



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D. C. 20555

PDR  
LPDR  
NSIC  
HTIS

OCT 1 1984

Docket No. 50-346

Toledo Edison Company  
ATTN: Mr. Richard P. Crouse  
Vice President, Nuclear  
Edison Plaza  
300 Madison Avenue  
Toledo, Ohio 43652

Gentlemen:

Subject: Performance Appraisal Inspection 50-346/84-19

This letter forwards the report of the Performance Appraisal Inspection conducted by Mr. L. J. Cailan and members of the Operating Reactor Programs Branch, Office of Inspection and Enforcement, on July 30 - August 10, 1984, and August 20-24, 1984, of activities authorized by NRC Operating License NPF-3 for the Davis-Besse Nuclear Power Station. This letter also refers to the observations presented to Mr. Wendell A. Johnson, you, and members of your staff on August 24, 1984, in your offices at the Davis-Besse Nuclear Power Station.

The enclosed report includes observations that may result in enforcement actions; these matters will be followed by the NRC Region III office. The report also addresses other observations and conclusions made by the inspection team for this inspection. Enclosure 1 to this letter is an Executive Summary of the conclusions drawn for the ten functional areas inspected. Enclosure 2 is Performance Appraisal Inspection Report 50-346/84-19.

As a result of the significant weaknesses identified in Corrective Actions, Non-Operator Training, and Operator Training, designated as Category Three, you are requested to inform this office within 60 days of receipt of this letter of the actions you have taken or plan to take to improve the management controls in these areas. Your response will be followed by the NRC Regional office.

In addition to the areas designated as Category Three, weaknesses were identified in your procedure control program and in the degree of management involvement in certain activities. Examples of problems in your procedure control program were identified in the areas of Quality Assurance (Observation 7), Design Changes and Modifications (Observation 3), Maintenance (Observations 1 and 3), Procurement (Observations 2, 3, and 6), and Radiological Controls (Observations 6 and 8). Examples of inadequate management involvement were found in the areas of Quality Assurance (Observations 5 and 6), Operator Training (Observation 2), and Non-Operator Training (Observation 3). Therefore, you are requested to include in the response requested above the actions you have taken or plan to take to improve your procedure control program and to improve management involvement in the areas of Quality Assurance and Operator and Non-Operator Training.

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Q PDR

Mr. Richard P. Crouse

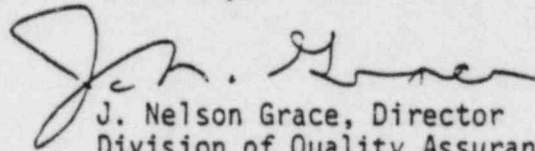
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In accordance with 10 CFR 2.790(a), a copy of this letter and the enclosures thereto will be placed in the NRC Public Document Room unless you notify this office, by telephone, within 10 days of the date of this letter and submit written application to withhold information contained therein within 30 days of the date of this letter. Such application must be consistent with the requirements of 2.790(b)(1).

The responses directed by this letter are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, PL 96-511.

Should you have any questions concerning this inspection, we would be pleased to discuss them with you.

Sincerely,



J. Nelson Grace, Director  
Division of Quality Assurance, Safeguards,  
and Inspection Programs  
Office of Inspection and Enforcement

Enclosures:

1. Executive Summary
2. IE Management Appraisal  
Report 50-346/84-19

cc w/enclosures:

Mr. W. A. Johnson  
President  
Toledo Edison Company  
Edison Plaza  
300 Madison Avenue  
Toledo, Ohio 43652

Mr. S. M. Quennoz, Station Superintendent  
Toledo Edison Company  
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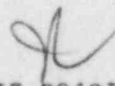
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
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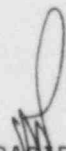
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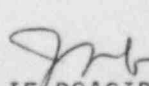
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## EXECUTIVE SUMMARY

A team of eight inspectors from the Operating Reactor Programs Branch conducted an announced inspection at the Davis-Besse Nuclear Power Station and the Toledo Edison Company offices during the period of July 30-August 24, 1984. Management controls in 10 areas were evaluated and assigned performance categories as follows: Committee Activities, Quality Assurance, Design Changes and Modifications, Maintenance, Plant Operations, Procurement, and Radiological Controls were rated Category Two; Corrective Action Systems, Operator Training, and Non-Operator Training were rated Category Three. In addition, weaknesses were identified in the licensee's procedure control program in all the areas inspected, and inadequate management involvement was noted in the areas of Quality Assurance, Operator Training, and Non-Operator Training.

Within the 10 areas inspected, 22 potential enforcement findings were identified. These findings, referred to in the inspection report as unresolved items, will be followed up by the NRC Region III Office. The following summarizes the observations and unresolved items in each area.

### Committee Activities: Category Two

Weaknesses identified in committee activities included: limited information in the minutes of onsite review group meetings; inconsistency between the Technical Specifications and the offsite review group charter; failure to review procedures, as required, and late review of procedure modifications by the onsite review group; failure of the offsite review group to review a design deficiency; and weak performance of audit responsibilities by the offsite review group.

Strengths were noted in some of the provisions of both the onsite and offsite review board charters, the staffing of both boards, and the records of technical reviews by the offsite review group.

### Unresolved Items:

1. Apparent failure of the Station Review Board (onsite review group) to review procedure modifications within 14 days of their effective date. One example was reviewed as much as 50 days after its effective date (Observation 7).
2. Apparent failure of the Company Nuclear Review Board (offsite review group) to review a recognized indication of a deficiency in the design of a safety-related component (Observation 8).

### Quality Assurance: Category Two

The quality assurance (QA) organization had a notable strength with respect to the experience and qualification levels of the quality control staff. A related strength was the degree of maintenance and surveillance activities routinely covered by the quality control organization.

Weaknesses were identified in the QA audit program. The audit checklists were often technically weak, and the QA audit teams were often not technically trained and experienced in the areas they were auditing. QA audits did not include observations of activities, especially in the areas of maintenance and plant operations. Management involvement in the QA audit process was lacking with essentially no management oversight by the Company Nuclear Review Board as well as minimal management attendance at post-audit conferences.

Unresolved Items:

1. Apparent failure to include observations of maintenance and operations activities in the QA audit program (Observation 2).
2. Apparent failure to provide adequate management representation at QA postaudit conferences (Observation 6).
3. Apparent failure to establish administrative procedures to cover procedure adherence, procedure changes, and procedure review and approval for support activities such as QA, Nuclear Training, Nuclear Purchasing and Procurement, and Nuclear Facilities Engineering (Observation 7).

Design Changes and Modifications: Category Two

A significant weakness in the plant modification program was that, contrary to 10 CFR 50.59, the program required written safety evaluations for only nuclear safety-related changes but not for other changes to the facility as described in the FSAR. Other weaknesses noted were the failure to update the FSAR to describe plant modifications and the failure to perform safety evaluations for temporary lead shielding installed on safety-related piping systems.

The efficient tracking and record keeping system for facility change requests was considered a strength.

Unresolved Items:

1. Apparent procedural deficiency that provides the potential for omission of safety evaluations required by 10 CFR 50.59 (Observation 3).
2. Apparent failure to update the Final Safety Analysis Report (Observation 4).
3. Apparent failure to analyze the loading effects of placing temporary lead shielding on safety-related piping (Observation 5).

Maintenance: Category Two

Inadequate use and control of procedures and instructions was a significant weakness. Relating to this were the lack of procedures to calibrate measuring and test equipment, the inadequate control of vendor manuals, and the inadequate instructions and procedures specified on Maintenance Work Orders (MWOs). There were also weaknesses pertaining to the lack of records for the review of out-of-calibration test equipment and a lack of in-the-field maintenance supervision.

The Davis-Besse Maintenance Management System (DBMMS), a computer based data management system used extensively to facilitate the control of maintenance and to track various other activities, was a strength.

Unresolved Items:

1. Apparent failure to provide the necessary procedures to control the calibration of measuring and test equipment (Observation 1).
2. Apparent failure to retain records of evaluations of prior use of defective measuring and test equipment (Observation 2).
3. Apparent failure to provide review and control of vendor manuals used to conduct safety-related maintenance (Observation 3).
4. Apparent failure of MiWOs to specify adequate work instructions and procedures (Observation 4).

Plant Operations: Category Two

A strength was the fact that there were sufficient licensed operators to permit six-shift rotation with additional licensed personnel available to perform management functions.

Weaknesses were the inadequate shift turnover checklists, the unintelligible intercom system between the control room and the Shift Supervisors office, and the failure to provide technically trained Shift Administrative Assistants.

Unresolved Items:

1. Apparent failure to develop and utilize shift turnover check-lists as specified by NUREG-0578 (Observation 3).
2. Apparent failure to establish an effective intercom system between the control room and the Shift Supervisor's office, as committed to the NRC (Observation 4).
3. Apparent failure to use technically trained individuals as the plant operations Shift Administrative Assistant as committed to the NRC (Observation 5).

Corrective Action Systems: Category Three

An apparent breakdown of the corrective action systems was found regarding the actions taken as a result of a common mode failure of the high pressure injection system. Weaknesses pertaining to this issue were

- ° the failure to recognize its safety significance
- ° the untimely review of deviation reports and vendor preliminary safety concerns
- ° the failure on the part of the Company Nuclear Review Board to review the design deficiency of a safety-related system

- ° the untimely implementation of corrective action
- ° an apparently inadequate safety evaluation

A weakness was also found in the method for resolving purchase order discrepancies.

Unresolved Item: Apparent failure to evaluate a vendor preliminary safety concern within the required time period (Observation 3).

#### Operator Training: Category Three

Weaknesses noted included insufficient staffing, ineffective self-study, and a lack of management oversight of contractor provided training.

Significant weaknesses were the lack of management oversight and the poor quality assurance measures directed toward the administration of senior reactor operator and reactor operator requalification examinations.

Unresolved Items: Apparent failure to base the requalification lecture series on weaknesses identified by the annual requalification examination (Observation 2).

#### Non-Operator Training: Category Three

Weaknesses identified in the area of non-operator training were staffing shortages in the Nuclear Training Department, poor quality of training being conducted, lack of a timely improvement program, and inadequate management involvement in training. Additional weaknesses were noted with the procedures governing training and with specific aspects of the General Employee Training Program.

Unresolved Items: None

#### Procurement: Category Two

Weaknesses identified in the area of procurement were the inadequate procedural guidance for preparing procurement documents and upgrading commercial material for nuclear safety-related use, the failure to comply with procedures for station material control, and the procurement of primary plant chemicals as non-nuclear safety-related materials.

A strength was noted in the improvements made since the last performance appraisal inspection.

Unresolved Items:

1. Apparent failure to review purchase orders before they were issued (Observation 3).
2. Apparent lack of procedural guidance for procurement of replacement parts to original specifications (Observation 6).
3. Apparent failure to return excess nuclear safety-related material to the storeroom within 30 days after job completion (Observation 7).

### Radiological Controls: Category Two

There were significant strengths in the radiological control program as evidenced by strong and competent management and by effective control of both external and internal doses to employees.

There were weaknesses relating to licensee procedures in the areas of

- ° Lack of procedures (bioassay program)
- ° Procedure content (respirator fit tests; exposure monitoring for visitors).
- ° Review of procedures (no Station Review Board (SRB) review of procedures related to analyses of effluent samples)
- ° Adherence to procedures (use of laboratory instrument control charts)

Finally, there were weaknesses in the licensee's program for calibration and functional check of some counting instruments.

#### Unresolved Items:

1. Apparent failure to recalibrate radiochemistry counting equipment as procedurally required (Observation 7).
2. Apparent failure of the SRB to review procedures as required by Technical Specifications (Observation 8).