

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/84-07(DPRP)

Docket No. 50-346

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, OH

Inspection Conducted: April 3 - 6 and 9 - 13, 1984

Inspector: T. P. Gwynn

Approved By: *I. N. Jackiw*
I. N. Jackiw, Chief
Projects Section 2C

5-2-84
Date

Inspection Summary

Inspection on April 3 - 6 and 9 - 13, 1984 (Report No. 50-346/84-07(DPRP))

Areas Inspected: Routine, unannounced inspection of actions on previous inspection findings; receipt, storage, and control of equipment and materials; licensee event report review and followup; and 10 CFR 21 inspection. The inspection involved 55 inspector-hours onsite by one NRC inspector including 0 inspector-hours onsite during off-shifts.

Results: Of the four areas inspected, no items of noncompliance or deviations were identified in three areas. One item of noncompliance was identified in the area of receipt, storage, and control of equipment and materials (paragraph 3 - failure to maintain adequate records).

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DETAILS

1. Persons Contacted

- *S. M. Quennoz, Assistant Station Superintendent for Operations
- *B. R. Beyer, Assistant Station Superintendent - Outage Management
- *C. K. Roshong, Procurement Director
- *R. K. Miller, Nuclear Materials Manager
- *R. A. Brown, Facility Modification Department Manager
- *C. T. Daft, QA Manager
- *J. G. Schroeder, Material Control Supervisor
- *J. L. Kaufman, Nuclear Purchasing Coordinator
- *C. L. Fosnaugh, Facility Modification Department Senior Engineer
- *D. Momini, Quality Engineering Supervisor
- *M. C. Baier, Associate QA Auditor
- *J. A. Faris, Administrative Coordinator
- *S. G. Wideman, Nuclear Licensing

*Denotes those attending the exit interviews on April 6 or 13, 1984.

The inspector also interviewed other licensee employees, including members of the technical, operations, maintenance, I&C, training, nuclear materials management, and contractors staff.

2. Licensee Action On Previous Inspection Findings

- a. (Closed) Noncompliance (346/81-03-04(d)): Nineteen deficiencies were identified in the implementation of administrative procedure AD 1847.00, "Materials Handling and Storage Requirements".

The following provides a summary of each identified deficiency and the results of this NRC review of each deficiency:

- (1) Class A storage facilities at the Toledo Edison Company (TEDCo) Davis-Besse warehouse were not adequate.

The inspector found that a new level A storage facility has been erected inside the TEDCo warehouse. That permanent facility was provided with filtered ventilation (including an electrostatic precipitator), temperature and humidity controls, continuous temperature and humidity monitoring, fire protection, and other necessary features. The licensee stated that the facility was designed to meet the requirements of ANSI N45.2.2 for level A storage. The inspector agreed that the facility was adequate to provide the protection required for level A storage.

- (2) Packaging requirements were not maintained for alarm panel instrumentation (level B required).

The licensee stated that TEDCo nuclear materials management is now conducting internal packaging of these and similar type items once receipt inspection is completed. The inspector identified no deviations from this statement.

- (3) Flammable materials were stored adjacent to safety-related materials.

The licensee stated that flammables have been segregated to one of two flammables storage areas, with a few minor exceptions. The inspector observed each of these storage areas and found that they were clearly marked with no smoking allowed and were generally separate from safety-related materials by eight feet or more. The inspector observed no specific exceptions during this inspection.

- (4) Open bags of calcium chloride were stored within ten feet of safety-related stainless steel pipe.

The licensee stated that calcium chloride and similar bagged chemicals are no longer stored in the warehouse. Calcium chloride in closed drums may be stored inside the warehouse. Stainless steel pipe storage is now in the outside (level D) storage area. The inspector observed no deviations from the above statement.

- (5) Facilities for the preparation and consumption of food and drinks were present in the warehouse storage area.

The licensee stated that a lunchroom had been provided where warehouse employees may consume food and beverages that is separate from the material storage area. The inspector verified the existence of the lunchroom and observed no food, drink, or salt tablets in close proximity to safety-related materials.

- (6) A reel of instrumentation cable (level C storage required) was found stored in the level D storage area.

The licensee stated that the affected cable reel had been transferred to level B storage. The inspector toured the outside laydown area and identified no items stored in a storage level below that specified.

- (7) The ends of partially used reels of cable were not sealed.

The licensee stated that the potential for recurrence of that situation still exists. A routine surveillance program was being developed to address this and other matters. This is an open item (346/84-07-01(A)).

- (8) Safety-related cable reels, cable ends, and loops were in contact with the ground.

The licensee stated that the observed deficiency had been corrected and that cable reels are now stored on dunnage. The inspector toured several storage areas (inside and outside) and observed no similar deficiencies.

- (9) The laydown areas outside the warehouse were not fenced or otherwise controlled. Access control to the main warehouse was not present.

The licensee stated that permanent outside storage areas are now fenced and locked. Authorized access lists were observed to be posted and keys were controlled. A list of personnel authorized unescorted access to the warehouse was posted and enforced. Visitors to the warehouse must be authorized, logged in and out, and escorted. The inspector observed these controls and verified their use. All key controlled storage facilities toured were found in a locked condition.

- (10) A newly acquired forklift (Pettybone Serial No. 0731) had not been certified by the manufacturer for the maximum load to be handled and no "load plate" was found on the forklift.

The licensee stated that this forklift was no longer under their control and that current material handling equipment had the required data. The inspector checked two forklifts present in the warehouse storage area for the required nameplate data. One forklift, a Toyota, was found to have the required data. The second, an older model Clark forklift, did not. The licensee stated that the required data would be obtained for this forklift as part of their inspection program for material handling equipment. This is an open item (346/84-07-02(A)).

- (11) No inspection program had been established for warehouse material handling equipment.

The licensee stated that a bi-weekly inspection program was being developed and that inspection results would be documented. However, the inspector noted that the program had not been implemented. This is an open item (346/84-07-02(B)).

- (12) Some stainless steel pipe was stored without plastic caps or other protective measures.

The licensee stated that pipe caps are now maintained by warehouse personnel to assure that storage requirements are met. A routine surveillance program was being developed to address this and other matters. This is an open item (346/84-07-01(B)).

- (13) Several "Q-accept" tags were weathered and deteriorated. These tags were not identifiable to the specific material stored in outdoor laydown yards.

The licensee stated that higher quality tags are now being utilized in outside storage areas. In addition, a semi-annual (once in the spring, once in the fall) surveillance is conducted by quality engineering (QE) in outdoor laydown areas to assure the integrity of the tagging system. The inspector verified this information with the responsible QE supervisor.

- (14) Trash and small scrap pieces of cable were scattered around the safety-related storage area. Weeds were growing around the cable reels.

The licensee stated that trash had been removed from the affected areas. Weeds are cut when needed during the summer months. The inspector observed no excessive accumulation of trash or weeds in any of the outside laydown areas toured.

- (15) Safety-related materials and components were found on pallets in the warehouse, but in some cases were not clearly identified or properly packaged.

The licensee stated that this condition existed because of the relocation of warehouse storage areas which occurred just prior to the inspection in 1980, and that this condition no longer exists in the warehouse. The inspector verified through numerous spot checks of "Q-accept" tags and item identification that each item observed was identifiable to the purchase order or other appropriate documentation.

- (16) Nuclear instrumentation components, requiring level A storage, were found in the original shipping crates but were not packaged or protected as required.

The licensee stated that these and other items requiring level B storage with dessicant have been moved to the level A storage area. The inspector inquired as to how the implementation of this commitment was controlled and the licensee representative was unable to provide assurance of implementation. No specific deficiencies were identified by the inspector related to this matter. This is an open item pending the provision of sufficient controls to assure that future materials received requiring level B storage with dessicant will be properly stored (346/84-07-01(C)).

- (17) Flexitallic gasket materials requiring level B storage and packaging were found exposed to dust and dirt. Some damaged gaskets were found.

The licensee stated that the damaged gaskets were disposed of or corrected. All flexitallic gaskets are now packaged in plastic to avoid contamination. The inspector confirmed that flexitallic gaskets stored in the warehouse were packaged in plastic.

- (18) The floor of the warehouse was not sealed to minimize generation of concrete dust.

The licensee stated that all exposed portions of the warehouse floor had been sealed. The inspector confirmed this.

- (19) The uncontrolled laydown area outside the warehouse was not adequately drained. Standing water was observed.

The licensee stated that small puddles form in the fenced outdoor laydown area after a rainstorm but that with adequate dunnage or cribbing the water does not pose a problem. The inspector observed standing water in the laydown area and noted that the integrity of safety-related materials stored therein was not threatened.

- b. (Closed) Noncompliance (346/82-08-01): During a tour of site material storage areas, a number of deficiencies were identified as summarized below:

- (1) Level C cable and unistrut were stored outdoors in a level D laydown area.
- (2) Level C cable was stored in a trash pile with a "Q-accept" tag attached.
- (3) Level D cable was stored in an area not meeting level D requirements.
- (4) Access to a level D storage area was found uncontrolled.
- (5) Accumulated trash and debris was found adjacent to a level D storage area.
- (6) Chemicals, inflammables, and ether based ink were stored in close proximity to safety-related materials in the warehouse storage area.
- (7) The weld preparation surface on a 20 inch flange was found to be unprotected.

These were examples of repetitive items of noncompliance as identified in noncompliance 346/81-03-04(d).

The inspector performed a detailed review of material receipt, storage, and control as documented in paragraph 3 of this report. No significant deficiencies were identified. In addition, the inspector verified that actions committed to in TEDCo letter serial No. 1-285 dated July 30, 1982 (in response to this item of noncompliance) had been carried out. This item of noncompliance is closed.

3. Receipt, Storage, and Control of Materials and Equipment

The inspector performed a detailed review of licensee activities related to the receipt, storage, and control of safety-related materials and equipment in order to verify that the licensee was implementing applicable quality assurance program requirements. This review consisted of a review of applicable procedures, observation of licensee activities and facilities, interview of responsible licensee personnel, and review of applicable records. Specific licensee organizations whose activities were reviewed included Nuclear Materials Management, Facility Modification Department, and the Station Maintenance Department.

a. Discussion/Observations

The following observations were noted:

- (1) The present program clearly shows management attention by the Nuclear Materials Management (NMM) Group. Improvements noted since the previous inspection in this area included the level A storage area which appeared to meet the ANSI requirements; sealed floors in the warehouse compound; designated flammables storage areas; a designated lunchroom for warehouse personnel which was separate from the materials storage areas; fenced and locked outside storage areas with posted access lists; and good control of shelf life items in NMM control.

Continuing improvements noted included the development of a routine surveillance program performed by warehouse supervision to assure continuing adequacy of storage conditions and control of storage areas; the development of a routine inspection program for material handling equipment by warehouse personnel; and the development of job descriptions for warehouse personnel which reflect the duties and responsibilities of personnel under the nuclear safety-related program which is unique to Davis-Besse in the TED material control program. These items were still being developed at the time of the inspection.

(2) Contractor Storage and Control (Facility Modification Department).

There were insufficient activities in progress to allow a representative sample. Those activities observed appeared to meet current procedural requirements. Several items were noted which appeared to be excess materials awaiting return to the warehouse.

(3) Maintenance Department Storage and Control.

In general, those items which should be in the control of the maintenance department were adequately identified, controlled, and stored. Some exceptions were noted as follows:

- (a) In every area visited, excess materials were noted which were awaiting return to the warehouse. This is not contrary to procedural requirements but is undesirable (from the standpoint of inventory control) and could result in lack of required routine maintenance (as identified below).
- (b) Several components were noted which had been cannibalized for parts. These items were identified only by a "Q-accept" tag although they were not in a fully conforming status. The current procedures for control of materials did not address the cannibalization of components for spare parts and methods required to control the cannibalized components until they are returned to a conforming status. The licensee stated that this matter would be considered in the next revision to the applicable procedure. This is an open item (346/84-07-03(A)).
- (c) Materials with expired shelf life were located in two Q-storage areas identified by "Q-accept" tags. This leaves the end user as the only control to assure appropriate use of the item. Current procedures applicable to maintenance activities do not address the method for control of shelf life items and appropriate methods for disposal thereof. The licensee stated that this matter would be considered in the next revision to the applicable procedure. This is an open item (346/84-07-03(B)).
- (d) A motor assembly had been removed from its installed status on the limitorque operator for valve RC-2 and had been stored in the electrical shop storage area since September of 1983. Since this item was not returned to the warehouse in a timely manner, it had not received the routine maintenance attention it would have received as stored in the warehouse. This item was immediately shipped to the warehouse for storage.

(e) A number of combined station maintenance/contractor Q-storage locations were reviewed by the inspector. The materials stored in these areas were excess materials either left over from initial construction or from past outage/modification work. These areas were generally clean and appeared to meet the requirements for level B/C storage. Several deficiencies were noted as follows:

- . Some unidentified items were observed which were mixed with Q-items.
- . A number of loose "Q-accept" tags were observed to be adrift in the area.
- . Expired shelf-life items were stored with acceptable materials.

Because this area was under dual control (ie, GEM contractor and station maintenance) it was not clear to the inspector which procedures were applicable to this area or who was responsible for ensuring these deficiencies did not recur. It appeared to the inspector that those materials not dedicated to current work items should be returned to the warehouse or procedures implemented to maintain adequate control. The licensee stated that this situation would be corrected. This is an open item (346/84-07-03(C)).

b. Findings

As a result of this inspection, the following deficiencies were identified:

- (1) Contrary to the TEDCo Nuclear Quality Assurance Manual, paragraph 7.2.3, weld filler materials which had been returned to TEDCo by ITT Grinnell (a former site contractor) were in stock in the warehouse identified by a green "Q-accept" tag signifying an acceptable receipt inspection had been performed on 5-12-83 but had neither a purchase order nor an acceptable receipt inspection checklist (GMIC) on file with records management. An unverified certified material test report (CMTR) from the manufacturer was on file. There was no evidence that the CMTR had been reviewed and accepted by QE prior to acceptance of the material. This was considered an item of noncompliance (346/84-07-04).

As a result of the above item of noncompliance, the TEDCo QA Manager committed to perform a receipt inspection for all materials presently in stock which were received from ITT Grinnell in order to ascertain the acceptability of the materials. Appropriate action was taken as a result of that inspection. Additional materials received from

another former site contractor (Johnson Controls) were checked and found to have acceptable purchase order and receipt inspection documentation on file. In addition, the licensee stated that procurement of essential and safety-related materials for use at Davis-Besse is performed by TEDCo. Thus the problem observed above will not recur.

As a result of the timely corrective action provided, no response to this item of noncompliance is required.

- (2) The inspector observed that an aerosol spray industrial mold cleaner and an aerosol spray industrial degreaser/solvent (ie, SPRAYON MOLD CLEANER AND SPRAYON INDUSTRIAL DEGREASER/SOLVENT) had been in use in the level A storage area. These sprays were used to remove magic marker ink from shelving used to store small items. The inspector was concerned that overspray and fumes from these sprays might contaminate level A clean surfaces and cause deterioration of any protective coatings. The inspector determined, upon questioning licensee personnel, that these sprays had not been reviewed and approved for use in level A storage. In addition, the inspector observed that the chemical contents of the cans were not identified on the label.

As a result of the above, the licensee removed the cans in question from the area and prohibited the further use of such sprays in the level A storage area pending the results of an investigation of the acceptability of their use. This is an unresolved item (346/84-07-05).

- (3) One minor deficiency was identified in the QE hold area of the warehouse related to materials on hold as a result of NRC IE Bulletin 83-05 (Hayward Tyler Pumps). These materials, although segregated in the QE hold area, were only identified by green "Q-accept" tags.

This matter was discussed with responsible personnel who directed that the materials be tagged denoting their unique status pending the determination of their acceptability under the requirements of the bulletin. This action was adequate to identify the current status of those parts.

No additional items of noncompliance or deviations were identified.

4. Licensee Event Report (LER) Review and Followup

The inspector reviewed LERs submitted to NRC Region III to verify that the details of the event were clearly reported and the LER form was accurately filled out; that the reporting requirements of the Technical Specifications had been met; that appropriate corrective action had been or was scheduled to be taken; and that continued operation of the facility was conducted in accordance with the Technical Specifications. The following findings relate to the LERs reviewed:

- a. (Closed) LER 83-056.

This report details inoperability of Emergency Ventilation System (EVS) Train 1 due to a blown fuse supplying electric power to a radiation element which activates the EVS. The EVS supplies emergency ventilation in the event a high radiation level is detected in the spent fuel pool/fuel handling area. The licensee's investigation determined that there was no apparent cause of the blown fuse which was subsequently replaced. The inspector verified that no fuel handling operations were in progress during the event.

- b. (Closed) LER 83-058.

This report details the identification and correction of a fire wall penetration that was not adequately sealed. The inspector noted several discrepancies in the LER form data as follows:

- (1) The report date (block 9) was not filled in; the report date should have been 11/18/83.
- (2) The cause code provided in block 12 was "C" which correlates with an external cause (such as lightning strike, tornado, or flood). The actual cause according to the cause description narrative was personnel error which correlates with cause code A.
- (3) The cause subcode provided in block 13 was "C", which is an error since cause code "C" does not require a cause subcode. If the correct cause code had been used (cause code A), then the proper cause subcode would have been "E"; construction personnel.

- c. (Closed) LER 83-059.

This report details the loss of position indication for an auxiliary feedwater pump steam isolation valve caused by a blown control power fuse in the valve control circuitry. An investigation revealed no apparent cause for the blown fuse which was subsequently replaced.

- d. (Open) LER 83-060.

This report details the inoperability of three separate primary containment isolation valves; one valve associated with hydrogen dilution train 1 and the other two valves associated with containment vacuum breakers. The licensee's investigation revealed that a torque switch failure caused the loss of hydrogen dilution train 1; the torque switch was replaced. The licensee's investigation revealed that the vacuum breaker isolation valve failures were caused by a gear limit switch cover improperly installed after valve operator maintenance and a faulty valve control switch, respectively.

The inspector observed a discrepancy in the LER supplemental information statement, as follows:

- . The "Analysis of Occurrence" section, paragraph 2, states, "An analysis by Bechtel has determined that nine containment vacuum breaker isolation valves will provide adequate protection against an excessive containment vacuum condition. At all times during this occurrence there were nine containment vacuum breaker isolation valves available."
- . The inspector noted that a total of ten vacuum breakers are installed.
- . The inspector noted that two of the ten installed vacuum breakers were isolated between 0230 and 1837 hours on November 10, 1983 (ie, only eight containment vacuum breakers were operable during this time).

This discrepancy was discussed with licensee personnel who confirmed the error and stated that the facility architect engineer (Bechtel Power Corporation) was performing an additional analysis in order to determine the minimum number of vacuum breakers required to protect the containment against an excessive reverse-pressure condition. The licensee further stated that preliminary results by Bechtel indicated that five or six vacuum breakers were actually required. This matter is unresolved pending review of a final report on this additional Bechtel analysis (346/84-07-06).

e. (Closed) LER 83-61.

This report details deenergization of the 120 vac Essential Instrumentation Panel Y2 caused by a blown fuse in the power source. A detailed investigation by the licensee revealed no apparent cause of the blown fuse which was subsequently replaced.

f. (Open) LER 83-070.

This report relates to a chloride concentration in the reactor coolant system in excess of steady-state technical specification requirements caused by a prematurely depleted demineralizer resin. The excess chloride concentration was reduced to within steady-state technical specification limits in less than 22 hours by placing an alternate purification system demineralizer in service. The inspector noted the following discrepancies in the report:

- (1) Although the LER stated that the time chlorides were outside technical specification limits was less than 22 hours, review of the LER description indicated that the event began at 0845 on 12/10/83 and ended by 0700 on 12/12/83; a period of about 46 hours. This matter was discussed with licensee personnel who stated that the date 12/12/83 was a typographical error; the event actually ended by 0700 on 12/11/83.

- (2) The proximate cause code assigned by the licensee was "E" which correlates with a component failure. However, the actual cause of the event was the procurement and use of the wrong type of resin in the reactor coolant purification demineralizer.
- (3) The procurement and use of the wrong type of demineralizer resin for the reactor coolant purification system may be indicative of a quality assurance program deficiency. There was not sufficient time during this inspection to ascertain all the circumstances surrounding this matter. This matter was referred to NRC Region III (Quality Assurance Programs Section) and remains unresolved (346/84-07-07).

g. (Closed) LER 83-072.

This report details the deenergization of 120 vac Essential Instrumentation Panel Y1 caused by a blown fuse in the power source (resulting from personnel error during performance of a facility modification). Because a certain component in the reactor integrated control system was powered from Y1, the reactor tripped. Three additional events were also included in this report, related to exceeding the technical specification limits for iodine activity in the reactor coolant; unidentified reactor coolant system leakage in excess of technical specification requirements; and a technical specification violation caused by a valving error. All items were investigated and corrected by the licensee.

The inspector noted that block 20 (effect on plant) was incorrectly coded. Code "B" (forced power reduction) was used when the correct code was "A" (the plant tripped and the generator was off-line for 162 hours).

The inspector discussed multiple event LERs with licensee management.

General Observations

The inspector noted that personnel filling out the LER forms were not always consistent in filling out the forms and sometimes did not follow the instructions provided in NUREG-0161, Instructions For Preparation of Data Entry Sheets For LER File.

The following specific matters were discussed with licensee management:

The instructions for the narrative sections of the LER form, blocks 10 and 27, state in part, "NOTE: The information must be adequate for meaningful understanding, yet short enough to fit the number of computer spaces available (7 lines of 72 spaces each)."

The inspector observed that every LER reviewed utilized in excess of 72 spaces per line of narrative description (on the order of 80-88 spaces per line, in most cases).

The instructions for block 17, occurrence code note (1) states, "For occurrence code 01 and 03, reference the specific applicable paragraph and subparagraphs of the Technical Specifications or license provisions in the letter transmitting the LER and any backup/supplementary information." The inspector observed that, although occurrence code 03 was used for all the reports reviewed, the letters transmitting those LERs never referenced the applicable Technical Specification subparagraph (6.9.1.9).

LERs 83-056 and 83-059 were both caused by a component failure (blown fuse); however, the cause subcodes used were different for the two reports. LER 83-056 used subcode "F" (natural end of life failure) while LER 83-059 used subcode "A" (electrical component failure).

The inspector noted a number of errors in the LERs, as noted under the specific LERs above.

These matters were not significant unto themselves, however, they were indicative of a lack of attention to detail and/or a failure to follow the instructions provided in NRC guidance. It is noted that effective January 1, 1984 10 CFR 50.73 was revised and modifies and codifies the Licensee Event Report (LER) system.

No items of noncompliance or deviations were identified.

5. 10 CFR Part 21 Inspection

The inspector conducted a review of licensee procedures and postings promulgated under 10 CFR 21 to verify the adequacy of the licensee's 10 CFR 21 reporting program.

a. Documentation Reviewed

- (1) Toledo Edison Nuclear Quality Assurance Manual, paragraph 15.7.
- (2) Toledo Edison Notice posted in accordance with 10 CFR 21 dated August 5, 1983.
- (3) Toledo Edison Quality Assurance Instruction 4150, QA Review of Nonconformance Reports, revision 7 dated March 12, 1982.
- (4) Toledo Edison Quality Control Instruction 3150, Control of Nonconformance Reports And Supplier Deviation Reports, revision 8 dated July 20, 1983.
- (5) Toledo Edison Nuclear Practices And Procedures ADMIN-010, Functioning Of An Ombudsman For Nuclear Safety Considerations, revision (not identified) dated July 23, 1982.

b. Discussion/Observation

The licensee's program for identification, evaluation, and reporting defects and noncompliances that could create a substantial safety hazard was described in the Toledo Edison Nuclear Quality Assurance Manual (NQAM). That program provided for the transmittal of potentially reportable deviations to Nuclear Facility Engineering (NFE) for evaluation. Those deviations which are determined through evaluation to be reportable under 10 CFR 21 would then be reported to the NRC through a licensee event report or a letter meeting the requirements of 10 CFR 21.

Review of the licensee's procedures adopted pursuant to 10 CFR 21.21(a)(1) to implement the program defined in the NQAM revealed the following apparent weakness:

- (1) The inspector found no evidence which would provide a reasonable level of assurance that potential 10 CFR 21 reportable items identified by Toledo Edison personnel would be forwarded to NFE for evaluation. Some limited controls were in place (ie, reference 5.a(4) above) but those controls did not always result in NFE evaluation of the identified deviation.
- (2) The inspector noted that the instructions (ie, reference 5.1(3) above) given to QA staff personnel resulted in bypassing of the programmatically required NFE evaluation of potential reportable deviations.
- (3) The inspector noted that neither the QA instructions (reference 5.a(3) above) nor the NFE instructions (reference 5.a(4) above) provided for preparation and maintenance of records of the results of evaluations performed pursuant to 10 CFR 21. In addition, these instructions contained no detailed criteria upon which to base the evaluation.
- (4) The instructions provided for notification of a responsible company officer appeared to leave the determination of reportability to that responsible company officer. This was not considered to be appropriate. That determination should be made by personnel who are technically trained and qualified in the discipline(s) affected and who are capable of judging the significance of a potential safety hazard.

The instructions provided for notification of a responsible company officer do not provide assurance that the required notification is made and do not provide for the preparation and maintenance of records to assure compliance with the provisions of 10 CFR 21.21(a)(2).

- (5) The inspector did not review any document which provided assurance that notifications made to the commission (ie, LERs or letters) pursuant to 10 CFR 21.21(a)(2) would meet the requirements of 10 CFR 21.21(b)(2) and (3).

In addition, review of the notice posted pursuant to 10 CFR 21.6 revealed one deficiency and two minor errors, as follows:

- (6) The last paragraph of the notice stated, "Any employee, who at any time is aware of any defect which could cause a substantial safety hazard to the Davis-Besse Nuclear Power Station, has the right, and indeed the obligation, to notify the Quality Assurance Director of the defect. In lieu of this notification, the guidelines of Nuclear Practices and Procedures (NPP) ADMIN-010 may be followed to maintain confidentiality. NPP ADMIN-010 may be obtained from any Nuclear Mission Area Head."

Review of procedure NPP ADMIN-010 revealed that notification made in accordance with the second sentence of the above paragraph would not procedurally result in an evaluation of the condition by NFE for reportability in accordance with 10 CFR 21.21(a)(1) and therefore could potentially result in a failure to report an identified reportable condition.

This matter was discussed in detail with the Toledo Edison Quality Assurance Department Director who committed to take prompt action to rectify this situation.

- (7) The inspector noted a typographical error in the posting which changed the word noncompliances to compliances, thereby changing the sense of the sentence. This error was to be corrected.
- (8) The inspector observed that the telephone numbers for NRC Region III and NRC Region IV provided in the posted material were incorrect. This was also to be corrected.

The apparent weaknesses documented above were discussed in detail with the Toledo Edison Quality Assurance Department Director. As a result of this discussion, the licensee committed to perform a detailed, indepth review of licensee activities and procedures relative to 10 CFR 21 reporting; to consider in that review the apparent weaknesses documented in this report; and to consider in that review the guidance provided in NUREG-0302, revision 1, Remarks Presented (Questions/Answers Discussed) At Public Regional Meetings To Discuss Regulations (10 CFR Part 21) For Reporting Of Defects And Noncompliance, dated July 12-26, 1977. The results of this review are to be documented as are any corrective actions which are required. This matter is unresolved pending review of the results of the licensee's review (346/84-07-08).

The actions committed to by the licensee during the course of this inspection were considered adequate to resolve the apparent deficiencies noted. The inspector specifically considered the lack of any evidence of failure to report a reportable deficiency in coming to this conclusion.

No items of noncompliance or deviations were identified.

6. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. Four unresolved items disclosed during this inspection are discussed in paragraphs 3.b, 4.d, 4.f, and 5.b.

7. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which involve some action on the part of the NRC or licensee or both. Open items disclosed during the inspection are discussed in Paragraphs 2.1 and 3.a.

8. Exit Interview

The inspector met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on April 6 and 13, 1984. The inspector summarized the scope and findings of the inspection activities. The licensee acknowledged the inspector's findings.