

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/92013(DRP)

Docket No. 50-346

Operating License No. NPF-3

Licensee: Toledo Edison Company  
Edison Plaza, 300 Madison Avenue  
Toledo, O. 43652

Facility Name: Davis-Besse Nuclear Power Station

Inspection At: Oak Harbor, Ohio

Dates: August 4 through September 14, 1992

Inspectors: W. Levis  
R. K. Walton  
J. A. Gavula

Approved By:

  
I. N. Jackiw, Chief  
Reactor Projects Section 3A

9-16-92  
Date

Inspection Summary

Inspection from August 4 through September 14, 1992  
(Report No. 50-346/92013(DRP))

Areas Inspected: Routine safety inspection by resident inspectors of corrective actions on previous findings, licensee event reports followup, plant operations, followup of events, radiological controls, maintenance/surveillance, emergency preparedness, security, engineering and technical support, and safety assessment/quality verification.

Results: No violations of NRC requirements and one unresolved item was identified. An Executive Summary Follows.

Plant Operations: The plant opera. at near full capacity during this period. Operations personnel demonstrated a weakness in configuration control as evidenced by a red tagged valve in the incorrect position. A task force is investigating this and other related events. A training deficiency with respect to inverter operation was demonstrated during a situation which required a transfer of the inverter (Paragraph 4).

Maintenance/Surveillance: A strength was noted in the maintenance performed on the containment spray pump in which the licensee identified a degrading condition and took action to correct the problem. A questioning attitude was also demonstrated concerning the proper torque values. A weakness was noted

in the work on the main generator exciter brushes which was performed without the operating crew's knowledge (Paragraph 6). A concern regarding a missed fire watch remains unresolved.

Engineering/Technical Support: The station blackout diesel generator successfully completed its 26 hour endurance run. The licensee has reviewed NRC Bulletin 92-01 including Supplement 1, and has instituted a roving fire watch in areas where the Thermo-lig fire barriers are installed on safe shutdown equipment (Paragraph 9).

Safety Assessment/Quality Verification: The QA organization has initiated a new trending program using statistical process controls to help identify weak areas. Review of the initial report shows that this can be a very effective tool. (Paragraph 10)

## DETAILS

### 1. Persons Contacted

#### a. Toledo Edison Company

- D. Shelton, Vice President, Nuclear
- \*G. Gibbs, Director, Quality Assurance
- L. Storz, Plant Manager
- \*J. W. Rogers, Manager, Maintenance
- \*M. Bezilla, Superintendent, Plant Operations
- E. Salowitz, Director, Planning and Support
- \*S. Jain, Director, DB Engineering
- \*R. Zyduck, Manager, Nuclear Engineering
- \*G. Grime, Manager, Industrial Security
- D. Timms, Manager, Systems Engineering
- \*J. Polyak, Manager, Radiological Control
- \*V. Sodd, Manager, Independent Safety Engineering
- \*G. Honma, Supervisor, Compliance
- B. DeMaison, Manager, Emergency Preparedness
- J. K. Wood, Operations Manager
- R. W. Schrauder, Manager, Nuclear Licensing
- T. J. Myers, Director, Technical Services
- \*N. K. Peterson, Engineer, Licensing
- G. Skeel, Gen. Supervisor, Nuclear Sec. Operations
- L. W. Worley, Manager, Quality Assurance
- N. L. Bonner, Manager, Design Engr.
- S. A. Byrne, Superintendent, Instrumentation and Control
- J. Moyers, Manager, Quality Assurance
- \*T. W. Haberland, Manager-Maint. Planning & Outage Mgmt.
- \*A. W. Rabe, Supervisor, Quality Verification
- \*G. R. McIntyre, Supervisor, Electrical/Control Systems
- \*E. C. Caba, Manager, Performance Engineering

#### b. USNRC

- \*W. Levis, Senior Resident Inspector
- \*R. K. Wallon, Resident Inspector
- J. A. Gavula, Reactor Inspector

\*Denotes those personnel attending the September 14, 1992, exit meeting.

### 2. Licensee Action on Previous Inspection Findings (92701, 92702)

(CLOSED) INSPECTOR FOLLOWUP ITEM 346/88021-02, Reportability of Emergency Diesel Generator (EDG) Start. NRR reviewed this issue as documented in a memorandum (Zwolinski to Greenman) dated July 31, 1992, and concluded that reportability issues will be resolved upon issuance of Revision 1 to NUREG 1022. This will provide additional guidance for defining ESF systems for reporting consistency. This item is closed.

(CLOSED) UNRESOLVED ITEM (346/88026-07(DRP)) The licensee found that overcurrent relay 51V-2 was not tested nor bypassed during a loss of voltage on the essential bus or on a safety feature actuation system (SFAS) signal. Technical Specification 4.8.1.1.2.d.2.c requires that all diesel generator trips, except engine overspeed and generator differential, are automatically bypassed upon a loss of voltage on the essential bus and/or an SFAS signal. In Inspection Report 346/88026, the inspectors documented their position that tripping the generator output breaker is the same as tripping the emergency diesel generator.

Although Regulatory Guide 1.108 states a diesel generator unit includes the diesel generator breaker, the licensee is not committed to this regulatory guide. The licensee is committed to Safety Guide 9 which provides no guidance as to whether the EDG output breaker is included as a part of the EDG unit. The successor to Safety Guide 9 (Regulatory Guide 9, Rev. 1, dated November 1978), however, refers to IEEE Standard 387-1977 to "delineate principal design criteria and qualification testing requirements that if followed, will help ensure that selected diesel generator units meet their performance and reliability requirements." This standard does not include the EDG output breaker as part of the EDG unit and therefore the output breaker trip is not included as an EDG trip.

Overcurrent relays 51V-1 and 51V-2 provide generator fault backup protection as well as system fault backup protection. Relay 51V-1 provides protection to the generator and is bypassed during an undervoltage condition on the vital bus or an SFAS signal. The licensee contends that relay 51V-2 is not an EDG trip, but is a trip provided to protect the switchgear from damage during periods of low voltage (59% normal rating) and high current. In revision 9 to the Safety Analysis Report, the licensee states that this relay enhances the availability of the diesel generator since it will trip the output breaker due to a fault on the essential bus, but does not cause the EDG to stop or lockout. EDG trips not only trip the output breaker, but also stop the diesel and prevents its automatic operation (lockout condition) unless operators intervene.

Since relay 51V-2 is not covered by surveillance testing, the inspectors questioned the licensee as to what testing, if any, is performed on the relay to ensure its reliability since misoperation of this relay could potentially disrupt the emergency supply of power to a vital bus during an accident condition. The licensee states that the relay is tested each refueling outage by DB-SC-04052 and 04053, 4160V System Transfer and Lockout Test Buses C1 and C2/D1 and D2.

(CLOSED) UNRESOLVED ITEM (346/90010-01): Determine Level of Reverification for Piping Calculations Used as Design Input for Modifications. The discrepancies identified during the previous NRC inspection were corrected with the issuance of Calculation No. 56B2, Revision 7, dated August 10, 1990. Also, Engineering Department Policy No. 5, "Use of Existing Calculations", Revision 0, was issued September 8, 1990. The policy stated that a calculation shall be

reviewed in its entirety when reviewing an existing calculation for subsequent use to establish a basic understanding of the calculation, check its methodology, and to confirm the assumptions and engineering judgements are still accurate, applicable, and adequately defined.

Recent piping modifications were reviewed to verify application of the policy statement. Calculation No. 84B, "Service Water System ECCS Room Cooler E42-4", Revision 6, dated July 16, 1992, was performed to evaluate the addition of two flanged spool pieces for inspection purposes. The piping was evaluated for three configurations with either both spools installed or either of the spool pieces removed. Three pipe support modifications were proposed to accommodate the new pipe configuration. It was noted during the NRC review that the previous calculation revision had been reviewed in detail by the analyst and all discrepancies had been addressed in the current calculation.

In addition, Calculation No. 68B, "Auxiliary Steam System", Revision 6, dated January 27, 1992 was reviewed by the NRC inspector. The calculation specifically denoted inaccuracies in the previous revision to the calculation as well as the lack of input documentation. The inaccuracies were reconciled and the input documentation was regenerated using available references in the current revision. Based on the above, it was concluded that an adequate level of reverification was being performed on previous calculations. This item is closed.

(CLOSED) VIOLATION (346/92003-02) Work Performed Outside Scope of MWO. The inspectors reviewed the licensee's response to the Notice of Violation dated May 27, 1992. The inspectors verified, through review of documentation, that the actions committed to in the licensee's response had been performed. This item is closed.

3. Licensee Event Report Followup (92701)

Through direct observation, discussions with licensee personnel, and review of records, the following licensee event reports (LERs) were reviewed to determine that reportability requirements were fulfilled, and immediate corrective actions to prevent recurrence were accomplished in accordance with Technical Specifications (TS).

(CLOSED) LER 92-02 and 92-02 Rev I Reactor trip from 40% Power Due to Main Turbine Trip. The inspectors reviewed circumstances of the reactor trip and verified, through review of documentation, that the necessary training and procedural changes had been performed. Replacement of 4 turbine bypass valves is scheduled for the eighth refueling outage. This item is closed.

(CLOSED) LER 92-004, Revision 2, Part 21 Report of HELB Analysis Error. In its revised submittal, the licensee added that modifications would be made to the facility during the eighth refueling outage to resolve this issue. The inspectors will continue to monitor the licensee's corrective actions and are tracking this issue as UNR 346/92005-02. This revision is closed.



4. Plant Operations (71707, 93702)

a. Operational Safety Verification

Inspections were routinely performed to ensure that the licensee conducts activities at the facility safely and in conformance with regulatory requirements. The inspections focused on the implementation and overall effectiveness of the licensee's control of operating activities, and on the performance of licensed and non-licensed operators and shift managers. The inspections included direct observation of activities, tours of the facility, interviews and discussions with licensee personnel, independent verification of safety system status and limiting conditions of operation (LCO), and reviews of facility procedures, records, and reports.

b. Off-Shift Inspection of Control Room

The inspectors performed routine inspections of the control room during offshift periods. The inspections were conducted to assess overall crew performance and, specifically, control room operator attentiveness during night shifts. The inspectors determined that both licensed and non-licensed operators were alert and attentive to their duties, and that the administrative controls relating to the conduct of operations were being adhered to.

c. Engineering Safety Feature (ESF) System Walkdown

The operability of selected engineered safety features was confirmed by the inspectors during walk-down of the accessible portions of several systems. The following items were included: verification that procedures match the plant drawings, that equipment, instrumentation, valve and electrical breaker line-up status is in agreement with procedures checklists, and verification that locks, tags, jumpers, etc., are properly attached and identifiable. The following systems were walked down during this inspection period:

- Auxiliary feedwater
- 4160 VAC Switchgear
- Service Water System (safety portion only)

During a Quality Assurance tagout audit on August 5, 1992, a licensee inspector found the #2 boric acid evaporator heat trace control switch tagged in the incorrect position. The licensee states that the switch was initially positioned properly by the operators and verified by the electrical maintenance personnel before work started but was probably later repositioned accidentally. The switch is an 'L' type of switch, waist high in a narrow passage. The switch did not have any locking device installed to prevent inadvertent operation and scaffold erection was being performed in the vicinity of the switch. This was the only discrepancy found during a 100% tagout audit.

On August 7, 1992, operations personnel were performing a temporary lift of a tagout on control room normal air conditioner compressor when the operator found two valves opened when they were required to be danger tagged closed. The two valves, AR9 and AR10, are capped valves. The valves are operated by removing the valve cap, inverting the cap and using the cap to position the valve stem. Operators have received training in the operation of these types of valves. But when the danger tags were hung, the operators failed to operate the valves properly. Operations management videotaped the proper operation of these valves and showed the videotape to all operators as part of normal training.

There are many different types of valves at the facility. To ensure that they are operated properly, the licensee is planning to assemble a valve operator aid book which will explain in detail, the operation of valves utilized at the facility. The aid is considered to be supplemental to valve operations training.

The licensee has formed a multi-disciplined task force to examine this and other events in which valves were mispositioned or clearance errors were made in an attempt to determine the root cause of these errors. Inspectors will review the results of this task force including proposed corrective actions when the licensee completes their review.

On August 24, 1992, a control room annunciator alarmed, indicating a problem with inverter YVA. Control room operators noted YAU voltage and amp swings and that various lights including valve position indication lights were blinking. Inverter YVA normal power supply is from the DC bus and an alternate power supply is from an AC bus. YVA inverts the DC supply to an AC signal and uses the output to feed the YAU uninterruptible instrumentation bus. This bus distributes power to various non-safety related control and monitoring systems.

An operator dispatched to the inverter noted that YVA was transferring between its alternate and normal source multiple times without any apparent reason. Operations personnel completed section 3.15 of CB-OP-06319, "Instrument AC System Procedure", to transfer YVA, to its alternate source of power. After performing the procedure, they believed that YVA was still powered from its normal source as indicated by lights above the Static Bypass toggle switch. The operators were familiar with the operation of the equipment and did not expect to see this light indication. The operators returned YVA to its normal source of power and noted power oscillations. After conversations with the responsible systems engineer, the operators returned the inverter to its alternate source of power, but left the inverter in the BYPASS TEST position. In effect, only completing half of the inverter switching procedure. For about 7 hours, the inverter remained in the BYPASS TEST position until the day shift crew arrived to provide assistance. Operations, engineering and maintenance personnel reviewed the electrical drawings, held a brief in the control room, and then completed the remainder of the inverter switching procedure which positioned the inverter to the BYPASS position.

Unknown to the operators, when the inverter was transferred to its alternate power source, the unloaded normal power supply returned to its normal voltage. Since the inverter is designed to automatically return to its normal power supply, the indicating lights reflected that the inverter was available for loading, but did not indicate that the normal power supply was supplying loads. This was not known to the operators.

Operations management submitted a training request for operators to receive additional training on the operation of the inverters. Also, maintenance information tags have been attached adjacent to the inverter switches and meters to clarify equipment operation. Permanent labels will be attached at a later date.

Since loss of YAU or YBU are presently not included in operator simulator training, operations management ran this scenario on the simulator to determine the effects on the plant. The licensee determined that the plant would trip in approximately 5 minutes after loss of power to YAU on low steam generator water level without operator intervention. This scenario will be included in future operator simulator training.

The licensee wrote a maintenance work order to troubleshoot and repair YVA. Inverter components were replaced, and inverter voltage was adjusted and load tested before being returned to normal operation.

No violations or no deviations were identified.

5. Radiological Controls (71707)

The licensee's radiological controls and practices were routinely observed by the inspectors during plant tours and during the inspection of selected work activities. The inspection included direct observations of health physics (HP) activities relating to radiological surveys and monitoring, maintenance of radiological control signs and barriers, contamination, and radioactive waste controls. The inspection also included a routine review of the licensee's radiological and water chemistry control records and reports.

Health physics controls and practices were satisfactory.

6. Maintenance/Surveillance (61726, 62703)

Selected portions of plant surveillance, test and maintenance activities on systems and components important to safety were observed or reviewed to ascertain that the activities were performed in accordance with approved procedures, regulatory guides, industry codes and standards, and the Technical Specifications. The following items were considered during these inspections: limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating work; activities were accomplished using approved procedures and were inspected as applicable; functional testing or calibration was performed prior to returning the components or



systems to service; parts and materials used were properly certified; and appropriate fire prevention, radiological, and housekeeping conditions were maintained.

The inspectors observed performance of Surveillance Test DB-SC-03151, Quarterly Testing of #1 Auxiliary Feed Water Pump, on August 28, 1992. The operators were knowledgeable of the procedures they were using and performed the Surveillance in a professional manner.

On May 28, 1991, the licensee documented on PCAQR 91-0303 that containment spray pump #1 runs with temperature perturbations on the outboard bearing and detected trace amounts of bearing wear products in the bearing oil. The corrective actions were to move the motor away from the pump slightly and to check other safety related pump/motor sets for shaft separation and bearing wear. The licensee believes that this condition existed since original installation and resulted in minor bearing wear which did not render containment spray pump #1 inoperable. The only other pump noted with bearing wear products from improper spacing was containment spray pump #2.

On August 4, 1992, the inspectors witnessed maintenance on containment spray pump #2. In lieu of moving the motor, the licensee removed a 5/8" (1.6 cm) spacer from the motor coupling and replaced it with a 3/16" (0.5 cm) spacer. The coupling was reassembled and the containment spray pump was operated. The licensee noted that the steady state bearing oil temperature was much lower compared to previous runs. The licensee will continue to monitor both containment spray pump's oil for wear products as part of their oil sampling program.

During reassembly of the containment spray pump, maintenance personnel questioned the coupling bolt torque in that it appeared to be excessive. The preventive maintenance (PM) work order specified that bolts be torqued to 100 ft-lbs, which was found to be in excess of vendor recommended torque requirements. On August 18, 1992, the licensee replaced the coupling spacer and bolts in #1 containment spray pump and had the removed bolts sent to a laboratory for destructive testing. The bolts tested to be greater than grade 8, thus verifying bolt integrity. The licensee believes that the improper torque specification was due to poor research work when the PM was written many years ago. The licensee checked all PMs which address limited infloat couplings to ensure the proper torque requirements were used. The licensee did not find any other improper torque values specified.

The inspectors note that a good questioning attitude by personnel in the maintenance department lead to detection and correction of this error.

a. Maintenance

The reviewed maintenance activities included:

- Containment Spray Pump #2 Maintenance
- DH63 VOTES Testing

- MU32 Troubleshooting
- Troubleshooting YVA Inverter
- Maintenance on Emergency Diesel Generator #1
- Troubleshooting #1 EDG Voltage Regulator
- Replacement of Main Generator Excitation Brush
- Spent Fuel Pump #1 Motor Maintenance

b. Surveillance

The reviewed surveillances included:

<u>Procedure No.</u>	<u>Activity</u>
DB-MI-03502	Seismic Monitoring System Functional Test
DB-SC-03070	Emergency Diesel Generator #1 Monthly Test
DB-SC-03071	Emergency Diesel Generator #2 Monthly Test
DB-SP-03151	Auxiliary Feedwater #1 Quarterly Test
DB-SC-03159	Auxiliary Feedwater Pump #2 Monthly Jog Test
DB-SP-03161	Auxiliary Feedwater Train 2 Level Control, Interlock and Flow Transmitter Test

On June 15, 1992, the licensee experienced a plant transient due to a failed memory module in the calibrating-integral portion of the integrated control system (ICS). This event was documented in Inspection Report 346/92008. The plant was recovered and the affected module was replaced. Troubleshooting the failed module using the calibration procedure revealed that the module functioned normally. The licensee submitted paperwork to modify the calibration procedure to better detect module failure. The licensee, recognizing an omission in the vendor manual, submitted a report to inform other nuclear facilities of the vendor manual omission.

On August 12, 1992, the licensee documented a similar failed memory module for valve MU32 on Potential Condition Adverse to Quality Report (PCAQR 92-0330). When MU32 was taken from automatic operation to manual operation, the valve closed. Troubleshooting of the MU32 failed memory module revealed that a different type of failure occurred relative to the ICS memory module but it had similar symptoms, specifically, the output went to zero. The failed memory module was replaced.

The licensee has 18 memory modules in the ICS and three memory modules in other non-safety related systems. The licensee plans to perform a preventive maintenance task which will replace all the ICS memory modules during the upcoming refueling outage with calibrated modules. The three remaining modules will be calibrated, then reinstalled. The removed modules will be tested and refurbished by the licensee for future in-plant use.

On September 2, an electrician performing checks of the main generator excitation system received an electrical shock of about 500 Volts DC. The individual was not hurt. While checking the generator excitation brushes with his right hand, his left elbow came in contact with a metal

barrier and provided a flow path from the generator exciter brushes to ground through his body. The individual had performed this task numerous times in the past and did not consider this evolution to involve working with energized gear. As a consequence, no special precautions were taken. The individual's supervisor documented this event as a 'near miss' and forwarded it to the safety department. An accident investigation will be conducted later. Control operators were not aware this work was being performed as the work order did not specify that the control room be informed prior to beginning work. As a result, operators did not expect nor initially understand the cause for the alarm they received when the electrician shorted the brushes. The work order, which is performed 3 times a week, has since been changed to require control room notification prior to its performance.

No violations or deviations were identified.

7. Emergency Preparedness (71707)

An inspection of emergency preparedness activities was performed to assess the licensee's implementation of the emergency plan and implementing procedures. The inspection included monthly observation of emergency facilities and equipment, interviews with licensee staff, and a review of selected emergency implementing procedures.

No violations or deviations were identified.

8. Security (71707)

The licensee's security activities were observed by the inspectors during routine facility tours and during the inspectors' site arrivals and departures. Observations included the security personnel's performance associated with access control, security checks, and surveillance activities, and focused on the adequacy or security staffing, the security response (compensatory measures), and the security staff's attentiveness and thoroughness. Security personnel were observed to be alert at their posts. Appropriate compensatory measures were established in a timely manner. Vehicles entering the protected area were thoroughly searched. The licensee improved their assessment capabilities with the installation of the video capture system.

No violations or deviations were identified.

9. Engineering and Technical Support (62703, 71707)

An inspection of engineering and technical support activities was performed to assess the adequacy of support functions associated with maintenance/modifications, operations, surveillance and testing activities. The inspection focused on routine engineering involvement in plant operations and response to plant problems. The inspection included direct observation of engineering support activities and discussions with engineering, operations, and maintenance personnel.

The licensee evaluated a recent Fort Calhoun event for applicability to Davis-Besse. On July 13, 1992, the Fort Calhoun Station experienced a reactor scram on high pressurizer pressure. During plant recovery, a pressurizer relief valve failed to reseat. The relief valves were removed and inspected. The cause of the malfunction was an adjusting bolt locknut which loosened and allowed the set pressure adjusting bolt to back out during valve actuation. It is believed that the laboratory that tested these valves did not properly tighten the locknut after maintenance was completed.

The relief valve found on the Davis-Besse pressurizer is manufactured by the same company as the relief valve at the Fort Calhoun Station, but a different model. The adjusting nut on the licensee's relief valve does not have a locking mechanism to prevent it from loosening when lifting. DB-MM-009001, Pressurizer Code Safety Valve Maintenance procedure, does not specify any torque requirements for the installation of the adjusting bolt nut but requires only that the nut be tightened.

The licensee uses four pressurizer relief valves. Two are installed and two are in a standby status. Each outage, the licensee replaces the installed relief valves with the two in standby. The removed reliefs are sent off site to the same facility for testing as the relief valves from Ft. Calhoun. However, Davis-Besse performs its own maintenance on these valves using licensee procedures while the valves are at the testing facility.

Davis-Besse has not had any history of pressurizer relief valves lifting when operating. The licensee's maintenance staff believes that there is adequate procedural maintenance guidance at this time and that no change need be made to procedures or to hardware. The licensee does see room for procedural enhancements in the long term such as dual verification of adjusting nut torque. The inspectors will address this item in a future report.

On July 20, 1992, the licensee performed an engineering evaluation of Thermo-lag 330 Fire Barrier system installed in 10 rooms on safe shutdown systems. The evaluation reasoned that there is insufficient combustibles in the rooms to fuel a one hour long fire. The licensee exited Technical Specification 3.7.10, and secured the hourly fire watch patrols for the affected rooms. The licensee stated that the Thermo-lag material was operable but nonconforming.

After reviewing Bulletin 92-01, supplement 1, on August 31, 1992, the licensee reestablished fire watches in 21 rooms that utilize Thermo-lag 330 Fire Barrier systems on safe shutdown systems and rooms with structural members protected by Thermo-lag. This matter will be resolved pending completion of industry initiatives and NRC review.

PCAQ 92-0367 was issued to document a missed fire watch for room 325 which is required as a result of the Thermo-lag issue. A routine security audit indicated that this room was not entered on September 8, 1992, from 5:06 p.m. until 6:22 p.m. In addition, the



individual performing the watch did not enter the room for the next required watch, although another qualified individual did. This room is 1 of 18 checked by the watch on an hourly basis. The time that the room is entered is written on the log and the fire watch signs the log sheet when all the rooms are completed. The log sheet used by the fire watch indicated that this watch had been performed. The licensee plans to report this event in an LER. This issue will be Unresolved (URI 346/92013-01) pending issuance of the LER and evaluating licensee's root cause determination and corrective actions.

On August 7, 1992, the Station Blackout Diesel Generator (SBODG) completed its 26 hour endurance test. The machine was operated at full load for 26 hours while various parameters were monitored to verify the SBODG reliability. The licensee will continue to run the machine for monthly tests and plans to complete the testing program during the eighth refueling outage with a simulated station blackout.

One Unresolved Item was identified.

10. Safety Assessment/Quality Verification (30702)

An inspection of the licensee's quality programs was performed to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. The inspectors considered areas indicative of overall management involvement in quality matters, self-improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's participation in technical and planning meetings. The inspectors reviewed Potential Condition Adverse to Quality Reports (PCAQR), Station Review Board (SRB) and Company Nuclear Review Board (CNRB) meeting minutes, event critiques, and related documents; focusing on the licensee's root cause determinations and corrective actions. The inspection also included a review of quality records and selected quality assurance audit and surveillance activities.

On August 20, 1992, the licensee Engineering Director and members of his staff met with the Director of the Division of Reactor Safety Region III and members of his staff to discuss current engineering issues and other items of mutual interest.

The QA organization has implemented a new process in their review of site events to more accurately note emerging trends. Their use of statistical process controls is now used for their quarterly review process. The inspectors reviewed the initial report and felt that it was a good initiative and useful tool to note trouble areas and ensure corrective actions were taken in a timely manner.

No violations or deviations were identified.



11. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. An unresolved item disclosed during the inspection is discussed in paragraph 9.

12. Exit Interview (30702)

The inspectors met with licensee representatives (denoted in Paragraph 1) throughout the inspection period and at the conclusion of the inspection and summarized the scope and findings of the inspection activities. The licensee acknowledged the findings. After discussions with the licensee, the inspectors ascertained there is no proprietary data contained in this inspection report.