# April 19, 2001

MEMORANDUM TO:	Susan Frant, Deputy Director Licensing and Inspection Directorate Spent Fuel Project Office, NMSS				
THRU:	Michael Tokar, Chief /RA/ Transportation and Storage Safety and Inspection Section Spent Fuel Project Office, NMSS				
FROM:	Thomas Matula, Safety Inspection Engineer /RA/ Transportation and Storage Safety and Inspection Section Spent Fuel Project Office, NMSS				
SUBJECT:	TRIP REPORT - OBSERVATION OF NUCLEAR PROCUREMENT ISSUES COMMITTEE/DRY STORAGE QUALITY GROUP AUDIT AT HI TECH MANUFACTURING				

On February 26 - March 2, 2001, staff observed an audit conducted by the Nuclear Procurement Issues Committee (NUPIC)/Dry Storage Quality Group (DSQG) at Hi Tech Manufacturing (HTM), which is located in Greensboro, North Carolina. The DSQG conducted the audit to verify the adequacy of the HTM quality assurance (QA) program and its implementation to safety related work being performed for the nuclear industry and to determine compliance with the requirements of 10 CFR Part 72, Subpart G.

# Audit Background

On February 6, 2001, the DSQG Audit Team Leader formally notified HTM of the audit. The eight-person DSQG audit team was comprised of two auditors from Consumers Energy, one auditor from Nuclear Management Corporation, two auditors and one Technical Specialist from Entergy, and two Technical Specialists from Sargent and Lundy. Each auditor was certified under their respective utility's 10 CFR Part 50, Appendix B, QA program as being qualified to perform audits and the Technical Specialists received indoctrination training from the Audit Team Leader. HTM is currently under contract to fabricate various safety-related components for use at independent fuel storage installations in accordance with the requirements of 10 CFR Part 72. HTM does not possess an NRC-approved QA program. However, HTM is required by contracts to fabricate these components under a QA program that meets the requirements of Subpart G of 10 CFR Part 72.

# Audit Findings

The audit team identified four findings: Finding 1 - One instance where required nondestructive examinations were not performed; Finding 2 - One instance where an unspecified weld was made; Finding 3 - Four instances of inadequate procedures; and Finding 4 - One instance where a measuring tool was out of calibration.

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