U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Inspection Report 50-244/94-19 License: DPR-18

Facility: R. E. Ginna Nuclear Power Plant
Rochester Gas and Electric Corporation (RG&E)

Inspection: July 26 through August 31, 1994

Inspectors: T. A. Moslak, Senior Resident Inspector, Ginna
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Approved by: W. J. Lazarus, Chief, Reactor Projects Section 3B 9/22/94 Date

INSPECTION SCOPE

Plant operations, maintenance, engineering, plant support, and safety assessment/quality verification.

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INSPECTION EXECUTIVE SUMMARY

Operations

At the beginning of the inspection period, the plant was operating at full power (approximately 97 percent). On August 9, 1994, the plant was taken off-line and cooled down to less than 350 degrees F due to a small, but unisolable, leak in the common recirculation line for the safety injection pumps. Following completion of repairs and post-maintenance testing, a reactor startup was performed, and full power operation was achieved on August 24, 1994.

Maintenance

In response to recent multiple failures of the B-Safety Injection pump, site maintenance coordinated enhanced testing of each SI pump. Testing included gathering motor and pump performance data at 30 minute intervals over a 90 minute period. From the extended run, maintenance concluded that the normal 15 minute test period provided representative data. Excessive pump noise and piping vibration of the B-SI pump resulted in its disassembly and the pump venting procedure being scrutinized. Elevated bearing vibration resulted in re-balancing the B-SI pump motor rotor.

The B-Motor Driven Auxiliary Feedwater pump required a complete overhaul and the A-Service Water pump was replaced following a failure of each pump to achieve the required differential pressure during testing.

Maintenance activities were well coordinated to complete repairs to a failed service water system valve within the 24-hour LCO period.

Engineering

A request for enforcement discretion regarding extending the allowed outage time for two days to complete B-MDAFW pump repairs and testing was comprehensive and detailed. The safety implications were addressed using PRA data and conservative assumptions regarding entry into the Limiting Condition for Operation. Site and corporate engineering organizations effectively supported enhanced testing, troubleshooting, and repairs of the B- and C-safety injection pumps.

Plant Support

Routine observations in the areas of radiological controls, security, and fire protection indicated that these programs were effectively implemented.

Safety Assessment/ Quality Verification

The NSARB reviewed recent events involving safety-related pump and motor operability and tasked site management with developing a 90-day action plan to identify possible programmatic shortcomings.

Root Cause Analyses have been initiated for the safety injection system recirculation line weld failure, V-4620 stem to disc separation, A-SW pump low differential pressure, and B-MDAFW pump low differential pressure.

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DETAILS

1.0 OPERATIONS (71707)

1.1 Operational Experiences

At the beginning of the inspection period the plant was operating at full power (approximately 97 percent). On August 9, 1994, the plant was taken off-line and cooled down to less than 350 degrees F due to a leaking weld in the B-safety injection pump recirculation line that could not be isolated from the other two safety injection pumps. Following completion of repairs and post-maintenance testing, a reactor startup was performed, and full power operation was achieved on August 24, 1994. There were no other significant operational events or challenges during the inspection period.

1.2 Control of Operations

Control room staffing was as required. Operators exercised control over access to the control room. Shift supervisors maintained authority over activities and provided detailed turnover briefings to relief crews. Operators adhered to approved procedures and were knowledgeable of off-normal plant conditions. The inspectors reviewed control room log books for activities and trends, observed recorder traces for abnormalities, assessed compliance with technical specifications, and verified equipment availability was consistent with the requirements for existing plant conditions. During normal work hours and on backshifts, accessible areas of the plant were toured. No operational inadequacies or concerns were identified.

1.3 Plant Shutdown Due to Inoperable Safety Injection System

On August 9, 1994, at 2:44 p.m., the licensee commenced a plant shutdown after determining that the safety injection (SI) system was inoperable due to a leak on the SI pump recirculation common return line. The generator output breakers were opened at 6:58 p.m. and the reactor was shut down at 7:16 p.m. Reactor coolant temperature was reduced below 350 degrees F (the point at which SI is no longer required by technical specifications) at 1:30 a.m. on August 10, 1994. Using the steam generator atmospheric relief valves for removal of reactor decay heat, operators maintained reactor coolant system temperature just below 350 degrees F for the duration of the 13-day forced outage.

The inspector observed portions of the plant shutdown. The inspector noted that operators promptly commenced power reduction after the SI system was declared inoperable. The inspector observed good procedure adherence and awareness of plant conditions. The licensee completed a non-emergency notification of the NRC within one hour, as required by 10 CFR 50.72. Management involvement during the plant shutdown was appropriate, with frequent management presence in the control room. The shutdown was completed without incident.

1.4 Plant Startup and Power Escalation

After completion of SI system maintenance and acceptance testing, a plant startup was conducted on August 22, 1994. Operators began a reactor startup at 3:02 a.m. and criticality was achieved at 5:53 a.m. The generator was closed on the distribution grid at 11:59 a.m. Following a hold at 50 percent for condenser waterbox inspection and off-site electrical distribution system maintenance, full power was achieved on August 24, 1994 at 5:50 a.m.

The inspector observed portions of the power escalation and considered that operations were conducted deliberately and professionally. Closing the main generator on the distribution grid, an operation that can produce transient instability, was well coordinated and resulted in no operational difficulties.

2.0 MAINTENANCE (62703, 61726)

2.1 Preventive/Corrective Maintenance

2.1.1 Service Water System Valve V-4620 Repair

Operations personnel noted that valve V-4620 (component cooling water heat exchanger B- service water outlet isolation valve) was making a rattling noise. This valve is a 20-inch globe valve and is used to throttle service water flow through the B-Component Cooling Water (CCW) heat exchanger. In response to the trouble report, maintenance planned to disassemble the valve to determine the cause. The maintenance isolation would render the B-CCW heat exchanger inoperable due to service water being isolated; this activity would therefore incur a 24-hour action statement per technical specification 3.3.3.2.

On the morning of July 28, 1994, service water to the B-CCW heat exchanger was isolated and drained for inspection and repair of V-4620. Upon disassembly, the valve disc was found to be separated from the stem. Separation occurred because the threads on the swivel nut that couples the disc to the stem were worn away. Additionally, the valve guide (a rod, welded to the bottom of the disc, that passes through a spider-mounted bushing in the bottom of the valve body to provide lateral support) was broken off at the disc.

Engineering evaluated the condition of V-4620 and determined that repair could best be accomplished by welding the swivel nut to the disc. They further concluded that the valve would perform satisfactorily without the valve guide, and that reinstallation should therefore not be performed. The licensee had determined that the internals for this valve were not safety related, since it was on the discharge side of the affected component and the valve performed no safety function. As such, repair activities were not subject to ASME code requirements. Therefore, the recommended repairs were acceptable, even though they deviated from the as-built condition of the valve. These deviations, along with justification and authorization for interim use, were recorded in Nonconformance Report (NCR) 94-106.

Work Order 19403422 was subsequently initiated to replace V-4620 during the 1995 refueling outage.

Attempts to weld the V-4620 swivel nut to the disc were unsuccessful due to the material composition of the swivel nut. A replacement piece for the swivel nut was fabricated from a material with acceptable welding characteristics. This piece was successfully welded to the disc and the valve was reassembled. The B-CCW heat exchanger was returned to service on the evening of July 28, 1994.

The inspector observed portions of this maintenance activity, including examination following disassembly and in-shop repair activities; no deficiencies were noted. The inspector observed that site and corporate engineering support were immediately available and actively supported the repair effort. Several meetings were held over the course of the day to review the progress of work and evaluate repair strategies. The inspector noted that these meetings resulted in good coordination of activities by the supporting trades. The inspector reviewed NCR 94-106 and evaluated the interim repair to be acceptable. The inspector had no additional concerns on this activity.

2.1.2 A-Service Water Pump Failure

On August 2, 1994, during the conduct of periodic test (PT)-2.7.1, "Service Water Pumps," differential pressure for the A-Service Water (SW) pump was determined to be low in the required action range. This condition was, to some extent, anticipated, in than differential pressure for this pump had been low in the alert range (a less degraded condition requiring increased surveillance frequency) during the previous performance of PT-2.7.1. As a result, refurbishment of the spare SW pump had been accelerated to ensure that it would be available to serve as a replacement, if required.

The A-SW pump was declared inoperable on August 2, 1994. Based on initial troubleshooting results which indicated that the pump shaft might be binding, the licensee concluded that the pump should be replaced. The A-SW pump was removed and replaced with the rebuilt spare. Subsequent acceptance testing, however, showed the rebuilt pump to have unacceptably low differential pressure. Additionally, disassembly and inspection of the replaced SW pump revealed no mechanical malfunctions and no wear on individual components that would account for degraded pump performance.

At the conclusion of the inspection period, the A-SW pump remained inoperable, and licensee investigation of the cause of degraded pump performance as indicated by PT-2.7.1 was continuing. Accurate calibration and proper utilization of the flow measurement test equipment were being verified with assistance from the vendor.

2.2 Surveillance Observations

2.2.1 Safety Injection Pump Enhanced Testing

In response to multiple failures of the B-Safety Injection (SI) pump and motor that have occurred during the past months, the site maintenance organization convened a meeting on July 28, 1994 of site/corporate engineering, operations, procurement, and quality assurance departments to identify the operational and

maintenance issues surrounding each failure and develop a plan to resolve each issue. Failures addressed included the B-SI pump interstage seal failure on April 9, 1994 (details are provided in inspection report 50-244/94-07), B-SI pump motor rotor bar cracking on June 10, 1994 (details in inspection report 50-244/94-16), and B-SI pump mechanical seal failures on April 3 and July 13, 1994 (details in inspection reports 50-244/94-07 and 50-244/94-16, respectively). Issues identified in associated Root Cause Analysis Reports included equipment aging degradation, pump venting adequacy, seal material/ boric acid compatibility, surveillance testing scope and depth, operational history, and pump use for accumulator fills. A Corrective Action Report (CAR 2095) was generated to track the diverse issues identified.

Immediately following this meeting, the Plant Operations Review Committee (PORC) met to discuss SI pump operability in light of information presented at the maintenance planning meeting. PORC concluded that all pumps are operable since the pumps meet the Technical Specification acceptance criteria for recirculation flow and differential pressure achieved during surveillance testing. Additionally, component vibration and temperature data are within acceptable ranges, not indicating a significant negative trend. Monthly surveillance testing was concluded to provide sufficient warning of any incipent failure. However, PORC recommended that future surveillance testing be enhanced to gather additional performance data over a longer running period (90 minutes) in place of the present 15 minute operating period. Subsequently, Periodic Test (PT) procedure, PT-2.1M, "Safety Injection System Monthly Test," was revised to include gathering test data at 30, 60, and 90 minute intervals. Test parameters to be measured included pump differential pressure, recirculation flow rate, inboard and outboard bearing vertical and horizontal vibration, and inboard and outboard pump seal pressures. Spectral vibration analysis was to be used to establish component vibration signatures and infrared thermography used to establish component temperature profiles.

Enhanced testing began on August 9, 1994 as part of the regularly scheduled monthly surveillance test. The A-SI pump and motor were initially tested and found to operating satisfactorily with all test parameters acceptable.

Upon completing the A-SI pump/motor test, the system was realigned to conduct the B-SI pump/motor test. While making the realignment, a technician observed a small water leak on a weld on the B-SI pump recirculation line for mini-flow back to the Refueling Water Storage Tank (RWST), downstream of valve V-1820C. No equipment was operating at this time and the pressure boundary (Class 2) was experiencing an RWST static pressure of about 32 psig. The weepage appeared to be from a small pinhole. A flow-limiting orifice upstream of the observed leakage reduces the SI pump discharge pressure from about 1500 psig to about 90 psig at the affected weld during the test. The test was stopped and PORC convened to assess the condition. PORC concluded that the testing should be resumed with the weepage being closely monitored. Upon starting the B-SI pump, the leak quickly worsened. The test was stopped and the leakage decreased. PORC reconvened and determined that since the recirculation flow path is common to all three SI pumps, all pumps should be declared inoperable and the plant be placed in Hot Shutdown in the next six hours and taken below 350 degrees F in the following six hours in accordance with Technical Specification 3.3.1.4. This decision was based on the fact that SI pumps

could not be considered reliable for all accident scenarios. Specifically, during a small break loss of coolant accident, the SI pumps would be recirculating to the RWST (via the failed line) and discharging a small flow to the reactor coolant system in mitigating the condition. Power was subsequently reduced and the plant cooled down to less than 350 degrees F by 1:30 a.m. on August 10, 1994.

Upon achieving cooldown conditions, the failed line section was cut out, sent to the licensee's metallurgical laboratory for analysis, and a prefabricated replacement was installed. To conform with ASME Section XI Code criteria, weld acceptance required that a hydrostatic test (VT-2) be performed for a Class 2 pressure boundary in which the line is pressurized to a minimum pressure of 1990 psig and a visual examination for leakage be performed over a 10 minute period. Attempts to achieve test pressure were unsuccessful as a result of check valve (V-891C) leak-by. An unsuccessful attempt was made to flush V-891C by briefly running the B-SI pump and then the C-SI pump to clear the seating surface of any foreign material. The check valve was subsequently disassembled and overhauled with new components. Following refitting and adjusting V-891C, a successful hydrostatic test of the repaired section of recirculation line was performed on August 12, 1994.

During the short run of the B-SI pump, excessive pump noise and line vibration were evident. This aberrant behavior is attributed in part to inadequate venting following drain down to permit repairs to the failed weld. However, to assure that the suction and drain/vent paths were not obstructed, radiographs were taken of key components (V-1820C, MOV-825B, and associated piping sections). No blockage was identified. Additionally, high points in the suction piping were vented to preclude sources for air binding; air was bled from the Boric Acid Storage Tank supply line. Following venting, a full flow test (PT-2.10.1) was conducted on August 11, 1994, in which the B-SI pump was operated for short periods (1.5 and 2.0 minutes at 360 gallons per minute) injecting directly into the reactor coolant system. The pump performed satisfactorily during both runs, with no excessive vibration or noise evident.

On August 11, 1994, enhanced testing was completed on the C-SI pump and motor. Performance of the C-SI pump was acceptable, but a higher than normal vibration (1.6 mils, placing it in the alert range of 1.24-1.86 mils) was observed on the outboard horizontal bearing. This degree of elevated vibration would normally require increased monitoring to trend the rate of degradation until the required action range (greater than 1.86 mils) was reached. Management directed that the cause be evaluated and corrected during this outage. Subsequently, the pump was realigned with the motor and successfully tested on August 20, 1994, exhibiting normal vibration.

On August 12, 1994, enhanced testing was successfully completed on the B-SI pump and motor with measured parameters being acceptable; however, recirculation piping vibration and pump noise were evident. Although the pump performance met testing criteria, the intermittent display of noise and piping vibration under low flow conditions, i.e., with only recirculation flow, led management to question the pump's reliability. Management directed that these conditions be corrected. Accordingly, the pump was disassembled, clearances measured, and the individual components inspected. The as-found condition did

not indicate any obvious problems. Under the direction of the vendor representative, pump diffusers were machined to a closer tolerance than specified in the equipment manual. The pump was subsequently reassembled.

In preparation for aligning the motor with the pump, the motor was run uncoupled. When high vibration was measured, the motor was shipped to a motor repair facility for balancing. Upon return, the motor was coupled and aligned to the pump. An enhanced (90 minute) test was performed with the pump meeting all performance criteria and returned to service on August 21, 1994.

Assessment

The inspector concluded that PORC's decision to perform enhanced testing on the SI pumps was prudent and timely. Testing over a 90 minute period assured that test data gathered during an abbreviated test period was representative for a prolonged run. Test procedures were sufficiently detailed; diagnostic test methods, including infrared thermography and full spectrum vibration analysis were appropriate to accurately measure performance parameters; and this activity received the integrated oversight of the operations, maintenance, engineering, and quality assurance organizations.

Upon identification that the recirculation line weld failure was degrading with operation of the B-SI pump, operations acted promptly to secure the pump and convene PORC. Site management's subsequent decision to take the plant off-line, achieve conditions to permit repairs, and complete testing before resuming operations, was appropriate. Plant Incident Reports (A-25.1-086 and -087) were generated for the initial leak identification and resulting weld failure, to inform various management levels of the operational impact and the need to evaluate reportability. Notification to the NRC Operations Center of the plant shutdown was subsequently made within one hour in accordance with 10 CFR 50.72(b)(1)(i)(A). LER 94-009 is being prepared in response to this event.

Replacement of the failed weld with a prefabricated spool piece was expeditiously carried out. The inspector observed lapses in foreign material exclusion control, i.e., plugs not installed in open recirculation line during grinding/welding, by craft personnel as the replacement piece was being installed. However, quality control provided oversight, requiring removal of visual debris, prior to fitup. Final installation resulted in a noticeable offset of the repaired section from the vertical direction. An NCR was developed to authorize interim use of the repair until realignment can be performed during the next refueling outage.

Verification that the weld repairs met ASME Section XI code requirements was properly carried out through maintaining a hydrostatic test pressure of 1990 psig for a 10 minute period and examining the weld for leakage indications by a Level II examiner. Other valves that are in the pressurized line section were also examined and found to have the requisite integrity.

Following successful testing of the B-SI pump, comprehensive troubleshooting to identify the possible sources of noise and line vibration was conducted. Vent and drain paths were inspected and the pump venting procedure was

scrutinized to assure adequate venting prior to operation. Air entrapment locations in suction paths were bled. Additional troubleshooting was performed on the motor to identify and correct vibration.

Throughout the enhanced testing and troubleshooting activities, management oversight and corporate engineering support were evident to resolve emerging issues and direct resources.

A Root Cause Analysis was appropriately initiated to determine the cause of the weld failure and corrective actions to be taken are being administratively tracked through CAR 2095. An independent consultant was contracted to review the operation, maintenance, and design of the safety injection system to identify systemic factors that potentially contributed to the elevated pump noise, piping vibration, and weld failure.

2.2.2 Routine Observations

Inspectors observed portions of surveillances to verify proper calibration of test instrumentation, use of approved procedures, performance of work by qualified personnel, conformance to limiting conditions for operation (LCOs), and correct system restoration following testing. The following surveillances were observed:

- PT-2.1M, "Safety Injection System Monthly Test," revision 12, effective date April 8, 1994, observed August 9 (A-pump), 12 (B- and C-pumps), and 21 (B-pump), 1994

  -- The August 9 test was stopped due to a leaking weld in the B-SI pump recirculation line; discussed in section 2.2.2 of this report

- PT-16M-A, "Auxiliary Feedwater Pump A - Monthly," revision 5, effective date May 19, 1994, observed August 16, 1994

- PT-16Q-B, "Auxiliary Feedwater Pump B - Quarterly," revision 14, effective date July 8, 1994, observed August 18, 1994

  -- Performed to troubleshoot low alert range differential pressure by isolating recirculation and bypass flow paths

- PT-12.2, "Emergency Diesel Generator B," revision 78, effective date June 29, 1994, observed August 25, 1994

The inspector determined through observing this testing that operations and test personnel adhered to procedures, corrective action was promptly initiated if test results and equipment operating parameters did not meet acceptance criteria, and redundant equipment was available for emergency operation.

3.0 ENGINEERING (71707, 37551)

3.1 Auxiliary Feedwater System - Request For Enforcement Discretion

On August 30, 1994, the licensee requested enforcement discretion, in accordance with 10 CFR 2, Appendix C, with respect to Technical Specification 3.4.2.1.a, regarding the number of operable Auxiliary Feedwater Pumps. The request was a contingency action in the event that repairs and testing on the B-Motor Driven Auxiliary Feedwater (MDAFW) Pump could not be completed within the seven day Limiting Condition for Operation (LCO) which was to expire at 5:30 a.m. on August 31, 1994. Based on supporting information provided by the licensee and discussions conducted with the NRC Region I and NRR staffs on August 30, 1994, the request was verbally approved at 5:20 p.m. on that date. Subsequently, the licensee completed repairs and post-maintenance testing of the B-MDAFW pump at 5:08 a.m. on August 31, 1994, within the allowed outage time, and the enforcement discretion was therefore not required.

In making this request, the licensee assumed that the B-MDAFW pump had been inoperable since August 24, 1994 at 5:30 a.m., when preventative maintenance began on the associated service water cooler and lube oil pump. Following completion of these activities, post-maintenance testing was performed. During this testing, operators determined that a recirculation line air-operated valve (AOV-4310) did not open as required and the pump ran deadheaded for about two minutes. The valve was subsequently repaired and performance test (PT-16Q-B) was performed to verify pump and valve operability. At 10:22 p.m. on August 26, 1994, the licensee determined that the pump did not achieve the required differential pressure of 1125.5 psid (actual 1123.2 psid). Major repairs were initiated which included complete pump disassembly. Through inspection, the licensee determined that the pump's interstage seals were missing on the third, fourth, fifth, and sixth stages and impeller hubs were badly worn requiring machining. Under the direct guidance of the pump's manufacturer representative, repairs were carried out. Through past trending of test data, the licensee had determined that the pump was slowly degrading in performance and had ordered a replacement rotating assembly in anticipation of overhauling the pump during the March 1995 refueling outage. Due to the emergent work, RG&E management expedited the procurement request but the new assembly would not be available for installation within the allowed outage time.

In justifying the request for a two day extension to the allowed outage time to complete the repairs and testing, the licensee evaluated the capability of the four available auxiliary pumps to mitigate accidents. There are a total of five Auxiliary Feedwater Pumps at the station. The preferred AFW system has two 100 percent capacity MDAFW pumps and one 200 percent turbine driven pump. The Standby Auxiliary Feedwater System has two 100 percent capacity MDAFW pumps which are manually started if the preferred pumps are not available. During this two day extension, three 100 percent capacity pumps and one 200 percent capacity pump were available to provide cooling water to the steam generators. Based on Probabilistic Risk Analytical data, the probability of requiring the B-MDAFW pump to mitigate a condition during this period is very small. The licensee's engineering organization prepared a comprehensive and detailed justification for the request.

4.0 PLANT SUPPORT (71750)

4.1 Radiological Controls

4.1.1 Routine Observations

The inspectors periodically confirmed that radiation work permits were effectively implemented, dosimetry was correctly worn in controlled areas and dosimeter readings were accurately recorded, access to high radiation areas was adequately controlled, survey information was kept current, and postings and labeling were in compliance with regulatory requirements. Through observations of ongoing activities and discussions with plant personnel, the inspectors concluded that the licensee's radiological controls were effective.

4.2 Security

4.2.1 Routine Observations

During this inspection period, the inspectors verified that x-ray machines and metal and explosive detectors were operable, protected area and vital area barriers were well maintained, personnel were properly badged for unescorted or escorted access, and compensatory measures were implemented when necessary. No unacceptable conditions were identified.

4.3 Fire Protection

4.3.1 Routine Observations

The inspectors periodically verified the adequacy of combustible material controls and storage in safety-related areas of the plant, monitored transient fire loads, verified the operability of fire detection and suppression systems, assessed the condition of fire barriers, and verified the adequacy of required compensatory measures. No discrepancies were noted.

5.0 SAFETY ASSESSMENT/QUALITY VERIFICATION (71707)

5.1 Nuclear Safety Audit and Review Board (NSARB) Meeting

On August 30-31, 1994, the NSARB met to review issues relevant to the safe operation of the Ginna facility. Issues reviewed included proposed changes to Technical Specifications and the Quality Assurance (QA) Plan, Licensee Event Reports, NRC Inspection Reports, results of QA audits, Performance Indicators, and recent technical issues. In-depth discussions addressed recent problems with pumps and motors in the Safety Injection, Auxiliary Feedwater, and Service Water Systems. As a result of these discussions, the NSARB Chairman tasked site management with developing an action plan in which the potential operational, maintenance, and design issues for these problems are identified. The action plan is to be presented to the NSARB within 90 days.

5.2 Periodic Reports

Periodic reports submitted by the licensee pursuant to Technical Specification 6.9.1 were reviewed. Inspectors verified that the reports contained information required by the NRC, that test results and/or supporting information were consistent with design predictions and performance specifications, and that reported information was accurate. The following reports were reviewed:

-- Monthly Operating Report for July 1994
-- Semiannual Radioactive Effluent Release Report (January - June 1994)

No unacceptable conditions were identified.

6.0 ADMINISTRATIVE

6.1 Senior NRC Management Site Visits

During this inspection period, two senior NRC managers visited Ginna Station. On August 8-9, 1994, Mr. Richard W. Cooper II, Director of the Division of Reactor Projects for region I, toured the site and met with senior licensee management. On August 11-12, 1994, Mr. James H. Joyner, Chief of the Facilities Radiological Safety and Safeguards Branch of the region I Division of Radiation Safety and Safeguards, toured the site and met with senior licensee management.

6.2 Backshift and Deep Backshift Inspection

During this inspection period, backshift inspections were conducted on August 10, 11, and 12, 1994. Deep backshift inspections were conducted on July 31, August 13, 14, 20, 21, and 28, 1994.

6.3 Exit Meetings

At periodic intervals and at the conclusion of the inspection, meetings were held with senior station management to discuss the scope and findings of inspections. The exit meeting for inspection report 50-244/94-20 (Implementation of revised 10 CFR 20 requirements, conducted August 8-12, 1994) was held by Mr. James Noggle on August 12, 1994. The exit meeting for the current resident inspection report 50-244/94-19 was held on September 1, 1994.