U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Report No. 50-346/88027(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 Nuclear Power Station, Unit 1

Inspection At: Davis-Besse Site, Oak Harbor, Ohio

Inspection Conducted: May 4 through September 2, 1988

Inspector: RWD for J. W. McCormick-Barger 9/12/88
Date

Approved By: Robert W. DeFayette, Chief 9/12/88
Reactor Projects, Section 3A Date

Inspection Summary

Inspection on May 4, through September 2, 1988 (Report No. 50-346/88027(DRP))
Areas Inspected: Special, unannounced safety inspection with regard to an allegation related to the operation of the Davis-Besse facility.
Results: One violation of the requirements of 10 CFR 50.7 was identified (Paragraph 2).

DETAILS

1. Persons Contacted

Toledo Edison Company (TED)

*D. Shelton, Vice President, Nuclear
*L. Storz, Plant Manager
*L. Ramsett, Quality Assurance Director
*T. Myers, Nuclear Licensing Director
*P. Hildebrandt, Engineering General Director
*R. Schrauder, Nuclear Licensing Manager
*M. O'Riley, Corporate Attorney
D. Harris, Quality Systems Manager
L. Wade, Quality Control Manager
C. Daft, Technical Planning Superintendent
S. Honma, Compliance Supervisor - Licensing

Other TED employee's were contacted during this inspection.

NRC

*P. M. Byron, Senior Resident Inspector
D. C. Kosloff, Resident Inspector
R. W. DeFayette, Chief, Section 3A, Branch 3, DRP
*J. W. McCormick-Barger, Reactor Inspector, Branch 3, DRP

*Denotes those persons present at exit meeting on September 1, 1988.

2. Allegation Review

Allegation RIII-88-A-0067 (Closed): The QC Manager refused to sign a Potential Condition Adverse to Quality Report (PCAQR) written by a QC inspector regarding a discrepancy in a Maintenance Work Order (MWO) for a Raychem insulation splice rework activity. Instead, the QC manager allegedly worked out the resolution with Engineering Department personnel. The QC inspector wrote a letter to the QA Director concerning the incident. A short time later the inspector was terminated during a layoff even though the inspector's supervisor had allegedly not listed him for release.

NRC Review: From a detailed review of records and interviews with plant personnel the following activities were found to have occurred concerning the above case.

Improper Invalidation of a PCAQR

On July 10, 1986 a Quality Control (QC) inspector wrote a PCAQR describing a concern he had with MWO-1-86-0991-04. This concern dealt with a Raychem environmentally qualified heatshrink tubing application on an electrical termination associated with the motor operator on the pressurizer liquid phase sample valve RC 239B. The concern was with the apparent conflict

between engineering specification E-302A Sheet 39Q, Revision 1, detail No. 3, which showed only an inline Raychem bolted connection for use in the containment, and the stub type connection that was specified in the MWO. The inspector was also concerned that the bolt, used to make the stub type connection was not ground flush with the associated nut prior to applying the heatshrink tubing. The engineering specification, described above, required the bolt to be ground flush for the inline connection, but the MWO package did not provide any guidance for the bolt length of the stub type connection.

On July 10, 1986, the QC inspector also completed QC checklist No. 86-E-421 for the MWO in question and indicated on the checklist that check point No. 3.21.3, "Raychem tubing has been installed per engineering instructions referenced on the MWO", was unsatisfactory. A note at the back of the checklist indicated that a PCAQR had been initiated.

From discussions with plant personnel and the QC inspector, the NRC inspector determined that the QC inspector delivered the PCAQR to the QC Manager for his signature prior to it being processed per Toledo Edison Company procedure, NMP-QA-702, Revision 1, dated May 25, 1986, "Potential Condition Adverse to Quality Reporting". Approximately five days after giving the PCAQR to the QC Manager, it was returned to the QC inspector with the following statement written on it:

> "Invalidate - Action committed in LER on Raychem problem identifies the requirement to change E-302A to coincide with the Raychem sketch - The revisions are currently in process".

The above statement was signed by a Quality Assurance Supervisor on July 15, 1986. The QC checklist described above also had a statement in Section 4.0 "Remarks," written just below the note indicating that a PCAQR was initiated, that stated "PCAQR not issued." This statement was signed by the QC Manager on July 14, 1986. The Quality Department's handling of this PCAQR was not in accordance with the licensee's procedure, NMP-QA-702 (described above) in that the PCAQR should have been forwarded to the Shift Supervisor and eventually to the PCAQR Review Board for its final review and approval of the supervisor's decision to invalidate the PCAQR. This is an unresolved item that will be addressed in a future inspection report (346/88027-03).

After receiving the invalidated PCAQR the QC inspector took no further action until he was asked by the new QC Manager about three months later (early October) to revise his Inspection Checklist for the subject MWO.

NOTE: The QC Manager in charge when the PCAQR was initially written was replaced by a new QC Manager (in October 1986) prior to the "new" QC Manager's request that the QC inspector revise his Inspection Checklist. However, it has been alleged that the new QC Manager was directly responsible for the invalidation of the PCAQR. Although the new QC Manager's involvement is documented in a memorandum from the QC inspector to him dated October 10, 1986 (see below), he did not recall any involvement with the PCAQR in question until early October 1986.

After receiving the request to revise the QC checklist, the QC inspector issued a revised checklist approving the Raychem installation and prepared a surveillance/inspection report dated October 8, 1986, which stated in part that his concerns as documented in the PCAQR remained the same. On October 9, 1986, the new QC Manager wrote a memorandum to the QC inspector asking him to reevaluate the PCAQR issues and reply with a specific description of his concerns no later than October 10, 1986. The QA Director was put on distribution for this memorandum. On October 10, 1986, the QC inspector prepared a memorandum in response to the QC manager's request, expressing his dissatisfaction with the way his PCAQR had been invalidated, and explaining his concerns with the MWO in question. This memorandum had the same distribution as the memorandum sent by the QC Manager to the QC inspector except that the Toledo Edison Senior Vice President - Nuclear was also placed on distribution.

To resolve the QC inspector's concern, the QC Manager directed him to initiate another PCAQR. The QC inspector prepared PCAQR No. 86-492, dated October 12, 1986, describing his concern about the bolt not being ground flush with the nut. The QC inspector's other concern about the conflict between the engineering specification and the MWO concerning the type of connection allowed had been previously resolved (at least in the QC inspectors mind) because the use of an MWO to specify Raychem splice rework other than that allowed by the specification was a procedurally approved method. The NRC inspector's review of the method engineering used to specify the Raychem application revealed that plant design procedures may not have been followed. Resolution of this concern will be reviewed at a later date and is considerd an unresolved item (50-346/88027-02).

The licensee invalidated the second PCAQR in accordance with plant procedures because the bolt length documented as being used in the installation (1/2 inch long) is the approved maximum bolt length specified by Raychem for the stub connection specified in the MWO. Since the maximum bolt length was not specified in the MWO, the NRC inspector verified that the Raychem specification allowed use of a 1/2" bolt without grinding.

Employment Discrimination

Shortly before the new QC manager asked the QC inspector to reevaluate the PCAQR issues (October 9, 1986), the manager asked each lead inspector to give him a list indicating the layoff sequence for contract QC inspectors that they supervised. This request was in preparation for an upcoming reduction in force to support an expected reduction in QC inspection activities.

The NRC inspector was informed by the QC inspector's lead inspector that the QC inspector was listed as one of four or five contract inspectors (out of approximately 20) that should not be layed off if possible. The lead inspector stated that he provided this list to the QC manager in late September or early October. The lead inspector informed the NRC that the QC inspector in question was a particularly good inspector who was capable of performing inspections in more than one discipline, making him more valuable to his section than many of the other contract inspectors.

In mid October, after the QC inspector had issued his October 10, 1986 memorandum expressing his dissatisfaction with the way his PCAQR had been invalidated and his concerns with the Raychem splice issue, the lead inspector was informed by the QC manager that he intended to lay off the QC inspector and that the lead inspector was to inform him of the earliest time that the QC inspector would be finished with his current inspection activities. Approximately one week later, the QC manager was informed that the QC inspector had finished his current inspection activities. The QC inspector was layed off a short time thereafter (October 31, 1986).

On October 29, 1986 (two days prior to the QC inspector's layoff), the QA director issued a memorandum to the QC manager criticizing the manager's handling of the QC inspector's Raychem issue and stating that the QC inspector "was proper in his handling of this situation."

The NRC inspector questioned the QA Director, QC Manager, and Corporate Attorney concerning its layoff of the QC inspector. These individuals provided no explanation for its actions other than that it was a "normal reduction in force" action. They stated that Toledo Edison had layed off contract inspectors before and after the layoff in question and provided the NRC inspector with a list of contract inspectors that either quit or were layed off during the September through December 1986 timeframe. The NRC inspector was also provided copies of organizational charts that showed QC staff levels before and after the contract QC inspector's layoff. From a detailed review of this information, the NRC inspector determined that the QC inspector in question was the first inspector from his particular contract and the first inspector in his particular section to be layed off in the September through December 1986 timeframe. In addition, from review of the October 15, 31, and November 18, 1986, organization charts it appeared that the QC inspector was replaced by another QC inspector within two weeks of his layoff. The replacement inspector was moved from another QC section to fill the vacancy left by the QC inspector who was layed off.

Also, the QC inspector's contractor submitted the QC inspector's resume to the QC organization for rehire to support the 1988 refueling outage. Although other QC inspectors that were layed off during the late 1986, or early 1987 timeframe were rehired, the QC inspector in question was not. The QC inspector was not rehired even though his lead inspector highly recommended him and the QA Director wrote a memorandum stating that the QC inspector had acted properly in his handling of the Raychem issue. The QC Manager and QA Director could provide no reason for not rehiring this QC inspector other than that they had decided to hire QC contractors from another lower priced contract organization. However, other previous QC inspectors who were with the same contract organization were offered employment after agreeing to switch to this lower priced contract organization. The QC inspector in question was never provided this option to switch to the lower priced contract organization.

Based on the above review, the NRC has concluded that the QC inspector's layoff is a violation of 10 CFR 50.7 in that the licensee discriminated against the QC inspector (discharged him) for identifying a violation of the PCAQR program and raising potential safety concerns to a level that would ensure an adequate resolution of his concerns (50-346/88027-01).

Conclusion

This allegation was substantiated in that a PCAQR was improperly invalidated and the QC inspector was discriminated against for raising this and other potential safety issues to a level that would ensure an adequate resolution.

This allegation is considered closed.

3. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. Two unresolved items disclosed during this inspection were discussed in Paragraph 2.

4. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection on September 1, 1988, and summarized the scope and findings of the inspection. The inspector also discussed the likely informational content of the inspection report. The licensee acknowledged the information and did not identify any of the information disclosed during the inspection as proprietary.