

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/85004(DRP)

Docket No. 50-346

License No. NPF-3

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

Facility Name: Davis-Besse, Unit 1

Inspection At: Oak Harbor, OH

Inspection Conducted: February 5 through March 11, 1985

Inspectors: W. G. Rogers

D. C. Kosloff

B. Burgess

R. Hague

Approved By: *W.D. Shales for*  
I. N. Jackiw, Chief  
Reactor Projects Section 2B

3-27-85  
Date

Inspection Summary

Inspection on February 5 through March 11, 1985 (Report No. 50-346/85004(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of licensee action on previous inspection findings, operational safety, operational events, licensee event reports, maintenance, surveillance, training, IE Bulletins and management meetings. The inspection involved 190 inspector-hours onsite by four NRC inspectors including 34 inspector-hours onsite during off-shifts.

Results: Of the nine areas inspected, no items of noncompliance or deviation were identified in eight areas and one item of noncompliance was identified in the area of training (failure to document requalification examination reviews - Paragraph 10).

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## DETAILS

### 1. Persons Contacted

#### a. Toledo Edison Company

- +J. P. Williamson, Chairman and Chief Executive Officer
- +o\*R. Crouse, Vice President, Nuclear
- #+oT. Murray, Nuclear Mission Assistant Vice President
  - S. Quennoz, Plant Manager
- o\*W. O'Conner, Operations Engineer
- #+oT. Myers, Nuclear Services Director
  - oD. Briden, Chemist and Health Physicist
- #D. Dean, Performance Enhancement Program Administrator
- o\*D. Lee, Maintenance Engineer
  - oC. Daft, QA Director
- o\*J. Faris, Administrative Coordinator
- \*S. Wise, Senior Reactor Operator
- #+oR. Peters, Licensing Manager
  - \*S. Wideman, Senior Licensing Specialist
- #\*J. Wood, Facility Engineering General Supervisor
- o\*J. Ligenfelter, Technical Engineer
  - +M. Stewart, Nuclear Training Manager
- #J. Syrowski, Nuclear Training Analysis and Evaluation Supervisor
- #L. Zarkesh, Configuration Management Coordinator
- #P. Carr, Engineering Services Manager
- \*E. Caba, Station Performance Engineer
- \*J. Ewald, Facility Engineering
- \*J. Lietzow, Licensing Specialist
- \*J. Byrne, Quality Assurance Auditor

#### b. Cleveland Electric Illuminating Company

- oR. Schuerger, Principal Engineer

#### c. NRC

- +J. Keppler, Administrator, RIII
- +A. Davis, Deputy Administrator, RIII
- +C. Norelius, Director, DRP
- #+oW. Shafer, Branch Chief, DRP
- #+oI. Jackiw, Section, Chief, DRP
  - +B. Burgess, Project Inspector, DRP
- #+oN. Choules, Reactor Inspector, DRS
  - #.J. McMillen, Section Chief, DRS
- +J. Hind, Director, DRSS
- #+o\*W. Rogers, Senior Resident Inspector
- #o\*D. Kosloff, Resident Inspector
  - +A. DeAgazio, Project Manager, NRR

- \*Denotes those attending the March 8, 1985 exit interview.
- oDenotes those attending the February 7, 1985, Regulatory Improvement Program (RIP) meeting.
- #Denotes those attending the February 8, 1985, RIP meeting.
- +Denotes those attending the March 6, 1985, SALP meeting in Region III.

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

## 2. Licensee Action on Previous Inspection Findings

- a. (Open) Open Item (346/84001-02): Use of short-term IE Bulletin 79-14 criteria for operability of hangers and anchors. The short-term criteria is acceptable provided the guidelines stated in the memorandum from R. L. Spessard to C. E. Norelius dated July 13, 1984 are followed. To assess the use of the interim criteria and to inform appropriate regional personnel of its use the licensee committed to inform the resident inspector verbally when the interim criteria is used. Once the licensee incorporates the commitment for notification into the appropriate procedures this item may be closed.
- b. (Closed) Noncompliance (346/82015-01): Lack of calibration of hydrometers and rotometers. This area was inspected during the 1984 QA inspection (IER 84-09) and proper control was being maintained on these types of equipment.
- c. (Closed) Open Item (346/81016-03): Cracked auxiliary building drain piping. The portion of the drain piping exhibiting cracks has been replaced. The inspector observed portions of the new piping.
- d. (Closed) Open Item (346/84004-04): Reporting to the resident inspector when a steam generator thermocouple fails. As a result of initial NRC reviews and discussion with regional management there is no need to continue to report thermocouple failures to the resident inspector. The overall question of whether the steam generator shell differential temperature indication performs a safety function will be reviewed under NUREG-0737 action plan item 1.D.1.
- e. (Closed) Unresolved Item (346/84001-03): Determination as to whether the No. 2 train Steam and Feedwater Rupture Control System's differential pressure switches should be protected as vital equipment under the security plan. Based upon a review conducted by the NRC and discussion with regional security personnel, these switches are not required to be protected as vital equipment, and this item is closed.
- f. (Closed) Noncompliance (346/82031-02): Failure to return the backfill surrounding a fire protection pipe to its original specification after maintenance. The inspector observed portions

of the backfill restoration in comparison to the required specification with no problems noted. The inspector has not observed this type of violation previously and A.D.1844.00, Maintenance, provides proper guidance in this area. This item is considered closed.

- g. (Closed) Noncompliance (346/83001-06): Inadequate control of drawings located at the radwaste panel in the auxiliary building. The inspector reviewed all the drawings located at the panel versus the most current index of revisions and drawing change notices and noted no discrepancies. Through discussion with licensee personnel the inspector verified that a person with access to the auxiliary building was responsible for keeping the radwaste panel drawings current. Based on these reviews, this item is considered closed. However, during the review of the drawings the inspector noted that P&ID M-009, M-010B, M-024B and M-033 had field change notices attached that modified drawing change notices denoting the as-built condition of the facility. The inspector discussed this practice with the Facility Engineering General Supervisor who concurred that this practice was not conducive to quick and easy understanding of the drawings. The Supervisor stated that the procedures would be changed to prohibit this practice in the future. This is considered an open item (346/85004-01) which will be closed based upon the appropriate procedure changes being made and the issuance of new drawing change notices encompassing the information contained on the original drawing change notices and the field change notices for P&IDs M-009, M-010B, M-024B and M-033.
- h. (Closed) Open Item (346/84006-05): Licensee review of IEB 79-24 response. The licensee reviewed the response and provided the inspector with an update of those actions taken to address the freeze protection concerns presented in the bulletin. This item is considered closed.
- i. (Closed) Noncompliance (346/84015-01A): Failure to follow procedures and ensure operability of the Control Room Emergency Ventilation System. One of the corrective actions the licensee stated would be performed in response to the item of noncompliance was to have a licensed senior operator review maintenance work orders for operability as applicable and insure proper post-maintenance testing. This review was incorporated into AD 1844.00, Maintenance. However, the written direction in AD 1844.00 was not clear with respect to the operability review. The licensee committed to clarify this operability review at the next revision to AD 1844.00. This is considered an open item (346/85004-02) pending the procedure modification.

- j. (Closed) Noncompliance (346/84015-01B): Failure to recognize that a maintenance activity rendered the Diesel Generator inoperable. The inspector ascertained through interview and unit log review that the startup feedwater pump suction valve was shut immediately after it was discovered open. A "Do Not Operate" tag was subsequently hung on the valve. The inspector verified that the matter was discussed with all personnel involved and with all licensed shift personnel. The inspector verified that AD 1839.00, Station Operations had been modified to require a licensed senior operator to N/A and initial the appropriate procedural steps and verify that all completed steps were signed.
- k. (Open) Unresolved (346/84028-03): Water seepage in the Miscellaneous Waste Monitoring Tank room. The licensee evaluated the seepage and determined the water source to be ground water which presented no danger to safety-related components. The inspector will submit the analysis to the appropriate regional personnel for their review. Closure of this item will be contingent upon the regional review.
- l. (Closed) Unresolved Item (346/84019-08): Installation of lead shielding on safety-related piping without performing a 10 CFR 50.59 evaluation. Item of noncompliance 346/84015-02 was issued concerning this item.
- m. (Closed) Unresolved Item (346/84004-01): Adequate prioritization of maintenance activities associated with implementation of the Torrey Pines study on motor operated valves. The inspector reviewed the licensee's actions during the 1984 refueling outage and determined that the facility changes necessitated by the study were properly planned and sequenced in the outage schedule.
- n. (Closed) Open Item (346/84028-08): Engineering review of lubricants used on threaded fasteners. The licensee has completed this review and the inspector reviewed the evaluation.
- o. (Closed) Unresolved Item (346/84007-06): Analysis concerning the number of vacuum breakers required to be in service to maintain containment integrity. The analysis was performed and concluded that two vacuum breakers could be out of service and still maintain containment integrity given the worst conditions. The licensee placed procedural requirements in the plant startup procedure that all vacuum breakers must be in service at the time of startup and ST 5099.02, Daily Instrument Checks, was modified to include verification that the minimum required vacuum breakers are in service.

### 3. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine

that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

(Closed) LER 83-18, Rev. 1, Loss of one source range indication due to a cut cable.

(Closed) LER 83-45 and Rev. 1, Loss of essential 120 VAC bus Y1 caused by a technician shorting leads.

(Closed) LER 82-08 and Rev. 1, Emergency ventilation system pressure transmitter failed due to ice buildup. The long term corrective action associated with this LER remains to be performed. The long term corrective action is implementation of facility change request (FCR) 84-206. An open item (346/85004-03) shall remain in effect until this FCR is implemented.

(Closed) LER 83-04, Jumper left in control circuit for DH12. One corrective action remains to be performed. This action is implementation of FCR 82-168. An open item (346/85004-04) shall remain in effect until this FCR is implemented.

(Closed) LER 82-09, Negative pressure boundary door 107 found blocked open. One corrective action remains to be performed. This action is implementation of FCR 78-309. An open item (346/85004-05) shall remain in effect until this FCR is implemented.

(Closed) LER 82-61, Fire doors 509 and 512 had improper fire rating labels. One corrective action remains to be performed. This action is implementation of FCR 83-09. An open item (346/85004-06) shall remain in effect until this FCR is implemented.

(Closed) LER 80-88, Inadvertent actuation of the safety features actuation system. An underlying question as to whether the common electrical return between channels 1/3 and 2/4 meet IEEE Standard 279-1971 was brought about by the event reported in this LER. The IEEE Standard question remains open pending NRR review of the electrical configuration. The resolution of this review and any corrective actions necessitated by the review shall be considered open item (346/85004-07).

(Closed) LER 83-08, Three station batteries found inoperable. One corrective action remains to be performed. This action is implementation of FCR 82-29. An open item (346/85004-08) shall remain in effect until the FCR is implemented.

(Closed) LER 84-12, Rev. 1 and Rev. 2, Inoperable fire barrier penetration into channel 2 cabinet of the reactor protection system. Revision 2 to the LER changed the cause code to a personnel error.

(Closed) LER 83-19, Steam and feedwater rupture control system channel 3 power supply failure. The licensee considered a vendor analysis of the power supply unnecessary. Revision 1 to the LER reflected this decision.

(Closed) LER 83-60, Failure of containment isolation valves CV5071, CV5090 and CV5070.

#### 4. Operational Safety Verification

The inspectors observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the month of February. The inspectors verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the auxiliary and turbine buildings were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance. The inspectors by observation and direct interview verified that the physical security plan was being implemented in accordance with the station security plan.

The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the month of February, the inspectors walked down the accessible portions of the Emergency Diesel Generator and High Voltage (4160KV) Electrical systems to verify operability.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

No items of noncompliance or deviation were identified.

#### 5. Monthly Maintenance Observation

Station maintenance activities of safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

The following maintenance activities were observed/reviewed:

Maintenance of the #2's emergency diesel generator (EDG) governor  
Replacement of an auxiliary feedwater (AFW) steam supply piping  
snubber

Following completion of maintenance on the EDG and AFW systems, the inspector verified that these systems had been returned to service properly.

No items of noncompliance or deviations were identified.

6. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the Safety Features Actuation System (SFAS), ST 5031.01, SFAS Monthly Test and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector also witnessed portions of the following test activities:

ST 5044.01, Inspection of safety-related hydraulic snubbers  
ST 5081.01, Diesel generator monthly test

No items of noncompliance or deviations were identified.

7. Followup on Operational Events

On February 19, 1985 at 1506, control rod 2-3 dropped into the core. The failure that caused the dropped rod was a loose connector in the control rod drive mechanism transfer switch. The connector was relatched and the rod withdrawn from the core to its group average.

On February 19, 1985 at 2057, control rod 7-12 dropped into the core. No failure mechanism was determined. The rod was withdrawn from the core to its group average.

On February 20, 1985 at 1316, control rod 1-3 dropped into the core. The failure that caused the dropped rod was a melted connector in the control rod drive mechanism transfer switch. The connector was repaired and the rod withdrawn from the core to its group average.

After each of the three dropped rod occurrences the inspector verified the appropriate action statements were adhered to and the shutdown margin was calculated.

On February 25, 1985, a leaking seal injection filter flange caused a 24 gallon per minute leak in the seal injection to the reactor coolant pumps portion of the makeup and purification system. Seal injection was isolated, the filter was taken out of service and the standby filter was placed into service. Seal injection was returned to the reactor coolant pumps 12 minutes after the leak started. The leak caused a reduction in the makeup tank level and did not affect pressurizer level. No degradation of reactor coolant seal performance was observed due to the loss of seal injection.

No items of noncompliance or deviation were identified.

8. IE Bulletin Followup

For the IE Bulletins listed below the inspector verified that the written response was within the time period stated in the bulletin, that the written response included the information required to be reported, that the written response included adequate corrective action commitments based on information presentation in the bulletin and the licensee's response, that licensee management forwarded copies of the written response to the appropriate onsite management representatives, that information discussed in the licensee's written response was accurate, and that corrective action taken by the licensee was as described in the written response.

(Closed) IEB 83-02, Stress Corrosion Cracking In Large-Diameter Stainless Steel Recirculation System Piping at BWR Plants

No items of noncompliance or deviation were identified.

9. Management Meetings

On February 7 and 8 the NRC met with the licensee to discuss the status of the RIP action plans.

On March 6 the licensee met with NRC personnel in the Region III office and made a presentation of their SALP response.

10. Training

The inspector conducted a followup inspection of the training department with respect to the Performance Appraisal (PAT) findings delineated in Inspection Report 50-346/84019 and the licensee's response dated December 14, 1984. The inspection included a review of training department procedures, attendance at various training lectures, conduct of interviews with members of the training, operations and maintenance departments and review of exams, exam masters and exam results from the Spring and Summer cycle of 1984.

In the area of operator training the following PAT deficiencies were inspected to ascertain the current status and to determine the adequacy of the licensee's corrective actions:

- 1.a (Closed) Staffing of the Nuclear Operation Training Department has increased from two full time permanent employees to five full time permanent employees. A total of ten full time positions have been authorized. Of the remaining five positions to be filled, one position was staffed temporarily by a licensed member of the operations department and two positions were awaiting the acceptance of a formal offer from the licensee.
- 1.b (Closed) Self-study time has been reduced from 3 days to 1.5 days. An internal memorandum from the Supervisor-Nuclear Operations Training to the Operations Department outlined the subjects and information to be reviewed during self-study sessions.
- 1.c (Closed) Contractor training lesson plans were reviewed by the Supervisor-Nuclear Operations Training to ensure that the appropriate content (i.e., plant specific information) was contained within each lesson plan. Development and review of each lesson plan had been proceduralized with duties and responsibilities of each participant of the development and review process outlined.
- 2.a (Closed) The Master Training Schedule for 1985 had scheduled examinations for alternate Fridays, with a different examination given each Friday, thereby limiting the risk of compromise.
- 2.b (Closed) Review of the summer 1984 examinations by the inspector revealed that the operator exam was not more difficult than the senior operator exam. The use of multiple choice and true/false questions in the senior operator exams is a recent practice of the training department and appeared to make the senior operator exam easier. However, results of the grading of the senior operator exams indicated some difficulty in answering by the senior operators due to unfamiliarity with questions of this type.
- 2.c (Closed) All examinations from the Spring and Summer 1984 exam cycles had been reviewed by the Supervisor-Nuclear Operations Training to ensure consistent grading criteria was utilized. In addition, the inspector reviewed selected exams from the same exam cycles and was unable to find significant grading disparities.
- 2.d (Closed) Unresolved Item (346/84019-22): The inspector followed the licensee's investigation as to the lack of documentation of evaluations for the results of the Spring and Summer 1983 exams. The licensee was unable to produce documentation of an evaluation of the Summer 1983 exam. 10 CFR 55, Appendix A, Paragraph 5 requires that records contain the results of evaluations and documentation of additional training administered in areas in which an operator or senior operator has exhibited deficiencies. Davis-Besse Technical Specifications, Section 6.4, Training, required a training program

that meets or exceeds the requirements and recommendations of Appendix "A" of 10 CFR 55. Failure of the licensee to document the evaluation of the Summer 1983 exams and the additional training performed for deficient areas is an example of an item of non-compliance as delineated in the Appendix (346/85004-09).

Subsequent to the PAT inspection, training department procedures were written and implemented to address the documentation of the evaluation of operator and senior operator exams and the inclusion of identified deficiencies into succeeding lesson plans. The inspector reviewed the appropriate procedures and determined that the noncompliance had been adequately resolved. Consequently, no response to this item of noncompliance is required and the inspector has no further questions regarding this matter.

In the area of non-operator training, the inspector reviewed the following PAT deficiencies to determine the status and adequacy of the licensee's corrective actions:

- 1.a (Closed) The total number of authorized training positions in the training department had increased from 21 to 38. Positions yet to be filled totaled 6 of which 2 positions were awaiting acceptance of formal offers.
- 1.b (Closed) This PAT identified deficiency was identified approximately one year ago. Interviews by the inspector failed to substantiate or refute this deficiency. Due to the lack of objective evidence this item is considered closed.
- 1.c.1 (Closed) With the increase in training staff and the subsequent increase in classroom training, required reading had been reduced. Required reading is still used to disseminate appropriate information on a limited basis.
- 1.c.2 Not inspected during this inspection.
- 2.a (Closed) The inspector was unable to verify or disprove the PAT identified weakness.
- 2.b (Closed) The inspector requested the schedule for the implementation of training improvements referenced in the PAT inspection report. The licensee stated that a formal schedule did not exist and that the schedule referenced in the PAT inspection report was the Action Status List which did provide milestones for completion of program improvements. Of the approximately 105 open open action items with milestones scheduled for completion prior to June, 1986, 34 approximately had been completed.
- 2.c (Closed) This item is adequately answered in the licensee's response dated December 14, 1984.

- 3.a (Closed) Improved management involvement and oversight of training have been accomplished through a reorganization of the training department in which the Training Manager reports directly to the Assistant Vice President-Nuclear and the establishment of the Training Review Board.
- 3.b The Training Oversight and Review Committee was disbanded in September 1984, with the reorganization of the Nuclear Training Department. As a replacement, the Training Review Board has been established which is chaired by the Plant Manager and consists of the Training Manager and supervisors from the various plant departments. The licensee committed to a management level oversight committee to be chaired by the Nuclear Services Director in a letter from R. P. Crouse to C. E. Norelius dated January 13, 1984 responding to noncompliance 50-346/84019-02d. The inspector requested and the licensee agreed to review and determine if the Training Review Board is consistent with their commitment to a management level oversight review committee (Open item 346/85004-10).
- 3.c (Closed) The inspector was unable to verify or disprove this PAT deficiency.
- 4.a, 4.b, 4.c (Open) Job/Task analysis to determine appropriate training for maintenance personnel, I&C personnel, etc., as required by the ANSI standards had been completed but not yet implemented fully in the form of mission wide procedures. Further development of training procedures is an integral part of the PEP program and will be followed in future inspections (Open item 346/85004-11).
- 5.a (Closed) The inspector discussed with the Training Manager the current training mechanism used to retain trainee interest during General Employee Training (GET). The licensee stated the majority of comments received from those who critiqued GET were in favor of the present mechanism which required numerous fill-ins during each subject of the presentation. Due to the subjectiveness of the finding and the overall quality of the GET presentation the inspector determined the current GET is satisfactory.
- 5.b (Closed) The inspector attended the Quality Identification presentation of the newly modified GET. Based on the inclusion the Quality Identification into the GET program, this item is considered closed.

In addition to the above inspection activities, the inspector identified additional weaknesses in the licensee's training programs as follows:

- a. Although the 10 CFR 55, Appendix A, requirement to evaluate SRO and RO exams for deficient areas has been proceduralized, the procedure does not address the method and controls to be used to incorporate evaluation results into subsequent training and is

left up to the discretion of the Supervisor-Nuclear Operations Training. The result of the lack of more stringent procedural controls was the inability to track deficiencies to the appropriate lesson plans as required by 10 CFR 55, Appendix A, Section 5.a. The inspector requested the licensee to review their current practice and to proceduralize where necessary to provide an auditable path from the evaluation results to the lesson plans. This item will remain open pending revision of the appropriate training department procedures (Open item 346/85004-12)

- b. The inspector attended the start of the Shaft Alignment/Vibration Analysis lecture scheduled to start at 7:30 a.m. As of 8:05 a.m., most of the class had not arrived as well as the class instructor indicating a lackadaisical attitude toward training. Although quality of non-operator training has improved, additional emphasis is needed to assure personnel and instructors are prompt in their attendance at scheduled training, thereby contributing to a functional training program and increased respect by trainees toward the training department (Open item 346/85004-13).
- c. The Nuclear Support Training Supervisor is currently responsible for Security Mechanical, Electrical, I&C, Chemistry & Health Physics, General Employee and Professional Development training. The magnitude of the job responsibilities clearly constrain the Nuclear Support Training Supervisor. The inspector was informed of a new position under consideration to remove the maintenance training responsibilities from the Nuclear Support Training Supervisor and place all maintenance training under a maintenance training supervisor. The inspector recommended expediting the posting of this position. The licensee responded that the position had been approved and was to be posted in the near future (Open item 346/85004-14)
- d. Many of the current quality measures in place to resolve many of the previously identified training problems are controlled informally outside of approved administrative or procedural controls by the use of internal memoranda or left up to the responsible supervisor's discretion to implement adequately. Examples are the internal memoranda control over operator self study, lack of procedural control for the implementation of results of evaluations of SRO and RO exams into succeeding lesson plans and lack of policy statements to govern and control various management meetings, i.e., the Training Review Board and the weekly training supervisors meetings.

The inspector requested the licensee to review the training program; identify those areas that are essential to maintain the current quality of the training program and are not presently controlled administratively or procedurally; and, consider their incorporation through the use of policy statements and/or procedural controls. The licensee agreed to review the training program and to provide appropriate administrative and/or procedural controls where necessary as determined by the licensee (Open item 346/85004-15).

11. Open Items

Open items are matters which have been discussed with the licensee, which will be reviewed further by the inspectors, and which involve some action on the the part of the NRC or licensee or both. Open items disclosed during the inspection are discussed in paragraphs 2 and 3.

12. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection on March 8, 1985, and summarized the scope and findings of the inspection activities. The licensee acknowledged the findings. During the exit the inspector discussed IE Information Notice 84-48, Failure of Rockwell International Globe Valves, and requested the licensee to ascertain the status of their review of the information notice. The licensee provided the requested information after the exit and the inspector determined that the information notice was not applicable to the Davis-Besse site. After discussions with the licensee, the inspectors have determined that there is no proprietary data contained in this inspection report.