

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/89015(DRP)

Docket No. 50-346

License No. NPF-3

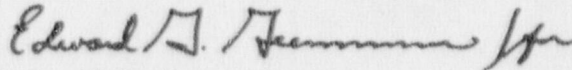
Licensee: Toledo Edison Company
Edison Plaza
300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse Nuclear Power Station, Unit 1

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

Inspection Conducted: June 5-9, 1989

Inspector: J. W. McCormick-Barger



Approved By: Richard C. Knop, Chief
Reactor Projects Branch 3

6-23-89

Date

Inspection Summary

Inspection on June 5-9, 1989 (Report No. 50-346/89015(DRP))

Areas Inspected: Special, unannounced safety inspection with regard to review of an allegation related to the operation of the Davis-Besse facility.

Results: No violations or deviations were identified.

DETAILS

1. Persons Contacted

Toledo Edison Company

- *L. Ramsett, Director, Quality Assurance
- *R. Schrauder, Nuclear Licensing Manager
- *S. Jain, Engineering General Director
- *P. Gaffney, General Supervisor, Design Engineering
- *R. Jarosi, Quality Control Supervisor
- G. Honma, Compliance Supervisor, Licensing

Other plant personnel were contacted during the inspection.

USNRC

- *P. Byron, Senior Resident Inspector
- *D. Kosloff, Resident Inspector
- *K. Walton, Resident Inspector
- *J. McCormick-Barger, Reactor Engineer, RIII

*Denotes those persons present at the exit meeting on June 9, 1989.

2. Allegation Review (92701)

Allegation RIII-89-A-0032 (Closed)

This allegation was received in February 1989 and contained a series of Quality Control related concerns. The following are the potentially safety-related concerns and the results of the inspector's reviews of each of the concerns:

Concern No. 1

The allegor overheard numerous one sided telephone calls where a QC staff member may have waived QC witness/hold points without preparing inspection waiver forms and cross referencing (annotating waiver number) to the applicable document requiring the inspection. The allegor assumed that the inspection requirements were either waived during the document final closure reviews or Potential Condition Adverse to Quality Reports (PCAQRs) were written to document and resolve the inappropriate bypassing of QC inspection witness/hold points. No specific examples of this activity were provided; however, the allegor provided the names of three QC inspectors who also observed this activity.

NRC Review

The inspector reviewed procedures QA-DP-00250, Revision 0, dated August 26, 1988 "Conduct of Quality Control (QC) Department," and QA-DP-00650, Revision 0, dated August 26, 1988 "Inspection of Maintenance

and Modification Activities." These procedures provided the instructions to be followed to waive witness/hold points. The procedures stated that witness/hold points could be waived if circumstances warranted, by filling out a waiver form, including providing proper justification for waiver, obtaining the discipline QC supervisor's review and approval for waiver, and either cross referencing or attaching the form to the QC inspection document.

The inspector contacted the three QC inspectors alleged to have knowledge of this activity and was informed by them that they were not specifically aware of the inappropriate waiver activity. The inspector interviewed two of the QC level III supervisors and several other QC staff members who have reviewed final work packages and was informed that any QC witness/hold points that were not performed during the work would have required either a PCAQR or a waiver form at the time of final QC review of the work packages. A verbal waiver would not have been accepted at the time of final QC review. The QC personnel stated that they were not aware of cases where waivers were granted verbally but not documented.

The inspector contacted the QC inspector alleged to have not documented the waivers. The QC inspector stated that he was given the responsibility to delegate some QC inspection tasks and, as a consequence, waived several inspection points due to lack of QC inspectors during busy times of the outage. The QC inspector stated that when he did waive an inspection, which was not often, he filled out a waiver form and obtained his supervisor's approval.

The inspector reviewed the QC waiver log and found less than 30 waivers initiated in 1988 (from late September through the end of December). Of these waivers, 2 were granted by the QC inspector in question.

Conclusion

This concern was not substantiated. The individuals alleged to have personal knowledge of the inappropriate waiver activity stated that they did not. The licensee's final QC review of work packages would have identified the practice and did not. In addition, the licensee's QC inspection waiver program appears to be acceptable and, based on the relatively low numbers of waivers generated at the end of the outage, the waiver system does not appear to be inappropriately used to bypass inspection requirements. This concern is considered closed.

Concern No. 2

There was not an adequate indexing system that identified QC inspection/review documents with the applicable documents that required QC inspection. Interim storage of QC inspection records did not meet ANSI N45.2.9 requirements.

NRC Review

The inspector reviewed the Inspection Documentation requirements specified in QA-DP-00250, Revision 0, dated September 26, 1988, "Conduct of the Quality Control (QC) Department (10.1)." This procedure provided instruction for the QC inspectors to obtain sequential QC file numbers for each inspection document and to log the file number, the applicable work order number, and the applicable QC inspector's name on the appropriate file index. After completing the inspection, the inspectors were required to file the inspection reports in sequential order in the appropriate files. In addition to this file index system, the NRC inspector was told that the QC department maintained an informal (non-proceduralized) computer data base which was to be continuously updated by each of the QC inspectors. This data base contained the same information that was contained in the file index system and could easily be sorted by the work order number.

QC management stated that not all QC inspectors were diligent about entering data into the computer which resulted in the data base being less effective than it should have been. Because of this, final QC reviews of completed work packages, which required the reviewer to assemble all associated QC records and include them in the completed packages, were more difficult than it could have been. Near the end of the 1988 refuel outage, the QC department performed a review of its QC inspection report indexing system and found approximately 40 QC inspection reports that had not been included in some final completed work packages. These reports were subsequently reviewed and, if acceptable, placed with the completed work package records. Inspection reports with unacceptable findings were reportably reviewed to assure that rework was performed and subsequently reinspected or a PCAQR written. Due to the problem with QC inspectors not inputting all inspections into the computer and/or carefully reviewing the file index system, the QC department now files the inspection reports in a file identified by the applicable MWO number. This solution apparently requires substantially more files than was required previously, but should allow rapid access to the QC inspection reports associated with MWOs during final package review. The licensee is also continuing to maintain the computer data base.

ANSI N45.2.9 requires completed quality records to be stored in, among other things, fireproof file cabinets. The inspector noted that the QC file index system did not include fireproof file cabinets. The licensee stated that they do not consider the QC inspection reports to be completed records until they have been added to the completed work packages and approved by the shift supervisor at which time the records are controlled in accordance with ANSI N45.2.9.

Conclusion

This concern was not substantiated. The licensee's file index system was adequate to identify QC inspection records with the applicable documents that required the inspections. However, the implementation of the system was reportably not effective since approximately 40 QC inspection documents were missed during final reviews of completed work packages. The licensee had taken adequate actions to resolve this problem.

Since the licensee does not consider its QC inspection reports as completed quality records until they become part of the work packages, it does not violate ANSI N45.2.9 requirements during its interim storage of the QC records. This concern is considered closed.

Concern No. 3

PCAQR 88-0799 was written to document that PCAQR dispositions were occasionally being originated and approved by the same individual (a supervisor or section head). The PCAQR was dispositioned that no remedial action was necessary since the intent of the procedure was to have a supervisor or above approve the disposition. The alleged believed that the disposition was inadequate. Since the procedure, which required the PCAQR disposition originator and supervisor or section head to sign the PCAQR, was not followed, the alleged believed training should have been required.

NRC Review

The inspector reviewed PCAQR 88-0799 and Procedure NG-QA-00702, Revision 0, "Potential Condition Adverse to Quality Reporting." As alleged, the licensee's disposition for "Proposed Remedial Action and Justification" was that no actions were required. The reasons provided were 1.) approval signature authority for PCAQRs gets overviewed by the PCAQR review board, Technical Planning (during processing), and QC/QA during closeout verification. The possibility of a PCAQR being approved by one person (not having an independent review) is not considered safety significant since it does receive the additional reviews; 2.) review of the trend data reports since the inception of the PCAQR program shows no instances of problems initiated as a result of improper approval of PCAQRs. The licensee eventually concluded on the PCAQR that all that was needed was a supervisor's signature on the disposition (would only require one signature if the originator was a supervisor) and required that the PCAQR procedure be changed to reflect this philosophy.

The inspector verified that NG-QA-00702, Revision 1, dated March 9, 1989, included the necessary changes to require only one signature if the individual that dispositioned the PCAQR was a supervisor or above.

Conclusion

This concern was not substantiated. Although the licensee did specify no remedial corrective actions for the PCAQR, the NRC inspector found both the licensee's justifications for not performing remedial actions and its corrective action (change the procedure) to adequately resolve the minor procedural problem. This concern is considered closed.

Concern No. 4

A QC inspector identified a discrepancy between the QC procedures and the work control procedures in two memorandums to his supervisor and to other QC management both dated October 5, 1988. The issue concerned

QC's requirement in QC checklist QA-DP-00650-1R1 to verify that a followup MWO number is provided in a completed MWO, when necessary, prior to when the planner is required by its work control procedure to include this information in the package. This issue was identified when an MWO was rejected by QC for not containing a followup MWO number. To the alleged's knowledge, this programmatic concern was never resolved by QC management.

NRC Review

The inspector reviewed the memorandums identified above, procedure AD 1844.02, Revision 3, dated December 11, 1987, and QC checklist QA-DP-00650-1R1. From the inspector's review, it appeared that procedurally the QC inspector was required to verify that a followup MWO is entered (when required) on block 27 of an MWO, prior to when the work control procedure required the planning department to enter a followup MWO in block 27.

The NRC inspector questioned the QC supervisor about the memorandums and associated issue and was informed that the requirement for planning to place a followup MWO in block 27 of the MWO was added to the end of the work control procedure to assure that discrepancies in MWOs that require no QC verification (non-Q packages) were checked by the planner prior to closing MWOs to ensure that a followup MWO was initiated and cross referenced. The supervisor stated that planning was aware that it was supposed to add followup MWOs to the package as soon as one was identified as being needed. Although this requirement was not specifically specified in the work control procedure, step 6.11.2 and 6.11.3 required the planners to review MWOs and resolve any discrepancies prior to delivering them to QC for its final review. The QC supervisor stated that the planning department had been adding followup MWOs to packages for years prior to the QC inspector's memos and that no action other than returning the discrepant MWO back to planning for inclusion of a followup MWO was needed.

The inspector reviewed the current work order procedure DB-PN-00007, Revision 00, dated April 4, 1989 and found it contained essentially the same instructions concerning followup MWOs as the revision in place at the time the memos were written. The inspector discussed the ambiguity of the work control procedure and the QC checklist with the licensee. The licensee stated that, in order to avoid further confusion, it would review the work control procedure and make necessary changes to align its procedure with the QC checklist during its next work control procedure revision.

Conclusion

This concern was substantiated. The licensee had not revised its work control procedure to align it with the QC checklist. However, although the work control procedure did not specifically require the planners to add followup MWO numbers to an MWO until after QC had performed its review, there were no requirements preventing this activity and based

on the information provided by the QC supervisor above, the planners apparently knew of their requirement to provide followup MWO numbers prior to delivering the MWO to QC for its review. Also, steps 6.11.2 and 6.11.3 required that the planners resolve any discrepancies in the MWO, which could be interpreted to include adding followup MWOs when necessary, prior to routing the MWO packages to QC for its review. During the inspection the licensee committed to review its work control procedure and make necessary changes to align it with the subject QC checklist during its next work control procedure revision. This concern does not appear to be safety significant and is considered to be closed.

Concern No. 5

A QC inspector wrote PCAQR 88-0748 to document that the licensee was about to use unapproved setpoint changes in an MWO to be utilized in the event calibrations became necessary while performing a system test. This PCAQR also identified that Request for Assistance (RFA) forms are being used to change design prior to the approval of design change documents. Subsequent to writing the PCAQR, the QC inspector identified a memo, dated October 21, 1988, from the Systems Engineering Manager to the Assistant Plant Manager which appeared to allow activities that the PCAQR concluded were wrong. The QC inspector wrote a memo to QC/QA management notifying them of this discrepancy on October 29, 1988. The allegation is concerned that plant management may not have adequately resolved the QC inspectors concerns identified in the PCAQR.

NRC Review

The inspector reviewed PCAQR 88-0748. This PCAQR identified two different concerns. The first was that Instrument and Control (I&C) Maintenance Engineering issued an MWO that contained instrument setpoints that were to be changed by a design change document, but had not been approved. The licensee agreed with the PCAQR initiator that this was an error and promptly resolved what they characterized as an isolated incident. The second concern was that I&C Maintenance Engineering was utilizing RFAs to make changes to design before design change documents were approved, essentially bypassing all the design controls established to meet NRC regulations. The licensee took exception to this concern arguing that the information identified in the RFAs, provided as examples in the PCAQR, were not changes to design.

The PCAQR disposition stated that plant procedures allowed an RFA to be issued when it was determined that the plant as-built conditions were correct or not determined to be incorrect. Engineering evaluated RFAs and responses would result in the following:

- 1) If the as-built condition was found to be correct, engineering would reference a Document Change Request (DCR) number on the RFA that would update the Instrument Index (lead design document). The RFA would allow I&C maintenance engineering to issue its data package for the applicable instrument possibly prior to the lead design document update approval.

- 2) If the plant instrument setpoint, tolerance, or accuracy was not correct, engineering would document the Setpoint Change Request (SCR) number on the RFA and process it in accordance with plant procedures. I&C maintenance engineering reportedly would not issue its data package until the Design Change was approved.

The inspector met with both design engineering personnel and I&C maintenance engineering personnel to discuss the PCAQR disposition. From these discussions and reviews of the PCAQR and RFAs provided as examples, the inspector learned that the information provided in the RFAs, and determined by the licensee to not constitute a design change, contained information that would not directly affect the operability of an instrument or would change the setpoint or setpoint tolerances utilized in safety analyses.

The information provided in the Systems Engineering Manager's memo dated October 21, 1988, appeared to describe the changes needed to resolve setpoint problems associated with the Steam and Feedwater Rupture Control System (SFRCS). The memo stated that an RFA was generated to request accuracy and reset tolerances for the SFRCS block pressure switches. A DCR was subsequently generated to add the accuracy and reset tolerances to the setpoint index. In addition, a change to the Technical Specification setpoint for the block pressure switches was discussed. The memo stated that a Facility Change Request (FCR) was generated (FCR 87-0116) along with a safety analysis (SE 87-0311) to revise the setpoints. The NRC was reportedly reviewing the FCR, and following NRC approval, the implementation of the FCR would resolve the block pressure setpoint and tolerance problem. The information did not appear to conflict with Davis-Besse procedures or direct actions that would result in violations of Davis-Besse procedures or NRC regulations.

During review of this concern, the licensee informed the NRC inspector that when deficiencies are discovered between as-built conditions in the plant and lead design documents, a PCAQR is written if it is determined that the hardware is installed wrong. However, if it is determined that the deficiency is associated with the drawing and not the as-built condition of the plant, an RFA and subsequently a DCR is written to correct the problem. The NRC is concerned that the RFA/DCR process does not provide a program for determining design document deficiency trending. There may also not be a program for performing root cause analyses and additional reviews of similar areas if trending identified a pervasive problem area. The licensee has been requested in the cover letter to this inspection report to provide a written response to this concern. Followup on this concern will be tracked as an unresolved item (346/89015-01).

Conclusion

This allegation was not substantiated. PCAQR 88-0748 identified two potential concerns. The first was valid, considered isolated, and adequately addressed by the licensee. The second concern was not valid and apparently the result of the QC inspector's misunderstanding of the

licensee definition of design and of its program for using RFAs. The inspector was unable to identify a safety issue with the second concern or with the licensee's resolution of the PCAQR. This concern is considered closed.

Concern No. 6

The allegor does not believe that the methods of determining inspection attributes, as were specified in Davis-Besse procedures, were consistent with the requirements of 10 CFR 50, Appendix B, or ANSI N45.2. The allegor stated that QC inspectors determine the inspection attributes rather than design or QA engineers, or a quality group. The allegor also stated that QC procedures do not specify the percentage of inspections to be conducted but rather specify "an appropriate sample and not 100 percent". The allegor stated that ANSI N45.2 requires inspections.

NRC Review

The inspector reviewed QA-DP-00250, revision 1, dated September 8, 1988, "Conduct of the Quality Control Section (10.1)". This procedure described the plant's method for determining inspection attributes and generally agreed with the allegor's description of the process. From review of the procedure and discussions with QC staff, the inspector learned that work packages were assigned to Level II or above QC planners (QCPs) (who were also QC inspectors). The procedure required these QCP's to review the packages and apply Hold/Witness points per the procedure. Some activities required Hold/Witness points, such as, Quality Class hangers, turbine bypass valves, activities that have been identified as requiring inspections by codes, standards, specifications, and procedures, and activities requested by the Station Management, i.e., critical maintenance activities, items important to post-trip response of the plant, etc. In addition, QA-DP-00250 referenced over 10 QA Division Procedures (QADP's) that also provide guidance to the QCP's for determining inspection attributes. The procedure stated that it was not the intent of the procedure to require QCP's to apply Hold/Witness points to 100% of the Q-list associated MWOs. QA-DP-00250 required the QCPs to consider the following when determining inspection attributes:

- (a) Complexity of design
- (b) Degree of standardization
- (c) Historical experience
- (d) Applicable Code Requirements
- (e) Requirements specified in design documents
- (f) Intended application/importance of Plant Safety/Reliability

The procedure also allowed inspection activities to be initiated by outside groups such as Engineering or Plant Management.

The inspector reviewed 10 CFR 50, Appendix B, and applicable ANSI Standards. ANSI N45.2, "Quality Assurance Program Requirements For Nuclear Facilities," Section 11 "Inspection", requires that "a program for inspection activities affecting quality shall be established and

executed by or for the organization performing the activity to verify conformance to the documented instructions, procedures, and drawings for accomplishing the activity." ANSI N45.2.6 "Qualifications of Inspection, Examination, and Testing Personnel for Nuclear Power Plants", Section 3.3, "Level II Personnel Capabilities" states that a Level II "shall have demonstrated capabilities in planning inspections, examinations, and test". The licensee, through its NRC approved QA manual and implementing procedures, has designated its QC organization as the organization responsible for executing a program for inspection of activities affecting quality. The licensee has also given Level II QC inspectors the primary responsibility for planning inspections including determining the required Hold/Witness points. Providing QC Level II inspectors with this responsibility is, as stated above, in accordance with the required capabilities for a Level II inspector as delineated in ANSI N45.2.6.

Conclusion

This allegation was not substantiated. The methods used by Davis-Besse to determine inspection attributes were determined to comply with NRC regulations and applicable standards. Inspection attributes are generally assigned by QC Level II planners, utilizing design documents, input from plant management, and other input, such as, planner experience gained from identified problem areas. The licensee's program of not necessarily requiring 100% inspection of any particular attribute but rather a sample based on input from various sources, complies with NRC regulations and standards. This concern is considered closed.

Concern No. 7

The allegor stated that during a final QC review of MWO 2-88-0142-04, the QC reviewer signed off the MWO even though two required QC verification sheets (88-VS-IC-352 and 88-VS-I-263) had not been completed. The allegor stated that although QC management was aware of the issue, to his knowledge the oversight was not corrected and a PCAQR was not generated.

NRC Review

The inspector obtained a copy of the subject MWO and determined that PCAQR 88-1011, initiated on November 20, 1988, was issued to identify and resolve the QC reviewer's oversight. The inspector reviewed the PCAQR and found it to adequately address the issue.

Conclusion

This concern was not substantiated. The identified QC oversight was addressed in a PCAQR and adequately resolved by the licensee. This concern is considered closed.

Concern No. 8

A QC inspector initially refused to write a QC inspection report (QCIR) to document his witnessing of a test because he felt the QCIR would represent more than he actually witnessed. Instead, the QC inspector only signed the test indicating that he witnessed the steps required and nothing more. A QA surveillance finding report SFR 88-TESTC-01-01 was written for failure to write a QCIR as required by QC procedures. The QC inspector subsequently wrote the QCIR and documented his and another QC inspector's concern that QC inspectors are required to verify the performance of Surveillance Tests (ST's) and Periodic Test (PT's) even though they were not adequately trained or knowledgeable of the testing processes. The allegor stated that QC managements attempt to rectify this problem in its memo to QC Staff, dated October 27, 1988, was inadequate because it did not include all ST's and PT's such as SC3114.00, and SC3163.00. In addition, the corrective actions for the QA surveillance finding report was inadequate because the QC inspector who initially refused to write the QCIR never attended the required training describing management's attempt to rectify the problem.

NRC Review

The inspector reviewed QA-DP-00352, Revision 0, dated August 28, 1988, "QC Verification of Station Surveillance and Periodic Tests (13.3)". This procedure established QC requirements for inspections of ST's and PT's. The procedure provided, as an option, instructions for the generation of QC inspection plans. The plans would identify the inspection attributes to be inspected. However, QC management stated that they do not generate QC inspection plans. Instead, they require QC inspectors to witness the performance of selected ST's/PT's and verify that plant staff performs the test in accordance with the applicable test procedures. QC management stated that they do not require QC inspectors to be completely knowledgeable of the testing process, but merely verify that plant staff perform the steps specified and obtain the results required in the tests. To resolve an issue concerning lack of QC inspector time to become familiar with PT's/ST's, raised by two QC inspectors in late 1988, QC management generated a memo dated October 27, 1988, that provided a listing of upcoming PT's and ST's and assigned two inspectors to follow each test. These inspectors were to become familiar with the upcoming tests prior to them being performed. The list of PT's/ST's are updated every six months.

The inspector was informed that the two tests identified by the allegor were not PT's or ST's but rather acceptance tests for completed modifications. The licensee stated that the SC tests required QC inspectors to review them just prior to or during performance of the tests and that no special training was required.

The inspector determined that the QC inspector who initially refused to write the QCIR did not receive the required training provided on November 10, 1988 (it was reported to have been his scheduled day off). However, the inspector voluntarily discontinued employment with Davis-Besse on November 19, 1988, (one week prior to his November 25, 1988 lay off date). SFR 88-TESTC-01-01 was not closed until December, 1988. The QC inspector reportably declined to be individually trained just prior to his leaving the site.

Conclusion

This concern was not substantiated. The alieger and the two QC inspectors identified above as having similar concerns apparently assumed that QC's verification of the performance of a PT/ST represented more than was expected by QC management or required by QC procedures. The licensee's efforts to resolve the two QC inspector's concerns about lack of time to become familiar with the tests appeared to have been adequate. The issue concerning the QC inspector not being trained is not safety significant since the identified concern was minor and the QC inspector left the site prior to the licensee closing SFR 88-TESTC-01-01. This concern is considered closed.

Concern No. 9

A contract inspector identified a minor change to the work control procedure. After providing the Procedure Change Request (PCR) to the QC supervisor, the supervisor did not return it to the initiator in a timely manner. After two days, the initiator wrote a memo to the supervisor, requesting that either the supervisor process it or explain why it is not being processed. The supervisor signed and returned the PCR to the QC inspector 3 days after it was initiated. However, the supervisor did not provide a tracking number on the PCR as supposedly required by procedure. The initiator again returned the PCR to the supervisor with a memo requesting that the supervisor add the tracking number to the PCR. The supervisor returned the PCR to the initiator with the tracking number included four days after it was initially originated. The alieger apparently believes this is an example of the QC supervisor's lack of knowledge concerning QC procedures and his reluctance to process identified concerns.

NRC Review

The inspector reviewed DB-DP-0003, "Procedure Preparation and Maintenance". This procedure stated that if an individual identifies a needed correction to a procedure he/she may request a correction of the procedure by filling out a PCR and submitting it to his/her supervisor for concurrence. The procedure stated that "if the supervisor concurs with the request, a Procedure Activity Tracking Number shall be obtained from Systems & Procedures." The PCR is then forwarded to the Division/Department responsible for the procedure change.

The inspector contacted the QC supervisor and was informed that during the time that the PCR was initiated he was very busy and apparently did not review it as timely as the initiator thought he should have. The supervisor stated that after signing and returning the PCR to the initiator, the initiator was again upset that a tracking number was not provided. The supervisor stated that contrary to the initiator's memo, the procedure did not require the supervisor to provide the tracking number. As alleged, the supervisor eventually obtained the tracking number and returned the completed PCR to the initiator (four days after it was originally initiated).

Conclusion

This allegation was not substantiated. The inspector determined that there was no procedural requirement concerning the length of time that a supervisor has for reviewing PCR's. The PCR in question was provided on a Friday morning and signed and returned on the following Monday (three days later). The NRC inspector found, considering that the change was minor (as alleged), that the supervisor's timeliness was adequate. The NRC inspector also determined that, contrary to the initiator's memo, the procedure did not require the supervisor to obtain the tracking number. The inspector concluded that this did not appear to be an example of when a supervisor may not be aware of procedures or was reluctant to process identified concerns. This concern is considered closed.

Concern No. 10

A QC inspector identified to QC management a minor change to QC checklist IC 2701.20, revision 1. A copy of the proposed changes was provided to the NRC. The allegor was concerned that this change may not have ever been processed by QC management.

NRC Review

The inspector contacted the QC supervisor alleged to have been provided the changes to IC 2701.20 by the QC inspector. The supervisor stated that he had initially requested that the QC inspector who identified the discrepancies process the change in accordance with QA-DP-00251, "Preparation, Review, Approval, and Control of QC Inspection Plans (10.2)". Because the QC inspector refused to comply with the request, the supervisor assigned the task to another QC inspector. The second QC inspector began processing the change when he realized that the change was not necessary. This was because the primary reason for the change was that the checklist made reference to old procedure numbers. Since the licensee's procedure cross referencing index contained all the old numbers referenced in the checklist and identified the new procedure numbers and revisions that currently apply, a checklist revision was not necessary. The second QC inspector informed the QC supervisor of this fact and the revision effort was discontinued. The supervisor provided the NRC inspector with the partially completed revision to the checklist, as prepared by the second QC inspector.

The inspector reviewed the copy of the proposed changes to the checklist provided by the allegor. The checklist was used to support inspection activities associated with I & C procedure IC 2701.20, "Instruction for the installation and removal of wire wrapped connections". This procedure had been revised and, in doing so, the procedure number was changed to the new procedure numbering system. Although a significant portion of the checklist change focused around the procedure numbering change, other information in the QC checklist was also wrong due to the revision of the contents of the wire wrap procedure. For example, the referenced procedure step numbers provided with most of the inspection attribute steps in the checklist were wrong due to the wire wrap

procedure change. In addition, some minor technical requirements had changed that would necessitate changes to the checklist. The NRC inspector notified the licensee of this condition and the checklist was subsequently revised.

Conclusion

This concern was substantiated. QC management had not processed the changes identified by the QC inspector because they had improperly concluded that the changes were not needed. The NRC inspector notified the licensee of this oversight during the inspection; the checklist was adequately revised prior to the end of the inspection period. The inspector does not find this oversight to have any safety significance. This concern is considered closed.

Concern No. 11

The allegor believed a named QC supervisor lacked knowledge or experience regarding licensing commitments (i.e. ANSI Standards and 10 CFR 50, Appendix B, etc.).

NRC Review

The inspector reviewed the named QC supervisor's qualifications. The supervisor's qualification records indicated that he had an engineering bachelors degree and ten years of QC experience. The supervisor had been a QC Level III inspector for over six years and was found to meet the ANSI requirements for the certification. The QC supervisor certified and re-certified as a Level III QC inspector by several different QC managers indicating that his qualifications and abilities have been widely accepted.

Conclusion

This issue was not substantiated. Based on the information provided in the QC supervisor's qualification file, and discussions with the QC supervisor throughout the review of this allegation, the inspector determined that the QC supervisor was knowledgeable of licensing commitments. This concern is considered closed.

Concern No. 12

A contract QC inspector who allegedly raised numerous QC department and plant safety concerns, was discharged from employment at Davis-Besse prematurely. The allegor believes this discharge was the direct result of the QC inspector's willingness to speak up regarding unsatisfactory QC program/procedure implementation or personnel actions which appeared to be discriminatory within the QC inspection group. The allegor stated that the reason he believed the QC inspector was prematurely released was because the QC inspector was one of the first laid off during the 1988 fifth refueling outage, where as he was one of the last to be laid

off during previous Davis-Besse outages, unless he had requested otherwise. The alleege provided a number of issues that the QC inspector raised as examples of problems identified. The potential safety-related concerns are identified and discussed in other concerns identified in this allegation.

NRC Review

In addition to reviewing each of the safety-related issues identified in concern numbers 1-11 of this allegation, the NRC inspector requested that the licensee provide its justification for choosing the contract QC inspector in question for lay off at the time they did. Plant management stated that prior to the contract QC inspector's discharge, they were aware of his performance and most if not all of the issues that he raised during his brief time at Davis-Besse. Management was also aware that the contract QC inspector might file a Department of Labor (DOL) employment discrimination complaint based on his perceived premature discharge.

Note: The QC inspector in question did not file a DOL complaint. Management apparently was particularly sensitive to potential employment discrimination complaints due to a past event, and choose to perform a detailed investigation into the circumstances leading up to the contract QC inspector's discharge. Management provided the NRC inspector with a copy of its report of the results of the investigation which included it's justification for the employee's release.

The report and discussions with QC management revealed that there were two primary QC contractor organizations utilized at Davis-Besse during the fifth refueling outage. The QC inspector in question did not belong to either of them. Late in the outage the QC inspector contacted his future Davis-Besse QC supervisor and asked if work was available. Since the QC inspector had worked for Davis-Besse in the past, the QC supervisor knew him personally to be a good inspector, and because of the early departure (prior to the end of the outage) of several of Davis-Besse's prime contractor QC inspectors, which left the QC department short handed during the latter part of the outage, the QC supervisor obtained permission to hire the QC inspector from the non-primary QC contractor. Prior to hiring the QC inspector, the QC supervisor reportably informed the QC inspector and his contractor management that the QC inspector would probably be one of the first inspectors to be released at the end of the contract. The NRC inspector contacted the QC inspector's contract management and verified that they were told the above. The QC inspector was brought in to the QC organization in late August, 1988, placed on second shift, and notified that he would be released on November 25, 1988, reportably when the workload was light and winding down on second shift. Note: the QC inspector voluntarily left the site on November 19, 1988. A total of three electrical and/or I&C inspectors were released with the first group in late November, and two other electrical/I&C inspectors were released in a second group on December 9, 1988.

Prior to releasing contract QC inspectors, the licensee established release criteria for electrical/I&C QC inspectors in an internal memorandum that was reported to have been agreed to by the QA Director, QC manager, and a

corporate lawyer. The lay off memo, written by the QC inspectors supervisor and sent to the QC manager, stated that the supervisor had reviewed the Plan-of-The-Day (POD) and concluded that the work load was dropping and recommended the lay off of three inspectors. The layoff's were to come in the following order; 1) personnel requesting layoff, 2) personnel brought in late in the outage to supplement the primary QC contractors, 3) personnel brought in to help with paperwork closeout, and 4) by job performance of personnel not covered by the before mentioned three criteria. The recommendation was for the layoffs to occur on either November 18 or 25, 1988. The licensee concluded that the QC inspector in question fell within criteria 2 and 3 and resulted in him being released in the first group. The investigation report also stated that the QC inspector's performance was not better than those individuals kept and that even if the QC inspector had no disagreements with QC management, he would have been released. The report also stated that the QC inspector's performance was not as good as those kept and provided several examples to support its contention.

The QC supervisor stated that he had presented the QC inspector's performance issues to Toledo Edison's legal department for its advice. The legal department stated that the supervisor had legitimate grounds to discharge the contract QC inspector based on the provided information. However, because of the possibility that the action might have had an outward appearance to have been due to the QC inspector raising safety issues, QC Management decided not to take action, but rather wait until the work slacked off and discharge him in accordance with its end-of-outage layoff criteria.

Conclusion

This concern was not substantiated. From review of the information provided above, it appeared that the contract QC inspector was appropriately discharged in accordance with reasonable end-of-outage layoff criteria. All safety-related issues reported to have been raised by the QC inspector appeared to have been adequately addressed by Davis-Besse Management. There did not appear to be any discriminatory actions taken as a result of issues identified by the QC inspector.

Davis-Besse Management performed an investigation to assure that its management did not discriminate against the employee. This investigation concluded that employment discrimination did not occur. In addition, QC Management may have had justification for discharging the employee earlier and choose not to, to avoid the appearance of employment discrimination based on 10 CFR 50.7. This concern is considered closed.

Additional Concerns

In addition to the above concerns, the NRC inadvertently identified two potential concerns. The first potential concern related to a QC inspector exceeding a Technical Specification (TS) administrative limit (TS 6.2.3) which does not permit a worker to work more than 72 hours in

any seven-day period without obtaining authorization from the Plant Manager or higher. The TS limit applied to "facility staff who perform safety-related functions; e.g., senior reactor operators, reactor operators, health physicists, auxiliary operators, and key maintenance personnel."

The issue concerned a QC inspector who worked 82 hours in a seven day period. The QA Director informed the NRC inspector that Davis-Besse's position is TS 6.2.3 does not apply to QC inspectors (ie., QC inspectors do not perform safety-related functions; they verify the performance of safety-related functions).

The specific case occurred when a QC inspector was called in during an outage on his day off without his QC supervisor being made aware of the call in. Although Davis-Besse did not consider its QC inspectors to fall under TS 6.2.3., it did have a non-TS administrative limit that disallowed QC inspectors to exceed a 72 hour work week. The specific incident resulted in the QC Manager writing a memo to the QA Director explaining the inadvertent violation of its non-TS administrative limit.

The NRC inspector reviewed the above information and had no further concern in this area.

The second concern related to QC Management not formally responding to a QC inspector's memos describing potential safety and programmatic concerns. The inspector reviewed the memos (many described in the preceding concerns) and found no safety-related issues that were not adequately covered in other documents, such as PCRs or PCAQRs or found, after further review, not to be safety significant.

The NRC inspector discussed this issue with the QC inspector's supervisor and was told that the supervisor was very busy during the time frame and only responded verbally to most issues when the QC inspector was available. The supervisor stated that the QC inspector in question was raising a different issue nearly every day or so, and would not usually accept the supervisor's explanations for resolution of the concerns. Based on the NRC inspector's review of the memo's, the actions taken by management to resolve some of the issues, and the supervisor's explanations for other issues, the inspector has concluded that the QC inspector's issues received appropriate management attention. The inspector has no further concern in this area.

No violations of NRC requirements were identified.

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. An unresolved item disclosed during the inspection is discussed in Paragraph 2.

4. Exit Interview (30703)

The inspector met with licensee representatives (denoted in Paragraph 1) on June 9, 1989, and summarized the purpose, scope, and findings of the inspection. The inspector discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any such documents or processes as proprietary.