

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
799 ROOSEVELT ROAD
GLEN ELLYN, ILLINOIS 60137

CENTRAL FILES

JUL 12 1976

Iowa Electric Light and Power
Company
ATTN: Mr. Duane Arnold
President
Security Building
P. O. Box 351
Cedar Rapids, Iowa 52406

Docket No. 50-331

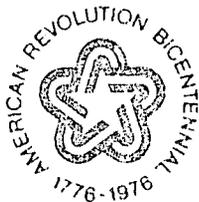
Gentlemen:

This refers to the inspection conducted by Messrs. H. B. Kister and R. C. Knop of this office on June 9-11 and 15, 1976, of activities at the Duane Arnold Energy Center authorized by NRC Operating License No. DPR-49 and to the discussion of our findings with Mr. Hunt and his staff at the conclusion of the inspection.

The enclosed copy of our inspection report identifies areas examined during the inspection. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations, and interviews with personnel.

During this inspection, certain of your activities appeared to be in noncompliance with NRC requirements, as described under Enforcement Items in the Summary of Findings section of the enclosed inspection report.

This notice is sent to you pursuant to the provisions of Section 2.201 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations. Section 2.201 requires you to submit to this office within twenty days of your receipt of this notice a written statement or explanation in reply, including for each item of noncompliance: (1) corrective action taken and the results achieved; (2) corrective action to be taken to avoid further noncompliance; and (3) the date when full compliance will be achieved.



JUL 12 1976

Certain other activities, set forth under Other Significant Items in the Summary of Findings section of the enclosed inspection report, appear to be deviations from commitments which you have made in previous correspondence with the Commission. Please advise us in writing within twenty days of the corrective action you have taken or plan to take, showing the estimated date of completion with regard to these deviations.

Noncompliance identified through your management control system and corrected in a timely manner is described under Other Significant Items in the Summary of Findings section of the attached inspection report. We have no further questions regarding this matter at this time.

On June 15, 1976, Messrs. Knop and Kister met with Mr. Lee Liu and his Quality Assurance Department staff at your corporate office to discuss the findings of our inspection of the Duane Arnold Energy Center Operating Quality Assurance Program. At the conclusion of the conference, Mr. Liu agreed to provide a formal response to the inspector's concerns delineated in the corporate management interview section of the inspection report. Your response should include your planned actions and estimated completion dates where applicable.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this notice, the enclosed inspection report, and your response to this notice will be placed in the NRC's Public Document Room, except as follows. If this report contains information that you or your contractors believe to be proprietary, you must apply in writing to this office, within twenty days of your receipt of this notice, to withhold such information from public disclosure. The application must include a full statement of the reasons for which the information is considered proprietary, and should be prepared so that proprietary information identified in the application is contained in an enclosure to the application.

Iowa Electric Light and
Power Company

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JUL 12 1976

We will gladly discuss any questions you have concerning this inspection.

Sincerely yours,

Gaston Fiorelli, Chief
Reactor Operations and
Nuclear Support Branch

Enclosure:
IE Inspection Report
No. 050-331/76-15

cc w/encl:
Mr. G. G. Hunt
Chief Engineer

bcc w/encl:
Central Files
PDR
Local PDR
NSIC
TIC
IE Mail and File Unit

UNITED STATES NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT

REGION III

Report of Operations Inspection

IE Inspection Report No. 050-331/76-15

Licensee: Iowa Electric Light & Power Company
Security Building
P. O. Box 357
Cedar Rapids, Iowa 52406

Duane Arnold Energy Center
Palo, Iowa

License No. DPR-49
Category: C

Type of Licensee: BWR (GE) 538 MWe
Type of Inspection: Routine, Unannounced
Dates of Inspection: June 9-11 and 15, 1976

Principal Inspector: *H. B. Kister*
H. B. Kister

7-9-76
(Date)

Accompanying Inspectors: None

Other Accompanying Personnel: *RC Knop*
R. C. Knop
(June 15, 1976, only)

Reviewed By: *RC Knop*
R. C. Knop, Chief
Reactor Projects
Section No. 1

7-12-76
(Date)

SUMMARY OF FINDINGS

Inspection Summary

Inspection on June 9-11 and 15, 1976 (76-15): Review of Plant Operations, Plant Startup after refueling outage, Reportable Events, and Quality Assurance Audits. Four items of noncompliance were identified relating to failure to adhere to operating procedures, failure to perform surveillance, and failure to perform the required Quality Assurance Audits.

Enforcement Items

A. Violations

None.

B. Infractions

1. Contrary to Technical Specifications, Section 6.8.1, the licensee failed to adhere to plant operating procedures as follows:
 - a. Certain items of the plant Prestartup Master Checklist were not complied with during the startup after refueling in April 1976. (Paragraph 3, Report Details)
 - b. Contrary to Operating Instruction (OI) 53, the sodium pentaborate tank sparging valve (V-24-11) was found unlocked. (Paragraph 2.b., Report Details)
2. Contrary to Technical Specifications, Table 4.1-1, functional testing of the APRM Flow Bias was not performed within the specified frequency prior to startup on April 15, 1976. (Paragraph 3.f., Report Details)
3. Contrary to 10 CFR 50, Appendix B, Criterion V, the licensee failed to adhere to the Administrative Control procedure for Jumper and Lifted Lead Control (ACP 1404.6) in that on May 3, 1976 the leads to a Main Steam Line High Temperature sensor were lifted without proper documentation in the Jumper and Lifted Lead Log Book. (Paragraph 2.a.(1), Report Details)

C. Deficiencies

Contrary to 10 CFR, Part 50, Appendix B, Criterion V, the licensee failed to adhere to Quality Assurance Directive 1318.2, paragraph 5.1 in that audits of corrective actions (QAd 1316.1) and Plant Investigations and Reporting Activities (QAD 1316.2) have not been performed as required. (Paragraph 6.b(3), Report Details)

Licensee Action of Previously Identified Enforcement Items

None identified.

Other Significant Findings

A. Systems and Components

None.

B. Facility Items (Plans and Procedures)

The plant is presently operating at 80 per cent power which is the maximum power obtainable due to Technical Specification operating limits for MCPR. The licensee has submitted a proposed change to the Technical Specifications to relax the MCPR operating limits.

C. Managerial Items

The licensee has instituted an operator training program for the purpose of affecting an increase in the number of licensed operators by six senior licenses and four operator licenses. The classroom portion began on June 7, 1976. The inspector noted that the Reactor and Plant Performance Engineer, the Maintenance Superintendent, and the Technical Engineer are in attendance as candidates for senior licenses. Although the above personnel are in training at the station and are available if needed, the inspector considers their absence an added burden on the already minimal plant staff.

D. Noncompliance Identified and Corrected by Licensee

1. Contrary to ACP 1414.6, Jumper and Lifted Lead Control;

- a. The Rod Sequence Control System was found to be inoperable due to an unauthorized jumper.
- b. A Main Steam Line High Temperature Sensor was bypassed without proper documentation and approval. (Paragraphs 4.c. and 4.e., Report Details)

E. Deviations

Contrary to the Duane Arnold Final Safety Analysis Report, Appendix D, Amendment 7 and Amendment 10;

1. The licensee failed to conduct quality assurance audits in the prescribed areas at least twice per year. (Paragraph 6.b(1), Report Details)

2. The licensee failed to prepare Quality Assurance Directives for all the subjects listed in the FSAR. (Paragraph 6.c(1), Report Details)
3. The licensee failed to include planned audits for several subjects committed to in the FSAR. (Paragraph 6.b(2), Report Details)

F. Status of Previously Reported Unresolved Items

None.

Management Interview

Site

At the conclusion of the inspection at the site, a management interview was conducted with Mr. Hunt and his staff. The following matters were discussed:

- A. The inspector summarized his review of plant operations and noted one item of noncompliance related to jumper and lifted lead control. The inspector also noted the need for review of the old jumpers and lifted leads that have been installed since 1974. (Paragraph 2.a(2), Report Details)
- B. The inspector summarized his review of the plant startup after refueling, noting several examples where the Prestartup Master Checklists were not adhered to. The inspector further noted that these examples represented failure to follow operating procedures and would be considered as items of noncompliance. The inspector also stated that the functional test of the APRM Flow Bias network had not been performed prior to startup which is in noncompliance with the Technical Specification frequency. (Paragraph 3, Report Details)
- C. The inspector summarized the results of his plant tour noting that cleanup of contaminated material from the recent refueling outage remains to be done. The inspector also stated that during inspection of the Standby Liquid Control System it was noted that the sodium pentaborate tank sparging valve (V-24-11) was not locked shut as required by Operating Instruction (OI) 53. Based on this example and examples noted during review of the startup checklists for locked valves, the inspector requested and obtained a commitment to check the status of all locked valves. (Paragraph 2.b., Report Details)
- D. The inspector summarized his review of reportable occurrences and stated that the improper installation of jumpers and lifted leads

related to the RSCS (76-28) and MSL Hi Temperature Sensor (76-32) will be considered as items of noncompliance identified and corrected by the licensee, therefore, no response to these items will be necessary. The inspector also stated the corrective actions related to the diesel generator fires (76-12 and 76-21) were considered acceptable noting that continued attention in this area will be necessary to insure further problems do not occur. (Paragraph 4, Report Details)

- E. The inspector stated that he had reviewed the circumstances surrounding the removal of a main steam line high temperature instrument channel from service on May 3, 1976. The instrument channel had tripped due to high temperature in the steam line tunnel and had caused a one-half group one containment isolation signal. The inspector further stated that this item would be left open pending review of the Licensee Event Report. (Paragraph 5, Report Details)

Corporate Office

A management interview was conducted at the corporate office on June 15, 1976 with regard to Quality Assurance Auditing and the effectiveness of the Quality Assurance Program at DAEC. Persons in attendance were:

- L. Liu, Vice President, Engineering
- G. Cook, Quality Assurance Manager
- D. Gembler, Quality Assurance Supervisor
- R. Rinderman, Quality Supervisor, DAEC
- R. C. Knop, Nuclear Regulatory Commission
- H. B. Kister, Nuclear Regulatory Commission

The following matters were discussed:

- A. Conflicts between Quality Assurance documents and the FSAR regarding audit frequency.
- B. Audit performance, corrective actions, and effectiveness of audits.
- C. Scope of audits and areas subject to audit.
- D. Program for quality assurance training, training responsibilities.
- E. Vendor Audit Program.
- F. Quality Assurance Program Assessment.

The inspectors summarized their concerns and requested the licensee to review their Quality Assurance Program with special attention to the following areas:

1. Scope of audits including those areas not presently being reviewed.
2. Review the audits and ensure that the findings and recommendations are adequately defining the problems and proper corrective actions are being developed to solve the problems.
3. Provide a quality assurance training program which includes all personnel with quality assurance responsibilities.
4. Provide a visible evaluation of the program effectiveness including indicators of quality trends. Evaluation of unfavorable trends should specify corrective actions on a generic basis.

In conclusion, it is the inspector's understanding that the licensee will provide a formal response to items 1 through 4 above. (Paragraph 6, Report Details)

REPORT DETAILS

1. Persons Contacted

Site

G. G. Hunt, Chief Engineer
E. Hammond, Assistant Chief Engineer
B. York, Operations Supervisor
D. Mineck, Shift Supervising Engineer
R. Zook, Shift Supervising Engineer
D. Kalavatinos, Training Coordinator
J. Vinqvist, Electrical Maintenance Supervisor
R. Rinderman, Quality Supervisor

Corporate

L. Liu, Vice President, Engineering
H. Rehrauer, Supervisor, Project Engineering; and Chairman, Safety Committee
G. Cook, Quality Assurance Manager
D. Gemblar, Quality Assurance Supervisor

2. Plant Operations

The inspector reviewed selected areas of plant operations. Included was a review of control room and supervisor logs, operating orders, jumper and lifted lead control, deviation reports, control room manning, hold-off log (caution and tag out), control room operations, and a tour of selected areas of the plant. Resultant comments are as follows:

- a. A review of the jumper and lifted lead control log resulted in two items of concern:
 - (1) On May 3, 1976, a main steam line high temperature sensing element was bypassed by lifting the lead and installing a resistor in the circuit (see Paragraph 5 for a discussion of the event). The Administrative Control Procedure for jumpers and lifted leads (ACP 1404.6) requires that a jumper and lifted lead clearance form be filled out and authorized, and an entry made in the jumper and lifted lead log. A review of the clearance forms and log was conducted, and the inspector noted that no log entry was made or clearance form initiated. The licensee stated that some confusion existed as to whether this event fell under the requirements of the ACP. The licensee

further stated that any misunderstanding would be clarified, and in the future bypasses of this type will be controlled as required by ACP 1404.6. The inspector stated that this event represented failure to adhere to Administrative Control Procedures and would be included as an item of noncompliance.

- (2) The inspector noted that several outstanding entries in the jumper and lifted lead log dated back to 1974. Two examples are 499-74, which concerns RCIC Suction Pressure instruments, and 315-74, which concerns a lifted lead in Panel 1C 04 involving the operation of RCIC system valves. In response to the inspector's inquiry, the licensee stated that he would review all old outstanding jumpers and lifted leads and take action to purge out these that are unnecessary.
- b. During the plant tour the inspector observed that the Standby Liquid Control Sodium Pentaborate Tank Sparging valve (V-24-11) was not locked closed. The valve was closed, however, its locking chain had been removed and was observed hanging from the adjacent pipe. The operating procedure (OI-53) requires the valve be closed and locked. The condition was brought to the attention of the operators, and the valve was locked closed. The inspector informed the licensee that failure to adhere to the operating procedure would be included as an item of non-compliance.

The inspector also noted that there were several temporary contaminated storage areas located around the reactor buildings with equipment and material remaining from the outage that had the potential for a housekeeping problem. The licensee stated that these areas had represented a low priority just after the outage, however, efforts were beginning to clean up the areas.

- c. The inspector observed control room operations and noted that manning was in accordance with Technical Specifications. No significant alarms were noted to be activated.
- d. The inspector reviewed water chemistry records from April 2, 1976 through June 8, 1976 and noted that analysis frequencies and water quality were within the Technical Specification requirements. Radiochemistry records for the same time period were also reviewed for fuel performance trends. The iodine level at the beginning of the period were low, as would be expected after a refueling, however, an increase by a factor of greater than 1000 was noted during the shutdown beginning on May 19, 1976,

due to residual buildup in the vessel when the Reactor Water Cleanup System was not in service, which suggested indications of some pin hole leaks of a minor nature. No Technical Specification limits were approached. The licensee is monitoring operations in an effort to pinpoint the source and develop an information base for continuing analysis.

3. Plant Startup after Refueling

The inspector reviewed facility records pertaining to the plant startup after the refueling which was conducted in March and April, 1976. Included in the review was status of systems prior to startup, surveillance testing, availability of control rod withdrawal sequence and proper rod withdrawal authorization. The above was accomplished reviews of the Prestartup Master Checklist and Systems Master Checklist package. The review resulted in the identification of several discrepancies, examples are as follows:

- a. The Prestartup and Systems Master Checklists, Table II.E.1 and II.E.3, specify time limits for individual item sign offs. The inspector observed several items which had been signed off in excess of the 60 hours prior to startup time specified, such as Table II.E.3, Item 20, R.B. H&V, signed off April 10, 1976, Item 24, SBL signed off April 10, 1976, and Item 36, ESW signed off April 9, 1976. Actual startup was April 15, 1976 which was essentially 120 hours later. The licensee stated that the times had been formulated in the original issue of the procedure and were unrealistic in many cases. The inspector stated that the procedure should be changed if there is justification.
- b. The procedures require that if there are exceptions to the requirements the exceptions will be noted on the back of the checklists including reasons. Almost all the checklists reviewed had exceptions, however, none had been noted and justified on the reverse side. An example was Table II.E.1, Item 9, Plant Area Control Checklist, which had many exceptions such as broken locks, hoses through doors, no locks installed, etc. None of the exceptions were noted as required.
- c. Annunciator Checklist, Table II.E.4 required the condition of the alarms to be verified. Those annunciators different from the indicated status were to be circled with exceptions noted. The inspector identified several cases where exceptions were not noted.

- d. Several discrepancies were noted in valve checklists reviewed, including instances where valves that were required to be locked were not locked, errors in valve lists, etc. One case, involving the RHR System (Checklist Table 11.C.57), the RHR Pump minimum flow bypass valves were indicated to be in the open position in lieu of closed as required by the checklist. (The inspector checked panel 1C-03 and noted that the valves were closed as required.) Also, the RHR Pump A&C Discharge valves, V-20-2 and V-20-4, were required to be locked in the open position, however, the checklist had the locked status crossed out. The inspector requested and received a commitment from the licensee to review all locked valves to ensure proper status.
- e. The Containment Integrity Checklist, Table II.E.10, was reviewed, and the inspector noted that the checklist had been signed by the Shift Supervising Engineer certifying that Containment Integrity was satisfactory for startup. However, it was noted that the Tip Penetration Covers under Item 2 had not been signed off. The inspector questioned the licensee regarding the missed sign off. It was finally determined that the description was such that the operators could not identify the covers, and therefore had apparently not checked them. Subsequently the covers were identified and verified intact. The licensee stated that a procedure change would be initiated to better identify the subject covers.
- f. Tables II.E.8 and II.E.13 provide certification that the necessary surveillance tests have been accomplished and the surveillance program is up-to-date prior to placing the mode switch in startup. Selected surveillance tests were reviewed and the inspector noted that the APRM Flow Bias Test (STP 41A018) had been last accomplished on January 28, 1976, prior to shutdown for refueling. The test is required by Technical Specifications to be performed monthly while the system is operating and prior to startup if the test frequency was terminated because of plant shutdown. The functional test was apparently not performed again until April 16, 1976 which was one day after the reactor was taken critical, and was not in compliance with the Startup Checklist or the Technical Specifications. The inspector also noted that the test identified four of the flow units required repair to make them operable which further highlighted the need for functional testing of systems prior to startup. In discussions with the licensee, the inspector

emphasized the importance of thorough review of completed checklists by supervision to ensure completeness and accuracy. In this case, two sets of signatures certified completion of required surveillance testing yet one test had not been accomplished.

The inspector further noted that absence of an experienced surveillance engineer probably contributed to the problem, pointing to the loss of their previous surveillance engineer who had resigned in March.

While reviewing surveillance test frequency requirements, the inspector noted that certain tables do not refer to the table notes that specify frequency variance when the system is inoperable (Table 4.2-A, note 2). The inspector discussed the problem with the licensee who agreed to pursue a change in the Technical Specifications to ensure clarification of these test frequencies which may be deferred if the system is inoperable or not in use.

In summary, the inspector noted that the Startup Checklists in general, were apparently quite thorough and sufficiently adequate, however, (1) they need to be revised and brought up to date, and (2) additional emphasis must be placed on proper execution of the checklist requirements and adequate review by supervision to ensure the information is sufficiently complete and valid. The inspector informed the licensee that failure to adhere to Operating Procedures would be considered as an item of noncompliance.

4. Review of Licensee Event Reports

A review of reporting, corrective actions, licensee review and evaluation and compliance with regulatory requirements was conducted for the following reportable occurrences.

	<u>Event Title</u>	<u>Event Date</u>	<u>Licensee Report Date</u>
a.	50-331/76-12, 1G21 Diesel Generator Exhaust Fire	February 27, 1976	March 26, 1976
b.	50-331/76-21, 1G21 Diesel Generator Exhaust Fire	March 18, 1976	March 30, 1976
c.	50-331/76-28, RSCS System Unauthorized Bypass	April 20, 1976	April 30, 1976

	<u>Event Title</u>	<u>Event Date</u>	<u>Licensee Report Date</u>
d.	50-331/76-31, MSL Hi Temp. Switch Shorted Out	April 27, 1976	May 26, 1976
e.	50-331/76-32, MSL Hi Temp. Switch Bypassed Without Proper Authorization	April 30, 1976	May 27, 1976

The inspector's review included discussions of each event with licensee representatives as required, examination of the report referenced above, and other documents related to the particular areas reviewed.

Items a and b - The inspector examined both diesel generators and noted that the corrective actions specified had been accomplished. It was also noted that the subject insulation had been coated with a special material to prevent oil soaking. Observation of the inspection covers on the front end of the engine confirmed that oil leakage had been essentially stopped. The above corrective actions coupled with the satisfactory implementation of the additional corrective actions specified in the licensee's response^{1/} to Inspection Report No. 050-331/76-05 are considered acceptable and should preclude future similar events.

Items c and e - The inspector reviewed the licensee's corrective actions and no problems were identified. The inspector informed the licensee that the two events would be listed as items of noncompliance identified and corrected by the licensee.

5. Main Steam Line Tunnel High Temperature Problem

The inspector reviewed the circumstances surrounding the removal from service of a MSL high temperature switch (TC 4445) on May 3, 1976, which had tripped due to a high temperature condition in the steam tunnel. The high temperature condition was later diagnosed as a partially closed ventilation damper.

^{1/} IEL&P ltrs dtd 4/20/76 and 6/3/76.

In summary, the switch is one out of sixteen provided by design, four for each trip system, two of four which are the minimum required to be operable by Technical Specifications. The plant had been experiencing abnormally high temperatures in the steam tunnel since startup after the refueling outage in April, and up to the subject event, had been apparently attributed to insufficient insulation on the main steam isolation valves.

The plant had been slowly increasing power, and at approximately 70%, a high temperature alarm annunciated and caused a one-half group I containment isolation signal. At this time an inspection of the steam tunnel was conducted which verified absence of any significant leaks. Based on the absence of leaks and the fact that the minimum number of operable channels were still available, the assistant chief engineer made the decision to remove the one-half group I signal by bypassing the alarming temperature sensor and reduce the probability of an inadvertent group one isolation pending further investigation of the temperature problem.

Subsequently (approximately six hours later) the Operations Committee met and recommended a reduction in power to reduce the temperature below the set point and removal of the instrument bypass. Power was reduced, the alarm cleared and the bypass was removed. Further investigation of the problem on May 4, 1976 revealed that a ventilation damper was partially closed. The damper was opened fully, and the temperatures in the tunnel returned to normal.

The inspector commented that a more in-depth review of the problem should have been done both prior to the event, since an abnormal condition had been recognized some time earlier, and prior to bypassing the alarm even though it would have meant a reduction of power as was eventually done on recommendation from the Operations Committee.

The inspector further noted that the administrative procedures for jumper and lifted lead control had not been adhered to in that bypass of the subject instrumentation had not been properly documented. The inspector informed the licensee that this would be considered as an item of noncompliance. Also, during the review, the inspector noted that the operating procedures do not provide operator response to a high MSL high temperature alarm and a one-half group I signal, only the full group one isolation is addressed. The inspector commented that proper alarm response procedures would help eliminate the need, in many cases for making impromptu decisions, and provide adequate time for evaluation of the problem. The inspector further commented that ANSI 18.7-1972, paragraph 5.3.3. states that

"procedures for correcting off normal conditions should be developed for those events where system complexity may lead to operator confusion." The licensee agreed to consider developing such procedures.

6. Quality Assurance Audits

The inspector reviewed the Corporate Quality Assurance Audit program and the Plant Quality Audit program. Comments are as follows:

- a. The inspector reviewed the plant quality audits starting with July 1, 1975 through April 30, 1976, and noted that 660 "audits" had been performed. Of interest was the fact that of the 660 audits performed, only 44 required some kind of corrective action, and of those 44 only 6 required formal response. The inspector commented that, based on the non-compliance resulting from NRC audits, it appeared that plant quality audits were not successful in identifying problems. Examples include:
- (1) Four audits conducted in the Emergency Diesel Generator Room in 1975, only ^{2/}one of which identified an oil collection problem^{2/}, and it did not require a formal response.
 - (2) Audits of the HPCI area in August did not identify the potential fire hazards pointed out in the NRC audit of late August 1975.^{3/}
 - (3) An audit in steam tunnel on March 3, 1976 (the same day NRC pointed out a secondary containment problem) did not recognize a secondary containment violation.
 - (4) An audit related to program boundary identified the fact that no safety related list existed, however, no response was required.

The inspector further noted that corrective actions resulting from Reportable Occurrences, NRC noncompliance, and commitments to NRC are not audited or verified as completed. Lack of a follow-up or verification of ^{4/}completion has resulted in commitments to NRC not being met.^{4/}

The inspector informed the licensee that it appeared as though the plant quality auditing program needed to be redirected more toward problem areas.

- 2/ IE Inspection Rpts No. 050-331/75-11, No. 76-05 and RO Rpts No. 75-70, No. 76-12 and No. 76-21.
3/ IE Inspection Rpt No. 050-331/75-13.
4/ IE Inspection Rpt No. 050-331/76-01.

b. The inspector reviewed the Corporate Quality Assurance Audit Program including several audits performed in 1975. Comments are as follows:

- (1) With regard to audit frequency, it was noted that conflicts exist between Amendment 10 to the FSAR, Quality Assurance Directives (QAD) 1318.2 and 118.10, audit guidance. The FSAR and 1318.2 discuss frequencies of twice per year and more, where as the audit guidance in 1118.10 states once per year. A review of the number of actual audits performed identified eighteen that were accomplished once in 1975, four that were not accomplished at all in 1975, and three that were several months past an annual frequency for 1976.
- (2) The inspector reviewed the areas audited and noted that several subjects were not included. Examples are as follows:
 - (a) Audit of Operations Committee and Safety Committee functions (Amendment 10, D1.20.7).
 - (b) Audit of Safety Committee Recommendations (Amendment 7, D1. 3-13).
 - (c) Audit of In Service Inspections, (Appendix D-7-10) ISI was not included in recurring audits, however, it was noted to be covered under nonrecurring audits.
 - (d) Audit of Procedures to ensure inclusion of activities affecting quality (Amendment 7-D1. 7-1).

The inspector considered the above examples, deviations from commitments in the FSAR.

- (3) The inspector also noted that QAD 1318.2, Quality Assurance Audits, paragraph 5.1, requires audits for compliance with all Quality Assurance Directives. Contrary to the above, audits of Corrective Actions (QAD 1316.1) and Plant Investigations and Reporting Activities (QAD 1316.2) apparently have not been performed.
- (4) The inspector reviewed several of the audits performed in 1975. Examples of the inspector's concerns with regard to effectiveness are noted below.
 - (a) Audit Number 61 on plant quality which was performed in October of 1975 essentially found no problems in plant quality with the exception of a lack of a work

inspection program.^{5/} The effectiveness of the plant quality was not addressed in the audit as noted in paragraph 5.a above.

- (b) Audit Number 55 performed in August 1975 on Control of Plant Work did an excellent job of pointing out deficiencies in the Maintenance Action Request system (MARS) relating to lack of review and release of work by the Shift Supervising Engineer, failure to perform or document performance of tests after maintenance, and lack of evidence of supervisor review and sign off of work accomplished. However, under required actions, none of the above findings were properly addressed. (The inspector noted some improvement in Audit Number 75 which was also related to MARS.)
- c. The inspector noted the following additional FSAR commitments that have apparently not been implemented:
 - (1) While reviewing FSAR, Appendix D, Amendment 10, the inspector noted that several of the proposed Quality Assurance Directives listed had apparently not been prepared and incorporated into the Quality Assurance Manual as stated. Examples are Plant Operations Committee, Reporting of Quality Assurance Status Administrative Work Procedures, Reporting 50.59 Changes, Procurement of NDE services. The inspector considered the above deviations from commitments in the FSAR.
 - (2) FSAR commitments regarding quality assurance training, particularly for training of personnel performing quality assurance functions are not being fulfilled. (Training was also discussed in a previous report.^{6/})
- d. In summary, based on the above comments, there appears to be a need to conduct a reassessment of the Quality Assurance Program at DAEC. The inspector's comments and concerns were discussed at a meeting with the Quality Assurance Management on June 15, 1976 at Corporate Office. Refer to the Management Interview section for the subjects discussed. It was the inspector's understanding that, in addition to responding to the noncompliance and deviations, the licensee would also formally respond to those concerns addressed in the management interview section.

^{5/} IE Inspection Rpt No. 050-331/76-01.

^{6/} IE Inspection Rpt No. 050-331/76-01.