Docket No. 50-346

License No. NPF-3

Serial No. 1-488

December 14, 1984

TOLEDO EDISON

RICHARD P. CROUSE
Vice President
Nuclear
(419) 259-5221

Mr. R. C. DeYoung, Director
Office of Inspection & Enforcement
United States Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. DeYoung:

This letter is in response to the Performance Appraisal Inspection 50-346/84-19 (Log No. 1-1037) conducted by Mr. L. J. Callan and members of the Operating Reactor Programs Branch, Office of Inspection and Enforcement, on July 30th, through August 10th, and August 20th, through August 24, 1984, of activities authorized by Nuclear Regulatory Commission (NRC) Operating License NPF-3, for the Davis-Besse Nuclear Power Station, Unit No. 1.

Attachment 1 of this letter addresses, as requested, the actions to be taken to improve the management controls in those areas designated as Category Three. Attachment 1 describes the responses to those Category Three items as identified in the Executive Summary of the report, but will not address those enforcement items to be followed by the NRC Region III office, except where required in Attachment 2 and 3.

Attachment 2 and 3 of this letter address, as requested, the observations made in regards to our procedure control program and the degree of management involvement in certain activities.

Toledo Edison takes exception to certain observations made in the report. However, we find that most observations identified specific weaknesses and we have completed or will be implementing the corrective actions needed to bring about constructive improvements.

Very truly yours,

RPC:SGW:nlf
cc: DB-1 NRC Resident Inspector

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CORRECTIVE ACTION SYSTEMS

Observation:

2. Interviews and the review of DVRs, NRC IE Inspection Reports, and AFRs revealed that extensive weaknesses were identified in the operator and non-operator training programs. Corrective actions taken to resolve these training problems were not being implemented in a timely manner and were not adequate to correct the problems (see Operator Training, Observations 1 and 2; and Non-Operator Training, Observation 1).

Response provided in Operator and Non-Operator Training Sections.

Observation:

3. An apparent significant breakdown in the corrective action system was found. Both high pressure injection (HPI) pumps were rendered inoperable due to a frozen common recirculation line on January 3, 1979. This issue has not been satisfactorily resolved as of August, 1984. The chronology of this issue is provided below.

   a. On January 3, 1979, the HPI common recirculation line froze. The resulting loss of recirculation flow constituted a common mode failure of both trains of HPI since a minimum recirculation flow is required to prevent HPI pump failure during operation against a shutoff head. This is significant at Davis-Besse because the HPI pumps have a shutoff head of approximately 1680 psig, as compared to the typical shutoff head of approximately 2900 psig for HPI pumps at other Babcock and Wilcox (B&W) designed nuclear plants. This means that in certain accident scenarios the Davis-Besse HPI pumps could be actuated at pressures significantly higher than 1680 psig causing extended operation against a shutoff head.

   b. DVR 79-012 was issued on January 3, 1979, regarding the frozen HPI recirculation line. This DVR stated that the HPI pumps were not rendered inoperable. The corrective action taken for this DVR consisted of thawing the line, increasing the thermostat temperature setting for the heat tracing installed, and building a temporary enclosure around the recirculation line. The Station Review Board (SRB) reviewed this DVR on February 6, 1979.

c. DVR 79-048 was issued on March 12, 1979, for the stated reason of "insufficient analysis of pump operability." The corrective action taken as a result of this DVR consisted of notifying the NRC of the event of January 3, 1979; modifying the recirculation line heat tracing to provide redundant and individually controlled freeze protection; and continuing an analysis of HPI pump operability by engineering personnel. The SRB reviewed this DVR on July 22, 1980.

d. As a result of the continued analysis of HPI pump operability referred to in DVR 79-048, the licensee submitted Licensee Event Report (LER) 79-034, dated March 23, 1979. This LER reported the inoperability of both trains of HPI on January 3, 1979. The corrective action as stated in the LER was essentially the same as for DVR 79-048.

e. A supplement to LER 79-034, submitted in April, 1979, provided a safety evaluation, which concluded that although the HPI pumps were rendered technically inoperable on January 3, 1979, they would have performed their intended safety functions. This determination was based, in part, on information provided by the HPI pump vendor who indicated that these pumps could operate against a shutoff head for several minutes with no recirculation flow.

f. FCR 79-308, approved on February 19, 1981, provided long-term corrective action by the installation of an additional HPI pump recirculation line. This additional recirculation line had not been added as of August, 1984.

g. The licensee was notified by B&W PSC 01-81, dated March 25, 1981, of a safety concern relative to the operation of HPI pumps without adequate recirculation flow. Specifically, B&W analysis revealed that operation of HPI pumps without recirculation and against a shutoff head could cause HPI pump failure within 30 seconds. Review of PSC 01-81 by the licensee was completed on March 23, 1983.

This issue was considered to represent a breakdown of the corrective action system in that:

a. DVR 79-012, issued on January 3, 1979, failed to identify that the frozen recirculation line rendered the HPI pumps inoperable.

b. The SRB reviewed DVR 79-012 on February 6, 1979, and apparently failed to recognize the safety significance of this event. It was not until DVR 79-048 was issued on March 12, 1979, more than 2 months after the event occurred, that the safety significance of this issue was realized by the licensee.

c. The SRB did not review DVR 79-048 until July 22, 1980, over a year after it was issued.

d. Personnel interviews and review of records revealed that there was no apparent evaluation of this issue by the Company Nuclear Review Board (CNRB) (see Committee Activities, Observation 8).

e. PSC 01-81 issued by B&W on March 25, 1981, provided additional information on potential HPI pump failure, indicating that damage to an HPI pump could occur after operating against a shutoff head for as little as 30 seconds. Personnel interviews and the review of records revealed that the apparent conflicting information provided by PSC 01-81 and the pump vendor was not reconciled. Personnel interviews additionally revealed that the licensee chose to accept the less conservative pump vendor data without technical justification. The review of this PSC was not completed until May 23, 1983, more than 2 years after it was issued. This is contrary to SERV-002, Babcock and Wilcox/Other Vendor Preliminary Safety Concerns, which requires that a PSC shall be evaluated within 30 days. The apparent failure to evaluate this PSC within the required period of time was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-16).

f. FCR 79-308, for the installation of the additional HPI pump recirculation line was prepared July 30, 1979, approved February 19, 1981, revised April 25, 1984, and had not been implemented as of August, 1984, more than 5½ years after the initiating event.

g. The safety evaluation included as part of the supplement to LER 79-034 appeared to be inadequate. Specifically, a loss of coolant accident caused by a stuck open pressurizer electromatic relief valve (ERV) provided the only basis for the rate of reactor coolant system (RCS) depressurization. Based on the fact that a stuck open ERV results in a relatively rapid RCS depressurization, the safety evaluation concluded that the HPI pumps would perform their required

safety function with a blocked recirculation line for any actual RCS leak. This conclusion does not appear to be justified.

Response:

Observation No. 3, under Corrective Action Systems, is an inaccurate assessment of the High Pressure Injection (HPI) mini-recirculation line freezing problem and the corrective action that was taken by Toledo Edison. An accurate assessment is as follows:

1. On January 3, 1979, the minimum recirculation line was detected to be frozen solid during testing of the HPI pumps.

2. This line froze because of a design deficiency in the class 1E electric heat tracing installation; not because the line did not meet the design criteria for Davis-Besse. The common section of this line was not subject to high or moderate energy pipe breaks, as it operates at the Borated Water Storage Tank (BWST) temperatures and pressures. The line was originally installed as an ASME Section III, Class 3 line, and it was installed Q and Seismic Class 1. During the review of Davis-Besse prior to the issuance of an operating license, it was determined that Valve HV-1556 in the common mini-recirculation line could fail closed. As a result, the air supply to HV-1556 was disconnected, so that no single active failure could fail this flow path.

   Davis-Besse was and is not required to take passive failures on low energy, seismic class I piping systems and, therefore, a redundant recirculation line was not provided or considered necessary.

3. The heat tracing system on this line did have design deficiencies. This heat tracing was installed with two redundant 100% capacity Class 1E channels. Each channel had one temperature element to control the entire channel. An investigation of the cause of line freezing determined that (1) the temperature elements that control the heat tracing were not installed in the proper location, (2) additional heating capacity was required, and (3) two sections of heat tracing with each section having its own temperature controlling element rather than one was needed in each channel. These modifications to the heat tracing system were made per FCR 79-186, Rev. A. These modifications were completed in March, 1981. During the period from 1979 to 1981, the resources at Toledo Edison were prioritized to assure timely completion of TMI-2 related modifications. As a result, the heat trace upgrade work required two years to complete. During this two year period, temporary heating was in place to prevent the refreezing of this line. No freezing occurred during this period.

4. In July, 1979, FCR 79-308 was prepared to provide a totally redundant mini-recirculation line for each HPI pump. This modification was initiated by Toledo Edison to improve the reliability of the HPI system and to reduce the probability of passive or multiple active failures that could cause the plugging of these mini-recirculation lines. At that time, there was no regulatory requirement for a redundant line. The NRC was told that the line was going to be installed, but no commitment was made as to when it would be installed. The observation that it took over five years for Toledo Edison to take corrective action is inaccurate. The permanent corrective action for the defined problem was taken by March, 1981, when the heat tracing problem was corrected.

5. The NRC's observation that Toledo Edison did not evaluate the Preliminary Safety Concern (PSC) 01-81 issued by B&W March 25, 1981, is also incorrect. This PSC did not specifically identify that it only applied to the high head HPI pumps, which are installed at all other B&W plants. However, it did state that a HPI pump could be damaged in approximately 30 seconds without flow through the pump. Toledo Edison had determined this information in the PSC did not apply to Davis-Besse's low head HPI pumps, since previous communication with the pump manufacturer (Hayward Tyler) had verified that the HPI pumps could operate for 10 minutes without any damage. Since plant operating procedures do not require the minimum recirculation flow path to be closed during normal HPI pump testing and the 30 seconds failure time did not apply to our pumps, Toledo Edison concluded that this PSC did not apply to Davis-Besse.

   It should also be noted that Procedure SERV-002, Babcock & Wilcox/Other Vendor Preliminary Safety Concerns, referenced in Observation 3, which required formal documentation of PSC resolution was implemented in December, 1982. Since previously evaluated PSC's were not necessarily documented in a manner consistent with the requirements of SERV-002, a backfitting effort was initiated. The subject PSC documentation was completed in May, 1983. Therefore, it is misleading to state that the evaluation was not completed until two years after the PSC was issued.

6. The inspection report stated that the Safety Evaluation for LER 79-034 appeared to be inadequate, as Toledo Edison had used a stuck open PORV depressurization rate. Breaks much smaller than this even can be handled by our Makeup Systems. Also, plant operating procedures do not require that our HPI pumps be manually started to protect against small break LOCA's. At Davis-Besse, the HPI pumps are automatically started by SFAS

when the RCS pressure decreases below 1650 ± 25 psig. At an RCS pressure of 1675 psig (1650 + 25) an HPI pump will deliver 60 gpm to the RCS, as compared to a required minimum recirculation flow required of 35 gpm.

The only time that the minimum recirculation flow path is required is under the following conditions:

a. The HPI pumps are manually started for testing.

b. The HPI pumps are automatically started and the two HPI containment isolation valves on one pump failed to open.

c. The HPI pumps started properly and then the RCS repressurized above 1700 psig. This repressurization will only occur after very small break LOCA's, where the steam generators are both lost as a heat sink for the RCS.

Observation:

4. The procedure for the timely identification, documentation, and correction of purchase order (PO) discrepancies was weak. The Nuclear Quality Assurance Manual (NQAM) and Quality Control Instruction (QCI) 3150 state that supplier deviation reports provide corrective action coverage for receipt inspection and open PO concerns. However, the discussion in the QCI and the NQAM concern the resolution of supplier-related deficiencies that are identified when the material is received. There is no discussion of the correction of PO discrepancies that were caused by the licensee. Additionally, the Quality Engineering Section had found problems with issued POs and had not identified them to the Purchasing Department for correction (see Procurement, Observation 3).

Response:

Quality Engineering inspects items and reviews supplier documentation against the requirements of the approved request for purchase and the purchase order itself. This eliminates the possibility of any administrative error made by Purchasing in converting the request for purchase into a purchase order causing quality problems in the receipt inspection effort. The SDR referenced in the NQAM and QCI 3150 is the document used to provide corrective actions identified by receipt inspection activities whether they were caused by Toledo Edison departments or by the supplier. However, the SDR is not used to identify minor purchase order discrepancies, which have no affect on the quality attributes of the received item.

The quality related activities of the Procurement Department are monitored by the Operations Quality Assurance Department. The Quality Engineering Department was informally keeping track of Purchasing mistakes in order to assist QA in those Procurement audits. Some of the mistakes identified were documented on SDR's (those that affected quality) while the minor ones were not. QA then uses this information to evaluate the discrepancies and to determine any trend that may be developing. QA includes this information in their Procurement audit and pursues resolution through that process. It should be reiterated that Toledo Edison procedures require that both the request for purchase and the purchase order be used for receipt inspection activities.

OPERATOR TRAINING

Observation:

1. The program for licensed and non-licensed operator training was considered adequate, but implementation was weak. The following deficiencies were noted:

   a. The staffing of the Nuclear Operator Training Department was insufficient. There were four staff positions authorized but only one was filled. This person was responsible for the entire operator training program, both initial and requalification. A second licensed operator had been temporarily assigned to training from operations in May, 1984.

   b. The operations staff was in a six-shift rotation, which allowed 1 week out of every 6 to be devoted to training. Two days of each 5-day training cycle were regularly allotted for lectures. The remaining 3 days were devoted to self-study. Interviews with trainees revealed that these sessions were poorly organized and lacked direction. There were apparently no set goals for the self-study program, nor were there any examinations or other attempts to measure progress achieved during this time. Interviews with operators led the inspection team to conclude that self-study time was largely wasted.

   c. Review of training records indicated that there was a high reliance of contractors to provide lectures for operator training. Interviews revealed that these contractors frequently did not have plant-specific knowledge in the areas in which they lectured. In addition, contractors appeared to receive an inadequate amount of guidance for lecture content. On the basis of interviews with opera-

tors, the inspection team concluded that the operators were generally dissatisfied with the scope and depth of the material presented.

Response:

a. Toledo Edison has increased the number of authorized staff positions to ten. Four of these ten positions have been filled. Although two of the positions were filled from outside Toledo Edison, completion of SRO certification is expected within one year for these two positions. The remaining open positions have been advertised and the personnel selection process has begun.

Toledo Edison is continuing its efforts to achieve adequate staffing in the Nuclear Training Department. These efforts include, among other things, efforts to make training a viable career path for qualified personnel. Toledo Edison also plans to institute a program to develop SRO licensed/certified instructors within the Nuclear Training Department to minimize dependency on Station Operations.

b. The 1985 training schedule allots three days, of the five day training cycle, for lectures. The remaining two days are reserved for self-study.

As adequate staffing is achieved (reference 1.a), efforts will be undertaken to develop and guide a systematic self-study program emphasizing individual study based on each operator's needs.

c. The high reliance on contractors to provide lectures for operator training is a direct result of insufficient staffing (reference 1.a). Two NRC Senior Licensed, B&W plant specific experienced, degreed instructors have been contracted to provide additional assistance in operator training. To assure that the quality of training is maintained, procedures governing lesson plan format/content approval, together with a method for evaluation of the quality of instruction were developed and implemented.

Observation:

2. Deficiencies were found to exist in the implementation of the licensed operator requalification examinations. These deficiencies involved the control, content, and grading of the examinations. The following specific items were noted:

a. The spring 1984 and summer 1984 examinations which took about 4 hours to complete, were given to operators on different shifts over the course of a week, allowing the

possibility of compromise. In both instances, the same examination was given for the entire week. This is contrary to good security practice in the administration of examinations.

b. The degree of difficulty of the examinations was considered to be uneven. For example, the summer 1984, reactor operator (RO) examination appeared noticeably more difficult than the senior reactor operator (SRO) examination. The latter contained many true/false and multiple choice questions which contributed to making it appear easier than the RO examination that consisted primarily of essay questions.

c. There appeared to be inconsistent grading among identical examinations. The NRC inspector reviewed all the spring 1984 and summer 1984 examinations and found many grading anomalies that made the comparison of examination scores difficult. For example, partial credit for the same question was frequently given differently.

d. 10 CFR 55, Appendix A, requires that the requalification lecture series be directed at knowledge weaknesses identified in the annual RO and SRO requalification examination. A review of training records revealed that no analysis of the 1983 RO and SRO examinations had been conducted to determine the content of the 1984 requalification lecture series. An analysis of the 1984 RO and SRO examinations had been conducted, but the results had not been incorporated into the 1984 lecture series at the time of the inspection. Further, the requirement to analyze the requalification examination results had not been proceduralized, nor had the licensee established a methodology for performing the analysis and providing feedback into the lecture series. The apparent failure to base the 1984 requalification lecture series on weaknesses identified in the annual requalification examination will remain unresolved pending follow-up by the Region III Office (346/84-19-22).

Response:

a. Toledo Edison conducted an evaluation of the 1984 examinations and the results indicated no evidence of compromise. To eliminate any potential for compromise during the 1985 requalification exam, a separate exam will be written for each exam day.

b. The spring and summer requalification examinations were contracted to an outside vendor for development and grading due to staffing concerns (see 1.a). The examinations were evaluated and a determination was made by the Nuclear Operations Training Supervisor that, in fact, the RO examination only appeared to be more difficult. This was due to the use of true/false and multiple choice questions on the SRO examination.

The 1985 requalification examinations will be developed by Nuclear Training personnel to ensure a comparable degree of difficulty between the examinations.

c. The spring examinations were re-graded by the Nuclear Operations Training Supervisor, due to apparent anomalies found by the NRC inspector in reviewing those examinations. The summer examinations, however, were reviewed and no grading anomalies were found.

To preclude further anomalies, the 1985 requalification examinations will be graded by Nuclear Training Department personnel to ensure consistent grading between examinations. Added emphasis will be placed on examination "answer guidance" development.

d. An analysis was conducted of both the spring and summer requalification exams. Weaknesses identified from the analysis were incorporated into the remaining 1984 scheduled training for licensed operators. Specifically, Emergency Procedures training was increased from a previously scheduled 16 hours of classroom training, to 56 hours of classroom training coupled with mock-up control room walkdowns. Also, B&W simulator training sessions included 16 hours of classroom training with simulator scenarios written by both B&W and the Nuclear Operations Training Supervisor to ensure a thorough utilization of Emergency and Abnormal procedures. Emergency Plan Training for 1985 will place emphasis on the knowledge weaknesses identified through the examination analysis in this area. Two Training Department procedures, NSP/NT-007, Training Program Implementation, and NSP/NT-008, Training Program Evaluation, have been implemented which proceduralize the analysis of examinations and provide feedback of that analysis into the training programs. The 1985 Requalification Training Schedule has been developed based on knowledge weaknesses identified through the analysis of the 1984 requalification examinations.

NON-OPERATOR TRAINING

Observation:

1. This section covers the training programs for the staff organizations that support plant operations. These organizations include Quality Assurance, Maintenance Engineering, Facility Modifications, Chemistry and Health Physics, and Procurement. Their respective managers were responsible for the establishment and conduct of the training requirements, and the Nuclear Training Department (NTD) provided assistance when requested. The licensee had recently completed a diagnostic analysis of its training program that identified a number of problems. The following items, covered in this analysis, were noted by the inspection team to be weaknesses:

   a. Over the past 2 years, there have been significant shortages in the NTD staffing. There were 21 authorized professional positions in the NTD to support both operator and non-operator training requirements. Of these 21 positions, 8 were vacant, and 4 of these vacancies were in the non-operator training section. Additionally, the position of Nuclear Training Manager had been occupied by five people in the past 3 years. It appeared that these staffing problems degraded non-operator training. In addition, the extent and duration of these staffing problems reflect a lack of management commitment of training.

   b. Personnel interviews revealed that some of the training conducted by the NTD was not plant-specific and consequently was of little value to the students. This was associated primarily with lectures given by support contractors. On one occasion, station personnel walked out of a lecture for the stated reason of poor quality. Interviews with a broad range of personnel revealed a lack of confidence in the NTD making station personnel reluctant to use the NTD assets to support their training.

   c. The training programs developed outside the NTD exhibited the following weaknesses:

      1. There was an excessive reliance on required reading to implement training. Personnel interviews indicated that this technique resulted in superficial understanding of the subject material.

2. The training conducted did not cover all the necessary aspects of the total job requirements. For example, maintenance personnel were not trained on material handling and storage requirements for nuclear safety-related material, yet they were responsible for the care of this material from the time it was issued until it was installed. This training deficiency contributed to the weakness identified with the control of materials in the station (see Procurement, Observation 7).

Response:

a. The number of Nuclear Training Department professional positions has been increased to 38. Of that number, 23 are currently filled by qualified personnel or by personnel undergoing training to acquire the necessary skills to meet the technical instructor and staff qualifications. This includes two of the vacant positions noted during the PAT inspection (Training Instructor - Electrical, and Training Instructor - QA/QC), which have subsequently been filled. Additionally, six offers have been accepted by qualified candidates who have not as yet reported. One of these is the Training Instructor - I&C, which was also noted as a vacant position during the Performance Appraisal Inspection.

The increase in allowable staffing levels has also resulted in the addition of two instructor positions in the non-operator training section. The Training Instructor-GET/Orientation position has been filled by an internal candidate, while the position of Training Instructor - Chemistry & Health Physics has been advertised both internally to the company and externally through various means.

Interviews are continuing in an effort to fill remaining vacant positions and offers of employment will be extended when acceptable candidates are found. Weekly meetings have been conducted between the Employment and Recruiting Manager and the Nuclear Training Manager to expedite efforts to fill these positions.

b. There is no knowledge or record of this occurrence available within the Nuclear Training Department. This comment is considered to be insufficient in detail for any direct response. However, Toledo Edison does recognize the need to consider its use of contractor personnel to support the training effort at Davis-Besse. The incorporation of more stringent and exact specifications for contract services within the Nuclear Training Department purchase order system has been accomplished, detailing the exact Davis-Besse knowledge items required to be taught.

Recently approved Nuclear Tra_ning Department procedures require vendor lesson plans be reviewed and approved prior to the commencement of training classes. Each class is evaluated by both the students and vendor as to the appropriateness of scope and presentation to the student knowledge requirements. With appropriate emphasis placed on the importance of a valid student critique, it will be possible to tailor the courses taught to the students.

c. (1) Although there remains a need for a required reading program to provide information to concerned parties about modifications, revisions to procedures, or administrative guidelines, the impending increase in the Nuclear Training staff should result in decreased reliance on the required reading program.

(2) Job requirements and tasks associated with maintenance activities are presently undergoing a detailed job/task analysis.

Tasks identified that require training are being noted, categorized, and evaluated to determine the most appropriate and effective means for the conduct of training. Tasks that require training for maintenance personnel are then incorporated into the applicable training programs.

Observation:

2. The diagnostic analysis was the basis for a training improvement program that required the involvement of both station and NTD personnel. The program concentrated on the long-term corrective actions and neglected actions necessary to improve the existing training activities in a timely manner. Additionally, allocation of resources to accomplish long-term training improvements could further degrade the ongoing non-operator training efforts as evidenced by the following:

a. The short-term improvement of the training program was the sole responsibility of the non-operator training section. This group, which was understaffed, was also heavily involved with the long-term effort. Consequently, the ongoing training program received very little attention.

b. The first step for improving non-operator training was scheduled for completion in June, 1986. There were no milestones established for the implementation of training improvements before this date.

c. The NTD staff had developed an informal program for implementing improvements into the ongoing training program. However, interviews revealed that this program was constrained by requiring: (1) no change in the scope of training, (2) less than 2 man-days effort to implement, and (3) minimal budgetary impact. No significant changes to ongoing programs have occurred as a result of this informal program.

Response:

a. The ongoing training programs and classes in the non-operator training area have not been overshadowed by the efforts to implement the long term improvement program. Courses have been developed to address specific Station requests and needs. Specifically, courses were developed and presented in the requested areas of valve maintenance, crane operation and repair, motor operated valves, radiation survey equipment, asbestos handling, vibration analysis, and monitoring and containment atmosphere sampling, as well as support for the training requirements associated with the onset and beginning of the fourth refueling outage. Where instructor time has not been available due to either prior commitment or vacant positions, vendor support was solicited.

b. Non-operator training program improvements are being implemented through the use of an Action Status List within the Nuclear Training Department. This lists provides milestones for accomplishing program improvements as they are identified.

c. This comment is based on information taken out of context. The informal program for implementing improvements referenced by this comment was put in place in July, 1984, as a short term measure to address training shortfalls based on Needs Analysis output. Its purpose was to start to make some improvements. The identified items were constrained by the referenced criteria because the output from the Needs Analysis phase was insufficient at that time to warrant major modifications to the scope of training.

In the interim, the "Action Status List", as referenced in 2.c, has been employed in the Nuclear Training Department to track and document activities associated with the correction of identified deficiencies. The "Action Status List" was developed as a management tool for implementing and tracking training program improvements.

Observation:

3. The involvement of management in the training program showed several weaknesses.

   a. The lack of management involvement had been a contributing factor to the degradation of the NTD (see Observations 1.a and 4).

   b. A Training Oversight and Review Committee was established in February, 1984. The committee reported to the Vice President, Nuclear, and was chartered to monitor and provide management direction to the training program. At the time of the inspection, only two meetings had been held and no record of meeting actions were available for review.

   c. Management awareness of the amount of non-operator training was weak. Upper management estimated that 10-15% of the non-operator's time was spent in classroom training. A review of the training record documentation showed, for a sample of 15 personnel, an average of less than 4% of their time was spent in classroom training.

Response:

In September, 1984, the Nuclear Mission underwent a reorganization in which the Nuclear Training Department was placed under the direction of the Assistant Vice President, Nuclear Operations. This reorganization has placed a higher level of management attention on the weaknesses in the Nuclear Training Department.

The members of the Training Oversight and Review Committee consisted of directors in the Nuclear Mission who participated in Vice President staff meetings, Performance Enhancement Program (PEP) Steering Committee, and other higher level management meetings. Although only two meetings were held of the Training Oversight and Review Committee, informal discussions were held regarding the nuclear training program at the above mentioned meeetings. The Training Oversight and Review Committee was disbanded with the reorganization because of the involvement of the Nuclear Training Manager in upper level staff management meetings.

Observation:

4. The licensee procedures on training were weak. There was no written policy guidance from upper management on the subject of training. The Nuclear Training Department Procedures (NSP/NT) attempted to provide direction, but they were limited in their

scope, jurisdiction, and distribution. Some specific weaknesses were:

a. There were no training procedures for the Procurement Division personnel involved with the acquisition and handling of nuclear safety-related material. These personnel were assigned to the Administrative Organization, but required training in accordance with licensee commitments to ANSI standards.

b. Procedure NSP/NT-001, Management and Organization of the Nuclear Training Programs, Revision 0, only addressed the NTD responsibility to support station requirements. The procedure neglected other areas of the nuclear mission such as Quality Assurance and Nuclear Facilities Engineering Division training requirements.

c. Procedure NSP/NT-003, Management of Mission Training Offered Outside the Nuclear Training Department, Revision 0, placed requirements on organizations outside the Nuclear Services Division, but was issued by the Nuclear Services Director. The procedure had no jurisdiction outside the Nuclear Services Division. Additionally, many of the organizations to be governed by this document were not on distribution for the NTD instructions.

Response:

Toledo Edison recognizes that procedures on mission wide training were weak. This was identified in the root cause analysis conducted as part of the Performance Enhancement Program (PEP). The development of mission wide procedures is being evaluated as part of the PEP Program.

Observation:

5. The General Employee Training (GET) Program, which consisted of General Orientation (GLT) and Radiological Controls Training (RCT), had some specific weaknesses.

a. The GET Program was designed to keep student interest by completing workbook fill-ins during an audio visual presentation. This approach was hampered, however, by the excessive number of fill-ins which distracted students from the presentation and caused confusion.

b. The Nuclear Quality Assurance Manual and AD 1807.00, Control of Conditions Adverse to Quality, Revision 9, place a high reliance on the ability of all employees to recognize and identify conditions adverse to quality. There was no coverage of this topic in the GET program.

Response:

a. Toledo Edison feels this observation is somewhat subjective. However, the General Employee Training (GET) course is being evaluated by the students as per established procedures, including specific references to the student handbook. This evaluation will be completed by February 28, 1985.

b. The GET QA module is being revised to reflect the corporate philosophy on Quality Assurance. This revision will stress the importance of an individual's responsibility to this program, and will address the major concepts of AD 1807.00, Control of Conditions Adverse to Quality. The GET QA module revision will be completed and implemented by February 1, 1985.

END OF ATTACHMENT 1

QUALITY ASSURANCE

Observation:

7. The QA organization does not appear to have adequate procedures to cover certain aspects of their activities. In particular, contrary to Appendix A of Regulatory Guide 1.33, November, 1972, the QA organization had not established administrative procedures covering procedure adherence, the method for implementing temporary changes to procedures, and procedure review and approval policy. Procedures do exist that cover the above topics, but they apply only to the Davis-Besse Station organization and not to support activities such as QA, Nuclear Training, Nuclear Purchasing and Procurement, and Nuclear Facilities Engineering. This apparent failure to establish all the administrative procedures for the QA organization that are required by Regulatory Guide 1.33, November, 1972, will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-05).

Response:

The Performance Appraisal Inspection Report indicates that Davis-Besse Station support organizations do not have all the administrative procedures required by Regulatory Guide 1.33, November, 1972. These procedures are required by the Toledo Edison Nuclear Qualification Assurance Manual to be developed and implemented by organizations performing quality-related activities. These procedures were in place at the time of the Performance Appraisal Inspection and are available for NRC review.

DESIGN CHANGES AND MODIFICATIONS

Observation:

3. Licensee procedures direct that written safety evaluations be conducted for only those modifications that are determined to be "nuclear safety related" as defined in AD 1845.00, Changes, Tests, and Experiments, Revision 6. Therefore, modifications that constitute changes to the facility as described in the safety analysis report, but that are determined not to be "nuclear safety related," are not procedurally required to receive written safety evaluations. This appears to be contrary to the requirements of 10 CFR 50.59(b), which states in part:

   The licensee shall maintain records of changes in the facility..., to the extent that such changes constitute changes to the facility as described in the safety analysis report.... These records shall include a written safety evaluation which provides

the bases for the determination that the change, test or experiment does not involve an unreviewed safety question.

This procedural weakness provides the potential for omission of required written safety evaluations. This item was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-06).

Response:

The processing and control of facility modifications at Davis-Besse are fully intended to meet the requirements of 10 CFR 50.59.

Since receipt of an Operating License in 1977 for Davis-Besse, Toledo Edison has basically used the same process for 10 CFR 50.59 evaluations which was explained in detail with members of the NRC Performance Appraisal Team (PAT).

The evaluation process is accomplished in two steps. First, a safety review is done to determine the safety significance of the modification. Secondly, a "safety evaluation" is performed for those modifications which, as a result of the safety review, are determined to potentially involve an unreviewed safety question. For those modifications which involve an unreviewed safety question, "safety analyses" are performed and submitted to the NRC for concurrence before the modification is made. Handling of unreviewed safety questions was not an issue with the PAT members, however.

The primary concern of the PAT members appeared to be in the form of documentation employed by Toledo Edison in the 10 CFR 50.59 evaluation process.

Toledo Edison considers both the "safety reviews" and the "safety evaluations" performed in accordance with approved procedures as jointly constituting 10 CFR 50.59 evaluations.

Regulation 10 CFR 50.59 makes repeated use of the phrase "as described in the safety analysis report". Safety analysis reports of the Davis-Besse vintage contain (by required format) a significant amount of information relative to non-safety significant systems and components (e.g., circulating water system). A strict literal interpretation of 10 CFR 50.59 would require that a change of any kind to an item detailed or referred in any way in the safety analysis report (e.g., a change to the circulating water system), would require a detailed written safety evaluation. For a plant such as Davis-Besse, this could en-compass essentially all plant changes.

Through the two step "safety review"/"safety evaluation" process, Toledo Edison has attempted to comply with even this strict literal interpretation of 10 CFR 50.59. The process is progressively documented, as the safety significance of the change is evaluated, to determine first the potential for an unreviewed safety question and then whether such a condition actually exists. The procedures, forms, and justifications generated during the process ensure that there is a documented logic trail providing the bases for the determination that the change did or did not involve an unreviewed safety question.

Enhancements of the Toledo Edison safety review/safety evaluation process have been made over time to improve the quality of the reviews and evaluations. The concern cited by the PAT members will be discussed with the NRC Region III office to determine what additional features, if any, need to be incorporated in the process as a result of this observation.

MAINTENANCE

Observation:

1. A review of the control of measuring and test equipment (M&TE) within the mechanical and instrument and control (I&C) maintenance groups was conducted. Personnel interviews and record reviews revealed that both groups have been calibrating M&TE without approved procedures. The mechanical maintenance group was found to be calibrating equipment such as torque wrenches and dial indicators using as guidance U.S. Government (NAVAIR) procedures which were not controlled, reviewed, or issued under the Davis-Besse procedure program. The I&C maintenance group was found to be calibrating pressure gauges, digital multimeters, digital potentio-meters, digital calibrators, and digital temperature indicators without procedural guidance.

   ANSI N18.7-1972, Section 5.3.6, states that procedures shall be provided for calibration of M&TE. The apparent failure to provide the necessary procedures to control the calibration of M&TE was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-09).

Response:

Technical Specification 6.8.1 requires written procedures to be established, implemented, and maintained covering activities referenced in Appendix A of Regulatory Guide 1.33, November, 1972. Regulatory Guide 1.33 requires procedures for the Control of Measuring and Test Equipment, to ensure that such devices are properly

controlled, calibrated, and adjusted at specific periods to maintain accuracy.

Davis-Besse has controlling procedures, AD 1849.00, MP 1410.03, and IC 2100.00, which cover the calibration of Measuring and Test Equipment (M&TE). These procedures have been reviewed and approved by the Station Review Board. Toledo Edison acknowledges "skill of the craft" as defined in Regulatory Guide 1.33, Section 9.2, in performing the calibration of M&TE, and rely upon independent review of the calibration data by two maintenance management personnel to ensure the test equipment is acceptable for use. It is important to control and document the use of test equipment, and plant procedures successfully accomplish that objective.

Observation:

2. Procedure IC 2100.00, Instrument Calibration and Testing Procedure, Revision 11, requires that when a piece of M&TE fails calibration, a list shall be compiled of all equipment calibrated with this defective test equipment, including all surveillances and tests in which it was used. This procedure further requires that a review of this list by the I&C Engineer and Maintenance Engineer be documented and retained. Personnel interviews revealed that when a piece of M&TE failed calibration, evaluations of prior use of such equipment were conducted. There were, however, no records retained of these evaluations. Additionally, Procedure IC 2100.00 did not require that this type of evaluation be conducted for lost or stolen M&TE. This is considered a weakness.

   The apparent failure to retain records of evaluations of prior use of defective M&TE as required by Procedure IC 2100.00 was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-10).

Response:

IC 2100.00, Instrument Calibration and Test Procedure was revised by modification number T-8207, to address the required evaluations for missing (lost or stolen) M&TE. The retention of records for evaluations of defective test equipment is being addressed. A calibration lab is being proposed for the Davis-Besse Station and its operation will enhance recordkeeping for measuring and test equipment.

Observation:

3. The procedures governing the control of vendor manuals were reviewed. These procedures, ENG-003, Vendor Manual Control, dated June 29, 1984, and NFED-040, Vendor Submittals, Revision 0, require that the Engineering Services group review vendor manuals before their use and that these manuals must be controlled by serial number to ensure that necessary changes are made when required. These procedures were considered weak in that they did not require Station Review Board (SRB) review of vendor manuals. The lack of SRB review was of particular concern because vendor manuals were found to be substituted for procedures used to perform safety-related maintenance. The following additional items and examples were noted:

   a. A review of vendor manual control records revealed that only 32 of approximately 1,000 vendor manuals, by title, had been issued as controlled.

   b. A significant number of vendor manuals covering safety-related equipment were available in the maintenance shops. Many of these manuals were found not to be controlled.

   c. Personnel interviews and a review of plant instrumentation calibration records revealed that the vendor manual used for the calibration of LT CF3B2, Core Flooding Tank 1 Level Transmitter, on September 7, 1983, was not a controlled manual.

   d. Personnel interviews and a review of maintenance work orders revealed that the vendor manual used to perform a calibration check of FT 4522, Auxiliary Feed Water Flow Transmitter, on June 25, 1984, was not a controlled manual.

   TS 6.8.1.a requires that procedures be established, implemented, and maintained as recommended in RG 1.33. RG 1.33 recommends that procedures be prepared for maintenance that can affect the performance of safety-related equipment. TS 6.8.2 further requires that all procedures implemented pursuant to TS 6.8.1.a be reviewed by the SRB and approved by the Station Superintendent. The apparent failure to provide the necessary review and control over vendor manuals used to conduct safety-related maintenance was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-11).

Response:

AD 1844.00, Maintenance, Revision 13, now requires all Nuclear Safety Related maintenance to proceed with only approved maintenance procedures, unless the work scope falls under "skill of the craft" as defined in Regulatory Guide 1.33, 1972.

IC 2001.00, Instrument Calibration and Test Procedure, was modified by modification number T-8393 to limit the use of uncontrolled manuals. These "information only" vendor manuals may now only be used to assist in the planning, inspection, and monitoring of conditions for information purposes. No design tolerances, setpoints, settings, measurements should be used, or modifications implemented based on information in uncontrolled manuals unless (1) verification of manual by a supervisory review is conducted prior to use, or (2) it is established through calibration to design criteria, as verified in equipment records, and/or post-maintenance testing will be conducted prior to returning the equipment or system to an operable condition.

PROCUREMENT

Observation:

2. There were inconsistencies with the procedures governing procurement document preparation. The preparation of nuclear safety-related (NSR) purchase requisitions (PRs) and purchase orders (POs) is complex and involved many licensee organizations. The station usually initiates a request for material, the Nuclear Facility Engineering Division (NFED) prepares the material specifications for the PR, Quality Engineering (QE) reviews the PR content, and the Purchasing Department prepares the PO based on the PR. The following weaknesses were identified:

   a. There were five different procedures describing the content of a preformatted data assignment sheet used to identify procurement standards and ASME code requirements for PR preparation. This sheet permitted the coding of lengthy specifications that were stored in the Purchasing Department computer and printed out on the PO. The following procedures discuss the use of the data assignment sheet:

      1. Facility Modification Department Procedure (FMDP) 6040.02, Preparation, Approval and Issuance of Purchase Requisitions, Revision 2

      2. Nuclear Facility Engineering Division Procedures (NFES) 070, Procurement, Revision 0

3. NFES 071, Purchase Requisitions for Spare and Replacement Parts, Revision 0

4. NFES 072, Purchase Requisitions for Engineered Items, Revision 0

5. Procurement Quality Assurance Instruction (PQAI) Section 2, Procurement Document Control, Revision 1

Procedure FMDP 6040.02 differed from the other procedures in the content of the data assignment sheet. The data assignment sheet most often used was not identified by any procedure but was a shortened version of the sheet described in other procedures.

b. There were conflicts in the procedures describing the preparation of General Material Identification Checklists (GMIC). The GMIC is used, in conjunction with the PR and PO, to direct and document the conduct of receipt inspections. Procedures NFES 071 and 072 require the NFED to identify the receipt inspection requirements on the GMIC at the same time the material specifications are prepared for the PR. The PR and GMIC are then approved together by management and QE. However, Quality Control Inspection (QCI) 3070, Receipt Inspection, Revision 10, also permits the receipt inspector to prepare a GMIC at the time of the inspection if there is not one in the procurement package. This allows bypassing the approval circuit and increases the potential for preparation of a second GMIC for the same material that differs from the original requirements developed by the NFED.

Response:

Toledo Edison has identified in the root cause analysis conducted as part of the Performance Enhancement Program that division level procedures governing cross-divisional activities are weak. The development of mission wide procedures is being evaluated as part of the PEP Program.

Observation:

3. The procedure for preparation of a PO was weak. Procedure PQAI, Section 2 provides information on the preparation of the PR but has little guidance for the completion of the PO. Specifically, there is no requirement for the review of the PO content before it is issued to the supplier. There have been instances where the issued PO was different from its corresponding PR. QE does review the PO after it is issued to the supplier. The discrepancies found in the QE review were not reported back to the

Purchasing Department so that the deficient POs could be corrected. (see Corrective Actions, Observation 4).

The Nuclear Quality Assurance Manual (NQAM) states that Toledo Edison complies with ANSI N45.2.13-1976. ANSI N45.2.13-1976 requires that procurement documents be reviewed before they are transmitted to the supplier to ensure the documents are complete and contain the applicable requirements. The failure to review POs before they are issued was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-17).

Response:

The requirement for an ANSI N45.2.13 review of procurement documents prior to transmittal to the supplier is satisfied by Toledo Edison's review of the request for purchase. The purchase order is then developed by Purchasing by including the request for purchase requirements and normal Toledo Edison commercial terms and conditions. As stated in a previous response, both the request for purchase and the purchase order are used in the receipt inspection process. Through the use of both of these documents, Toledo Edison can ensure that the technical and quality requirements are met by the received materials.

To address the Performance Appraisal Team concerns, the procedure for preparation of a purchase order will be revised to require a review of the purchase order by the purchasing buyer to ensure the request for purchase requirements have been incorporated into the purchase order.

Observation:

6. The procedures governing the procurement of NSR replacement parts did not ensure that applicable materials were purchased either the original construction Specifications or acceptable substitute specifications that were evaluated in accordance with ASME Section XI, IWA 7200. The existing guidance, in Exhibit I of both procedure NFES 071 and 072 noted, in the instructions for completing the PR, that "When a 'construction phase' specification is references, list in the 'description' column all modifications necessary to bring the 'construction phase' specification in line with the current operational requirements." This instruction implies that the operational phase requirements were the basis for procurement document specifications. This confusing guidance has contributed to procurement problems in at least the following two instances:

a. Audit Finding Report (AFR) 1110-1, issued October 20, 1983, identified a problem with replacement parts associated with pressurizer code safety relief valves. A particular shipment of parts had been received and installed before it was discovered that they were procured to the wrong ASME code year and addenda without the proper evaluation being conducted. The action taken to resolve this finding was limited to correcting the problems with this particular shipment. The programmatic issues that contributed to the problem were not addressed.

b. Supplier Deviation Report (SDR) 84-0092 identified a problem with the material specifications for TIG welding rod ordered on May 1, 1984. The PO referenced certification to the wrong ASME code year and addenda.

The NQAM states that Toledo Edison complies with the requirements of RG 1.123. RG 1.123 invokes the requirements of ANSI 18.7-1976, Section 5.2.13, for procurement of replacement parts during the operational phase of the nuclear power plant. ANSI 18.71976 requires that procedures be established to ensure that materials are purchased to specifications equivalent to the original specifications or a proper revision. The lack of procedural guidance for procurement of replacement parts to original or acceptable specifications was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-18).

Response:

Toledo Edison agrees that existing procedures governing the procurement of Nuclear Safety Related spare and replacement parts do not specifically address the course of action that the purchase order preparer/reviewer must take to ensure that ASME Section XI requirements are met. Procedures NFES-071, Purchase Requests for Spare and Replacement Parts, and NFES-072, Purchase Requests for Engineered Items, will be revised to address those actions necessary to ensure that ASME Section XI requirements are met. These procedural modification will be completed by February 28, 1985.

Observation:

6. Discrepancies were found between the procedure governing fit testing of respirators and actual practices. These discrepancies were considered to be weaknesses.

a. Procedure HP 1605.02, Revision 11, Respiratory Equipment, included the following:

6.5.1.1 Each individual being certified will be fit tested on each type of respirator available.

6.5.1.2 The fit testing should be quantitative using the respirator fit test system.... The only personnel requiring quantitative fit testing should be permanently assigned Davis-Besse personnel. All other personnel may be qualitatively fit tested per NUREG-0041, Section 8.5.

6.5.1.6 C&HP management personnel shall sign each individual's respiratory protection certification, certifying the individual as far as fit testing is concerned for all respirators for which the individual had an acceptable fit test.

Personnel interviews revealed that quantitative fit testing of respirators had not been used for approximately 3 years. Qualitative fit testing had been performed exclusively during that period. The licensee used one model of air purifying respirator and one model of self-contained breathing apparatus (SCBA). In practice, the type of respirator used was dictated by the type of work planned and the projected airborne radioactivity area, individuals were fit tested qualitatively on the type of respirator selected for use.

b. The licensee had committed to performing qualitative fit tests in accordance with NUREG-0041, Section 8.5. This section requires the individual undergoing respirator fit testing to perform several simulated work activities including "running in place." The licensee's procedure on fit testing was ambiguous regarding this requirement. Section 6.5.1.2 of HP 1605.2 excluded "running in place" as a required movement during fit testing. However, the same section also referenced Attachment 3 which included the requirement for running in place. Licensee representatives stated that the procedure was in error and that fit tests did, in fact, include running in place.

Contrary to Section 6.5.1.6 of HP 1605.02, no records were maintained of the results of qualitative fit tests. Licensee representatives stated that the requirements for fit test records was meant to apply only to quantitative fit tests.

Response:

Major Modification M-7977 to HP 1605.02, Respiratory Equipment, was prepared on October 2, 1984, to address the weaknesses identified in this observation. In order to appreciate the relative significance of the Performance Appraisal Team concerns regarding fit testing, internal dosimetry results at Davis-Besse over the last year indicated that the average personnel internal exposure was 0.0004 of the 10 CFR 20, Appendix B limits for 1900 individuals whole body counted.

Observation:

8. Certain procedures used for analyses of liquid and gaseous effluents had not been reviewed by the Station Review Board as required by Technical Specifications.

Technical Specification 6.8.1 requires that procedures recommended in Appendix A to Regulatory Guide 1.33, November, 1972, be established, implemented, and maintained. Technical Specification 6.8.2 requires that these procedures and changes thereto be reviewed by the Station Review Board and approved by the Station Superintendent. Regulatory Guide 1.33, November, 1972, recommends the preparation of procedures used to determine concentrations and species of radioactivity in liquids and gases prior to release, including representative sampling, validity of calibration techniques, and adequacy of analyses.

Licensee Procedures AD 1850.01, Revision 13, Radioactive Liquid Release, and AD 1850.03, Revision 8, Radioactive Gaseous Release, provide requirements to be met in discharging liquids and gases to unrestricted areas. These procedures and changes thereto had been reviewed by the Station Review Board and approved by the Station Superintendent. Certain other procedures covering analysis of samples to determine concentrations of radionuclides released were referenced in AD 1850.01 and AD 1850.03 and were required to be followed. These procedures included the following:

RC 4502.00	Gamma Spectral Analysis
RC 4504.00	Gross Alpha and Beta-Gamma Activity
RC 4509.00	Tritium Determination
RC 4564.00	Determination of Strontium-89 and Strontium-90
LI 4811.00	Gamma Spectroscopy System

Although these procedures had been approved by the Station Superintendent, none of them had been reviewed by the Station Review Board.

The apparent failure of the Station Review Board to review procedures as specified in TS 6.8.2 was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-21).

Response:

These procedures are covered under a controlling procedure, LI 4782.00, Instrument and Reagent Calibration, which is a Station Review Board (SRB) and Quality Assurance (QA) approved procedure. On November 6, 1984, R. C. Paulus (NRC Washington, D. C.), M. C. Schumacker and D. E. Miller (NRC Region III) contacted D. W. Briden, Chemistry and Health Physicist, Toledo Edison, in a conference telephone call to discuss this issue. Bob Paulus stated it would be non-productive to have all CH, RC, and LI procedures SRB reviewed. Chemical and radiochemistry control procedures do require SRB review, whereas laboratory instructions and lab equipment calibration procedures do not. They concluded that if a document would specifically reference the criteria that the SRB uses to determine Regulatory Guide 1.33, Section 10 compliance, and documentation exists for the decision, then these non-controlling procedures do not need SRB review. This document is being prepared for SRB approval.

END OF ATTACHMENT 2

QUALITY ASSURANCE

Observation:

5. The QA organization performs audits required by TS 6.5.2.8 under the cognizance QA of the Company Nuclear Review Board (CNRB). These audits comprise approximately one-third of all the audits performed by QA.

   Interviews with QA and CNRB personnel and review of audit and CNRB records revealed an apparent lack of CNRB involvement in the audit process. For example, the CNRB does not appear to assure the quality of the QA audit checklists or the technical proficiency of the QA audit teams prior to the performance of audits, as evidenced by the weak audits described in Observation 2. In general, the CNRB performs a passive role with regard to audits, limiting their involvement to a review of audit findings at the conclusion of the audits. In view of the CNRB's TS responsibilities relative to audits performed by QA, this lack of CNRB involvement in the audit process was considered a weakness.

Response:

The Company does not feel that the corporate safety review committee structure and activities must support the detail of involvement in the audit function that is suggested by this observation. The CNRB is not expected to routinely address audit checklist content nor audit team qualifications any more than it would routinely check plant procedure details or specific operating personnel qualifications. However, any of these areas are open for CNRB review should nuclear program performance warrant. Pressing the CNRB to review the details of audit checklists and auditor qualifications would undermine its responsibilities and effectiveness elsewhere. CNRB direct involvement in audit checklists and audit team qualifications is not likely to improve its overall role in nuclear safety overview. The CNRB reviews the QA audit schedule and audit results, and is in a position to suggest audit improvements, if audit results are inadequate.

The Company Performance Enhancement Program (PEP) includes safety review committee activity improvement action plans. Under consideration is the possibility of the CNRB utilizing subcommittees to provide more depth to its activities in areas such as auditing and audit report reviews.

Observation:

6. The degree of management involvement on the QA audit process was weak. Quality Assurance Instructions 4181, Audits, and ANSI N45.2.12-1977 require that management of the audited organization participate in a post-audit conference with the auditing organization. In practice, this requirement was generally met with the lowest level of management allowable. A typical example is the post-audit conference for audit 1162, Nuclear Training, performed during April, 1984, which was attended by the Nuclear Training Manager but not by his supervisor, the Director of Nuclear Services.

   In the case of Audit 1202, Nuclear Licensing, performed during July, 1984, there was no management representation of the post-audit conference. This apparent failure to provide adequate management representation at QA post-audit conferences was discussed with the licensee and will remain unresolved pending follow-up by the NRC Region III Office (346/84-19-04).

Response:

As noted in ANSI N45.2.12, the purpose of the post-audit conference is to present audit findings and clarify misunderstandings. It is Toledo Edison's position that the supervisor's attendance at the post-audit conference is not necessary to accomplish this purpose, provided he is represented at the post-audit conference by individuals knowledgeable in the area being audited. In each of the audits cited in the Performance Appraisal Inspection Report, knowledgeable personnel of the audited area were in attendance at the post-audit conference. It should be further noted that the formal audit report, with any associated findings, is transmitted to supervisory personnel of the area audited. To strengthen Toledo Edison's commitment to the Quality Assurance Program, Toledo Edison management will issue a directive to require, as a minimum, attendance of the direct supervisor of the audited area at the post-audit conference. In addition, when the results of the audit warrant, higher level supervisory personnel will attend the post-audit conference when so requested by Quality Assurance.

OPERATOR & NON-OPERATOR TRAINING

See response to Operator Training - Observation 2, and Non-Operator Training - Observation 3, in Attachment 1.

END OF ATTACHMENT 3