisfactory with the exceptions of the event listed below. Knowledge and training of personnel were satisfactory.

On October 18, 1990, licensee personnel were removing incore detector cables from a radiological trash barrel and cutting them into shorter pieces to permit shipment in waste casks. A pre-work radiological survey of the barrel was performed indicating low levels of contamination were present. During the course of work, the workers identified other material present in the barrel which was not expected. This material was also cut up and disposed of. The workers completed their task and upon exiting the auxiliary building, set off contamination alarms. One worker had internal and external contamination and was later decontaminated. The licensee issued Management Corrective Action Report (MCAR) 90-03 to address this and other radiological control program deficiencies. This event is under review by a Region III specialist and will be discussed in more detail in Inspection Report 50-346/90022.

The licensee has completed its spent fuel pool trash removal tasks. Approximately 20 cubic feet of irradiated hardware which had accumulated in 13 years of plant operation were shipped off site on November 1 and 5, 1990.

On October 8, 1990, a chlorine gas release occurred in the water treatment building resulting in the evacuation of the building and declaration of an unusual event. The licensee conducted an investigation into the event and has concluded that with the chlorination system secured and the screenwash system in operation coincident with a full sodium hypochlorite supply tank, the chemical flowed from its supply tank to the water treatment sump due to differential head pressure and intersystem leaks. Until a chlorination system modification is complete, the licensee has established administrative controls to prevent

recurrence of this event. The inspectors have discussed their concerns to the licensee to ensure that adequate chlorination of the service water system continues to prevent zebra mussel intrusion into and microbiologically induced corrosion of the service water/component cooling water coolers.

No violations or deviations were identified.

6. Maintenance/Surveillance (61726, 62703, 92701, 93702)

Selected portions of plant surveillance, test and maintenance activities on systems and components important to safety were observed or reviewed to ascertain that the activities were performed in accordance with approved procedures, regulatory guides, industry codes and standards, and the Technical Specifications. The following items were considered during these inspections: limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating work; activities were accomplished using approved procedures and were inspected as applicable; functional testing or calibration was performed prior to returning the components or systems to service; parts and materials used were properly certified; and appropriate fire prevention, radiological, and housekeeping conditions were maintained.

a. Maintenance

The reviewed maintenance activities included:

- o Spent Fuel Pool Trash Collection activities
- o DB-MI-09040, Preventive Maintenance on Heat Tracing Circuitry
- o IC 2005.08, Process Radiation Monitor Calibration
- o Troubleshoot Rod Group 8 Normal Bus Circuitry
- o Thermography of CRDM Cabinets
- o DB-ME-09104, 13.8 Kv and 4.16 Kv Breaker Clean and Inspect
- o Preventive Maintenance on Auxiliary Feedwater Pumps

b. Surveillance

The reviewed surveillances included:

<u>Procedure No.</u>	<u>Activity</u>
DB-MI-03004	RPS Channel 4 Functional Test
DB-MI-03014	RPS Channel 4 Functional Test

DB-MI-03053	RPS Channel 3 Temperature Calibration
DB-MI-03207	RCP Monitor Channel 2 Functional Test
DB-MI-03211	SFRCS Channel 1 Functional Test
DB-MI-03811	Fire Detection Functional Test (C3720)
DB-MI-04534	String Check Room 122 Radiation Monitor
DB-MI-04551	String Check Personnel Lock Radiation Monitor
IC 2005.15	Process Radiation Monitor HRH Calibration
DB-SC-03070	Emergency Diesel Generator 1 Monthly Test
DB-SP-03150	Monthly Jog Test of Auxiliary Feedwater Pump 1

Personnel performing maintenance or surveillances used correct procedures and proper work control documents. Work authorization had been obtained for the jobs performed. Prerequisites for performing the job, such as worker protection and tagging had been performed. Surveillance continues to be an area where only an occasional minor problem arises.

No violations or deviations were identified.

7. Emergency Preparedness (71707)

An inspection of emergency preparedness activities was performed to assess the licensee's implementation of the emergency plan and implementing procedures. The inspection included monthly observation of emergency facilities and equipment, interviews with licensee staff, and a review of selected emergency implementing procedures.

No violations or deviations were identified.

8. Security (71707, 81020)

The licensee's security activities were observed by the inspectors during routine facility tours and during the inspectors' site arrivals and departures. Observations included the security personnel's performance associated with access control, security checks, and surveillance activities, and focused on the adequacy of security staffing, the security response (compensatory measures), and the security staff's attentiveness and thoroughness. Security personnel were observed to be alert at their posts. Appropriate compensatory measures were established in a timely manner. Vehicles entering the protected area were thoroughly searched.

No violations or deviations were identified.

9. Engineering and Technical Support (62703, 71707, 92701)

An inspection of engineering and technical support activities was performed to assess the adequacy of support functions associated with operations, maintenance/modifications, surveillance and testing activities. The inspection focused on routine engineering involvement in plant operations and response to plant problems. The inspection included direct observation of engineering support activities and discussions with engineering, operations, and maintenance personnel.

Independent Safety Engineering (ISEG) is conducting a Safety System Functional Inspection (SSFI) on the Emergency Diesel Generator (EDG) portion of the electrical distribution system. The inspection will review design/design changes, maintenance practices and testing to ensure that the EDG electrical distribution system meets its technical requirements.

No violations or deviations were identified.

10. Safety Assessment/Quality Verification (92701, 92702, 30703, 35702, 92700, 90712, 35502, 38702, 92720)

An inspection of the licensee's quality programs was performed to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. The inspectors considered areas indicative of overall management involvement in quality matters, self-improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's participation in technical and planning meetings. The inspectors reviewed Potential Condition Adverse to Quality Reports (PCAQR), Station Review Board (SRB) and Company Nuclear Review Board meeting minutes, event critiques, and related documents; focusing on the licensee's root cause determinations and corrective actions. The inspection also included a review of quality records and selected quality assurance audit and surveillance activities.

The inspectors review of QA surveillance reports revealed that in some cases the findings did not support the conclusions. The inspectors met with Quality Verification personnel several times during the reporting period to discuss their concerns. The discussions centered on one surveillance report which exemplified the inspectors' concerns. The licensee concurred with the inspectors and is in the process of reviewing its surveillance implementation program to strengthen the identified weaknesses.

The licensee commissioned a multi disciplined task force to assess its corrective action program and provide recommendations to improve the program's effectiveness. The team determined that the in place corrective action program is adequate, but that its implementation is weak. The task force attributes this to a lack of management support and the attitude and quality of those implementing the program. The report was presented to licensee management on November 5, 1990. The licensee is currently evaluating the report and developing solutions for the issues which were identified.

4. Allegations

1. (Closed) Allegation (RIII-90-A-0055)

The NRC received a multi-part allegation involving several sites. One of the parts related to Davis-Besse. It was alleged that piping section, 4"-EBD-37, was designed and hydrotested to 1150 psig and 1725 psig respectively. This line connects to line 18"-EBD-9 which was designed and hydrotested to 1350 psig and 2025 psig respectively and the 4" line sees the pressure of the larger line. The allegor stated that he talked to a Bechtel engineer who stated that he did not want to change the piping as others would have to be changed. A potential condition adverse to quality report (PCAQR) was written by the allegor to document that there was a possibility that EBD-37 down stream of FW106 could be over pressurized. The inspectors reviewed the referenced PCAQR. The licensee had Bechtel review the issue and Bechtel determined that there was no adverse effects. Bechtel also stated that all piping and components with a given pipe class, i.e., EBD, is designed for the maximum design pressure expected for any piping system within that given pipe class. In addition, the licensee verified that both sections of pipe were hydrotested at the higher pressure, 2025 psig. The inspectors reviewed both the original construction hydrostatic test results and the Bechtel response.

The inspectors also reviewed Facility Change Request (FCR) 86-0192 which was listed in the concern. The FCR involved repowering the start up feedwater pump (SUFP) and the addition of a minimum flow recirculation line. The two lines in question, EBD 9 and 37, were not referenced in the FCR package. This part of the allegation is not substantiated.

The concern also stated that the individual reviewed a drawing for a non safety system and found numerous discrepancies. He corrected the deficiencies and submitted the drawing for corrections. This supervisor insisted that he sign the uncorrected drawing. The allegor refused, then pointed out the errors to the supervisor, who allegedly requested the removal of the allegor. The inspectors were unable to substantiate this part of the allegation. This issue has no safety significance and the inspectors consider it to be closed.

The allegation pertaining to the Davis-Besse facility is closed.

2. (Closed) Allegation (RIII-90-A-0088)

Region III received an allegation about a licensee employee which involved fitness for duty issues. The named individual has protected area accesses. Region III assigned the allegation to the licensee for investigation. The licensee gave the individual two fitness-for-duty tests with negative results. The licensee also

contacted law enforcement agencies for additional information with negative results.

On October 31, 1990, the licensee transmitted the results of its investigation to Region III. On November 16, 1990, Region III responded to the licensee and concluded that the individual posed no threat to the facility and had no additional questions. This allegation is closed.

No violations or deviations were identified.

11. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection period and at the conclusion of the inspection and summarized the scope and findings of the inspection activities. The licensee acknowledged the findings. After discussions with the licensee, the inspectors have determined there is no proprietary data contained in this inspection report.