

U.S. NUCLEAR REGULATORY COMMISSION  
OFFICE OF INSPECTION AND ENFORCEMENT

REGION III

Report No. 50-358/79-06

Docket No. 50-358

License No. CPPR-88

Licensee: Cincinnati Gas and  
Electric Company  
139 East 4th Street  
Cincinnati, OH

Facility Name: Wm. H. Zimmer Nuclear Power Station

Inspection At: Wm. H. Zimmer Site, Moscow, Ohio

Inspection Conducted: February 27-28, March 1-2, 19-23, and  
April 9-11, 1979

Inspectors: *F. A. Maura* 5/3/79  
F. A. Maura  
*R. W. Dettenmeier for* 5/3/79  
R. W. Dettenmeier  
*B. M. K. Wong for* 5/3/79  
B. M. K. Wong (April 9-11)  
*J. F. Streeter for* 5/7/79  
Approved By: J. F. Streeter, Chief  
Nuclear Support Section 1

Inspection Summary

Inspection on February 27-28, March 1-2, 19-23, and April 9-11, 1979  
(Report No. 50-358/79-06)

Areas Inspected: Routine, unannounced inspection of Preoperational Test Program; previous unresolved items and actions on previous inspection findings; preoperational test results; system turnover for preoperational testing; control rod blade inspection; licensee events. The inspection involved 160 inspector-hours onsite by three NRC inspectors.

Results: Of the six areas inspected, no items of noncompliance or deviations were identified in four areas. Three items of noncompliance (two infractions - failure to follow procedures - Paragraphs 7, 8.b, 8.c, 9.c.; inadequate procedure - Paragraph 10.f.; and one deficiency - inadequate records - Paragraph 10.e) were identified in two areas.

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## DETAILS

### 1. Persons Contacted

- \*J. Schott, Station Superintendent
- P. King, Assistant Station Superintendent
- S. Martin, Test Coordinator
- R. Link, Operations Supervisor
- R. Price, Training Supervisor
- D. Anderson, Turnover Coordinator
- \*J. Wald, Station Quality Engineer
- \*\*\*B. Culver, Project Manager
- \*\*W. Schwiers, Principal Quality Assurance and Standards Engineer
- \*\*\*R. Wood, QA&S Engineer
- \*H. Gear, Construction Supervisor
- \*\*\*T. Bloom, GE Resident Site Manager
- M. May, GE Site Operations Manager
- \*\*\*L. Aiello, GE Quality Assurance Engineer
- V. Pence, GE Unit Manager, Driveline Components
- J. Occoner, Reactor Controls, Inc.

The inspectors also interviewed other licensee employees including members of the administrative, technical, operating and QA&S staff; employees of the General Electric Company, employees of EDS Nuclear, and employees of Reactor Controls, Incorporated.

\*Denotes those attending the exit interview of [redacted] 19.

\*\*Denotes those attending the exit interview of [redacted] and April 11, 1979.

\*\*\*Denotes those attending the exit interview of [redacted] 11, 1979.

### 2. Licensee Action on Previous Inspection Findings

(Closed) Noncompliance (358/79-01-01). Failure to follow safety tagging (switching order) procedure. The inspector found that the licensee is conducting safety tagging refresher training for all operations personnel and systems engineers as stated in their letter, Borgmann to Heishman, dated February 28, 1979.

(Closed) Noncompliance (358/79-01-04). Failure to develop appropriate procedure to implement to QA&S responsibility assigned in SU.ACP.03. The inspector found that the QA&S Principal Engineer has issued a letter to the Station Superintendent requesting QA&S be informed 48 hours in advance of a flush of a safety related system so that appropriate audits can be conducted on the valve lineup. A QA&S engineer has been assigned responsibility to perform the audits. According to EPD personnel the responsibility to inform QA&S has been delegated to the system engineer in charge of the flush. This action is in accordance with the response given in the letter, Borgmann to Heishman, dated February 28, 1979.

(Open) Unresolved Item (358/78-05-02). Three core support plate pins "repaired" prior to taking bend measurements. During a meeting between the licensee, General Electric Company personnel, and the inspectors, the problem of what could happen if the three pins failed in time, due to the unknown level of cold working each pin experienced, and how to monitor for such failure was discussed. No conclusions were reached. The inspector stated that the licensee's written response to the NRC on this subject to close the outstanding 50.55(e) report should address the following items:

- a. State why the licensee feels the pins will not fail in time (should not be replaced) and give the basis for such position.
- b. Assume the pins will fail and state what possible effects, if any, it could have on plant operation, refueling, maintenance on control rod blades, etc. Among the possible effects, consider possible rotation of the fuel support piece so that the coolant flow paths do not align with the path in the control rod guide tube.
- c. Discuss what methods are available, if any, to monitor for the possible failure of the pins. Include among the methods visual examination during each refueling outage. List the methods the licensee will commit to follow.
- d. Commit to develop prior to power operation the acceptance criteria, for each of the monitoring programs committed to in Item c., and the required corrective action whenever one of the limits is exceeded.

(Closed) Unresolved Item (358/79-01-02). Operator training on the performance of valve check lists and switching orders. The inspector found that the licensee is revising Station Administrative Directive (SAD) OS. SAD.02, Revision 1, "Station Operations" to include under Paragraph 5.1.7 the specific criteria to be followed by plant operators during the performance of checklists. Operators become familiar with changes to SAD's through the use of the All Read Folder which they are required to read once/month and sign off. In addition, the licensee stated all Shift Supervisors are required to discuss the changes with his crew.

Regarding operator performance of switching orders, the licensee has written an Operations Memo on the subject which requires the operator to place the control switch in the close or open position, whichever is called for in the order, to verify the valve position.

### 3. Other Areas Inspected

(Closed) 10 CFR 50.55(e) Event No. M-11, Control Rod Interferences. The inspectors found that the licensee had modified 80 of the control rods by grinding a chamfer in the upper corner of the

control rod velocity limiter. The licensee completed this modification on site in accordance with the General Electric Field Disposition Instruction No. 94/6300, Revision 0 to eliminate the potential interferences between the control rod and the fuel channel. A review of the control rod inspection records for the 80 control rods modified revealed that:

- 51 control rods were modified on all four corners.
- 10 control rods were modified on three corners.
- 11 control rods were modified on two corners.
- 8 control rods were modified on one corner.

No items of noncompliance or deviations were identified.

4. Preoperational Test Program

The inspector reviewed the revision to the Startup Administrative Control Procedures (ACP's) and Startup Project Procedures as of March 2, 1979 to ensure the changes do not conflict with FSAR commitments. The inspector stated that ACP No. 18, "Work Requests" is considered unacceptable and must be rewritten as a Station Administrative Directive in line with the comments given to the licensee by the Project Inspector.

As of April 4, 1979, of the 114 preoperational tests required to be completed prior to fuel loading the licensee has completed writing 108 and has approved for use 77 test procedures. Twenty-two systems or partial systems have been turned over for preoperational testing, 17 preops are in progress and four tests have been completed. No test results have been approved by the SRB yet.

No items of noncompliance or deviations were identified.

5. Preoperational Test Results

The inspectors reviewed the results of the testing performed as of March 20, 1979, on the 24/48 VDC and 125 VDC systems. During the review it was noted that:

- a. Stratification of the electrolyte in the 24/48 VDC lead-calcium battery cells is creating an operational problem for the licensee during recharge following a discharge test in that it took approximately two months before the specific gravity of the sample obtained at the top of the cells reached an acceptable reading (1.205). While most lead-calcium cells have an electrolyte withdrawal tube which permits sampling at a point one-third down from the top of the plates and, according to the vendor, gives a more accurate indication of the state of charge, the Model DC-9 being used for the 24/48 VDC system is not equipped with such a tube.

The inspector stated that while the test results meet the acceptance criteria, the length of time it took to obtain acceptable specific gravity readings appears to be undesirable during plant operation. Some method to obtain a more representative sample of the electrolyte should be considered.

- b. Two cells on the 1B 125 VDC battery failed to meet the acceptance criteria (cell #84 specific gravity of 1.201, and cell #88 voltage of 2.06 volts). The licensee plans to individually recharge these two cells prior to the next test which is the 80% of one-hour rating discharge test. The inspectors stated that if these two cells fail to meet the acceptance criteria following the next discharge test, they should be replaced. This is an unresolved item (358/79-06-01) pending the results of the next discharge test.
- c. Specific gravity readings were informally corrected by the licensee for changes in the electrolyte level without affecting the results of the tests. The licensee has agreed to require such corrections as part of his test procedure.

No items of noncompliance or deviations were identified.

6. Review of System Turnover for Preoperational Testing

The inspectors reviewed the system turnover process for system release for preoperational testing to ensure compliance with the Startup Manual procedures. The review revealed that:

- a. The Master Punchlist, which consolidates the lists of items remaining to be completed, although continuously updated by the turnover group, appeared to be missing an approximately month old item for the low pressure core spray release package identified by one of the licensee's construction contractors. Members of the licensee's staff indicated that a problem existed in the adequacy of the continuous updating of the Master Punchlist and that this inadequacy was impacting on the performance of the preoperational testing. The licensee indicated that the system for compilation of the Master Punchlist was only recently enacted and that the numerous sources of input to the system created problems in assuring a complete punchlist. The licensee has initiated a program to compile punchlist items on computer printout listings as well as to define responsibilities among the licensee's staff. This is an unresolved item (358/79-06-02) pending further review of the system turnover for preoperational testing by the inspectors.

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- b. When revisions are made to drawings on systems which interconnect or interface with the scoped system for release for preoperational testing, and especially in the case of electrical drawings where the connecting drawings are part of the release boundary, the system engineers stated that they felt they were not given enough information in the revision notification to determine how the revision would effect or impact upon the preoperational test or results. It was indicated by the licensee that although additional research might be involved on the part of the system engineer, all information for determining the impact of revisions to interconnecting or interfacing drawings to the preoperational test or its results is available somewhere on site. It was also indicated by the licensee that the turnover group will prepare a brief summary of how the revisions to drawings of interconnecting or interfacing systems will effect the scoped system for release.

This problem with interconnecting and interfacing systems originates from the fact that there is a difference in the number of drawings used in preparing the preoperational test and the number of drawings used when scoping the boundaries of the system for release for preoperational testing. Although the drawings contained in the release package are frozen to the point that no new revisions of the drawings will be released without authorization from the system engineer, the system engineer has no control of the release of revisions of drawings which were used in preparation of the preoperational test procedure which are not also included in the release package for turnover for preoperational testing. The inspectors indicated that these differences in capability to control revisions to drawings which could effect the preoperational test could lead to portions of systems or interconnecting portions between systems not being preoperationally tested. This is an unresolved item (358/79-06-03) pending further review of the preoperational test program by the inspectors.

- c. There seems to be some confusion among the licensee's staff members as to a method for dealing with revisions to drawings for systems which have been preoperationally tested but not turned over for operation. The licensee indicated that procedures are already developed to handle revisions as well as how the revisions affect the validity of the preoperational test results. The licensee indicated that he will review these procedures with the staff personnel.
- d. The licensee has procedures for control and tagging of areas, components, panels and systems which have been turned over for preoperational testing. These procedures

do not address situations where components or panels are shared by one system which is turned over and by another which is not. During the plant tour, it was found that the "Division I LPCS/RHR-A Relay Board" did not have any of its internal components tagged as being turned over even though the LPCS system had been turned over. The licensee indicated that tagging the panel or all of the LPCS relay components within the panel or any other similar situation was a matter of judgement since construction was still allowed on the RHR-A portion of the panel.

It was also noted during the plant tour that most of the electrical control and relay panels such as the "HPCS Relay Board" which was tagged as turned over had their doors completely removed even though there was no work being conducted within the panels in most cases. The inspectors questioned the ability to control further work by construction in such areas as well as in shared system panels. The licensee indicated that the procedures for "System Release for Turnover" SU.RPR.01 and "Construction Work Authorization for Equipment Turned Over for Preoperational Testing", SU.PRP.04 controlled construction work on and around turned over systems, components and areas. The licensee indicated that QA&S also audits the proper completion of the authorization forms involved. Field audits to verify conformance to the above mentioned procedures to verify actual initiation of authorization forms are not done. The licensee indicated that he would review the above procedures with regard to the inspectors comments. This is an unresolved item (358/79-06-04) pending resolution by the licensee and further review by the inspectors.

- e. In discussions with the system engineers, turnover groups and operations personnel it was indicated that there was some confusion as to the disposition of the "Construction Work Authorization" form PRP-04-1 and the "Return of System/Equipment to Construction" startup form 6.5 while construction work was in progress under this authorization. The operations personnel indicated that some of the above mentioned forms were available in the control room although there was no way to know if they reflected all work going on under all such authorizations since there was no designated disposition while work was in progress nor a sequential numbering system established for filing or traceability. The licensee indicated that operations personnel have a definite need for notification of such authorization and would resolve the questions concerning the authorization forms. This is an unresolved item (358/79-06-05) pending resolution by the licensee and further review by the inspectors.

No items of noncompliance or deviations were identified.

7. Plant Tour

The inspectors conducted tours of various areas of the plant to observe activities in progress, general housekeeping and cleanliness, and equipment caution safety and or green preoperational testing tagging. The tours revealed that:

- a. The enclosed area of the spare and 1B 125VDC battery chargers, which have been turned over for preoperational testing, was cluttered with debris. Brooms, general trash, metal grating, hard hats and a welding oven (PL-5) surrounded the 1B battery charger within the wooden barricade.
- b. The spare 125VDC battery charger had one of its side panels missing. Pieces of insulation and concrete chips and heavy dust deposits had settled onto the internals of the spare charger. It was noted by the licensee's staff that the panel had been missing at least since the chargers had been turned over for preoperational testing in October 1978.

Startup Manual procedure SU.ACP.16 "Equipment and Building Cleanliness" requires in Section 5.2 that all safety related equipment shall be maintained free of excessive oil, water or other material which could prevent the equipment from performing its intended safety function. The licensee has failed to follow the Startup Manual procedure SU.ACP.16. This failure to follow procedures is contrary to the requirements of 10 CFR 50 Appendix B, Criterion V, and is considered to be an example of an item of noncompliance (358/79-06-06A) of the infraction level.

8. Overpressurization of Low Pressure Core Spray and Condensate Systems Piping

The inspector reviewed the event of January 19, 1979, during which high pressure core spray (HPCS) water entered the condensate (CD) and low pressure core spray (LPCS) systems because valves 1E22-F003 and F031 had been left open causing a rupture of the steam jet air ejector condenser 1A. The review consisted of interviews with testing and operating personnel and a review of the licensee's final report on his investigation of the event. The review showed that:

- a. Procedure OP.HP.01-4, Revision 0 was used to lineup, fill and vent the HPCS system.
- b. At the completion of the fill and vent operation the operator never completed Step 5.1.5 which required him to close valves 1E22-F003 and F-31. With these two valves open the CD and HPCS systems became crosstied thru the cycled condensate (CY) system. The operator claims he informed the Shift



Supervisor that he had left the two valves open while the latter does not recall being told. This failure to follow procedures is contrary to 10 CFR Part 50, Appendix B, Criterion V and is considered to be an example of an item of noncompliance (358/79-06-06B) of the infraction level.

- c. For some unknown reason, valve 1E21-F025 which had been safety tagged closed under Switching Order No. 781317, dated November 16, 1978, was in the open position. This completed the cross connection of the LPCS and HPCS systems. Violation of Switching Order No. 781317 is contrary to 10 CFR 50, Appendix B, Criterion V and is considered an example of an item of noncompliance (358-79-06-06C) of the infraction level. The switching order was cleared on January 24, 1979. The corrective action which the licensee is currently taking regarding a previous noncompliance with the safety tagging procedure (358-79-01-01) is also applicable to this event, therefore the inspector stated no response to this item of noncompliance is required.
- d. Paragraph 13.0 of Safety Tagging Procedure EC.SAD.02, Revision 00 allows for the operation of equipment for test purposes without the removal of the safety tags. It is possible that valve 1E21-F025 was operated for test purposes thru tags and subsequently left open by error. The inspectors have objected to Paragraph 13.0 of the Safety Tagging Procedure.

On March 21, 1979, the licensee issued operating memo 79-2, Revision 9, which specifically requires that "Do Not Operate" tags must be removed before energizing electrical equipment or opening valves. An exception is made in the case of electrical testing conducted by EOTD in which case only the EOTD master tag will be left in place.

- e. On December 12, 1977, a General Electric system engineer recommended that a check valve be installed on line 1HP18A3 downstream of valve 1E22-F031 because a similar overpressurization of a small section (up to valve 1CY013) of low pressure piping had occurred. The recommendation was rejected because the licensee thought that two valves (1E22-F003 and F031) plus administrative controls were sufficient to prevent recurrence. The licensee stated the check valve will be installed. All other ECCS systems have check valves in the line from the CY system.

The inspector stated his concern regarding repeatable occurrences where a lack of communication or understanding between parties have resulted in damage to equipment. It is our intention to closely monitor the licensee's performance during the preoperational test program to determine the

the adequacy of plant staffing and training as fuel load date approaches.

9. Flooding of LPCS/RHR-A Pump Room Event

The inspectors reviewed the event which occurred on March 17, 1979, involving the LPCS/RHR-A pump room. The inspectors interviewed construction and operations personnel involved in the event and reviewed the operations and shift engineering logs. The review revealed that:

- a. On March 17, 1979, flushing was being conducted on the fuel pool cooling and cleanup system. The licensee normally flushes to the suppression pool. The suppression pool was unavailable due to modifications. This flush was to the clean-up phase separator tank which was lined up to the reactor building equipment drain tank for overflow.
- b. At lunchtime the engineer in charge of the flush told the pipe fitters working under him to close the valves to secure flushing and break for lunch. The valves were not closed to stop the flush. Water overflowed from the reactor building equipment drain tank and into the corner room which contained the RHR-A, LPCS and jockey pumps and its associated instruments and valves for the LPCS system as well as the RHR-A system. The configuration of the corner room is such that it will act as a pool up to approximately five feet. When water was discovered flowing out of this corner room into the annular area at the base of the wetwell the uncontrolled flush was terminated by closure of the valves from the condensate storage tank supply. The sump pumps in the RHR-A and LPCS pump room had been out of service due to maintenance. LPCS system has been turned over for preoperational testing.

The licensee indicated that all instrumentation involved in the flood of the RHR-A/LPCS pump room would be dried, cleaned inspected and recalibrated. Restoration of the instrumentation had already begun while the inspectors were on site. The licensee also indicated that the method of using available storage tanks for deposition of flushing waters would not be continued due to the problems experienced. The licensee did not, however, indicate what methods would be used during the time that the suppression pool was not available.

This event, as well as others experienced by the licensee in recent months are considered to be examples of poor communications experienced during operation of systems for testing and flushing. The inspectors indicated to the licensee that a need for developing better communications existed. This is considered to be an unresolved

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item (358/79-06-07) pending resolution by the licensee and further review by the inspectors.

- c. During the flushing on the 17th of March, 1979, the floor drains were also filled and backed up in the reactor building at the 503 level. This backup resulted in a water washdown of the HPCS motor and pump. It was indicated by the operating staff that the HPCS pump motor and the RHR-C pump motor, both in the same corner room, had been washed down in similar events several times in the past few months. HPCS has been turned over for preoperational testing. Startup Manual Procedures SU.ACP.16 "Equipment and Building Cleanliness" requires in Section 5.2 that all safety related equipment shall be maintained free of excessive oil, water or other material which could prevent the equipment from performing its intended safety functions. The licensee has failed to follow Startup Manual Procedure SU.ACP.16 in the cases of the flooding of the LPCS/RHR-A pump room and the wash down of the HPCS pump motor. This failure to follow procedures is contrary to the requirements of 10 CFR 50 Appendix B, Criterion V. These two failures to follow procedures are considered examples of items of noncompliance (358/79-06-06D) of the infraction level.

10. Control Rod Blades Inspection

The inspectors reviewed the results of the control rod blade inspections performed by the licensee during the months of July thru October 1978. Our review revealed that:

- a. Of the 137 control rod blades originally inspected using 0.280 inch and 0.320 inch envelope gauges, 86 failed to pass the .280 inch envelope gauge and of those 86, four also failed the .320 inch gauge.
- b. In accordance with the Inspection Procedure 22A4387, a clamp, which applied approximately 40 pounds of pressure against the blade sheath, was placed approximately one to two inches from the area in question (it should be noted that the procedure does not state where to place the clamp). Thickness measurements were taken with a micrometer and of the 86 control rod blades 11 still exceeded .280 inches in thickness. According to Reactor Controls, Inc. (RCI) records the 11 blades in question were:

<u>C. R. Blade Serial No.</u>	<u>Blade No.</u>	<u>High Spot</u>
A400	1	0.286
A420	4	0.283
A435	2	0.289

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A440	2	0.281
A443	2	0.282
A453	1	0.281
A461	3	0.285
A484	3	0.285
A501	2	0.282
A510	2	0.290
A515	4	0.282

- c. Of the 11 control rod blades four (A400, A435, A443 and A461) also failed the 0.320 inch gauge and were rejected per Field Deviation Disposition Request (FDDR) No. KN-1-288. Blade A484 was rejected solely on the basis of a 0.285 inch reading. The exact location of the high area was not recorded. In addition, control rod blade A437 was rejected on the same FDDR due to numerous nicks in the sealing area.
- d. The Inspection Procedure 22A4387 R4 was modified and the changes recorded by FDDR No. KN-1-286. On the FDDR the exact size and location of the high area was determined for the remaining six control rod blades (A420, A440, A453, A501, A510 and A515). The size of the inspection area was reduced and the 40 pound clamp was placed directly over the high point area while deep throat micrometer readings were taken around the clamped area.
- e. As a result of FDDR No. KN-1-286 the six blades in question were accepted on the basis that the thickness of the high point area was reduced to less than 0.280 on five of the blades with the 40 pound clamp over the area. For the sixth blade (A-510) the thickness remained at 0.290, but the blade was accepted on the basis that half of the high point area was located outside the reduced area of interest and a statement that it "met the intent" of 22A4387.

A review of RCI's records showed that no records were kept of the work done as a result of FDDR No. KN-1-286. No raw data exists to verify the conclusions presented by the FDDR.

Failure to maintain sufficient records is contrary to 10 CFR 50 Appendix B, Criterion XVII and Paragraph 17.1.17 of the FSAR and is considered to be an item of noncompliance (358/79-06-08) of the deficiency level.

On April 10, 1979, the six blades in question were reinspected by the licensee, RCI, and the General Electric Company. The reinspection was witnessed by NRC inspectors. Accurate, detailed records of the reinspection were kept this time

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and as a result no response is required from the licensee on the above item of noncompliance.

- f. During the review of Inspection Procedure 22A4387 and FDDR No. KN-1-286, which supposedly clarified the inspection procedure, it was noted that both failed to specify what direct readings were desired, where such readings were to be taken, how the clamp was to be used, etc. and as a result, both the Inspection Procedure and the FDDR are considered to be inadequate. This inadequacy is contrary to 10 CFR 50 Appendix B, Criterion V and Paragraph 17.1.5 of the FSAR and is considered to be an example of an item of noncompliance (358/79-06-09) of the infraction level.

A meeting was held on April 10, 1979, between the General Electric control rod design engineer, the licensee and the NRC inspectors at which time the blade acceptance criteria (.280"), the use of the 40 pound clamp and the results of thin control rod qualification tests, etc. were discussed. The prototype tests were performed by the General Electric Company using 0.080" and 0.120" wall fuel channels for the purpose of determining the degree of misalignment, channel deformation, water gap reduction, etc. at which the operational performance of the control blade would be affected. The test results showed that considerable misalignment (between 10 to 14 times the allowable during core internals installation); or reduction of the water gap, due to misalignment and channel deformation, by a factor of approximately 1.5 to 2.0 would be required before operational difficulties were first experienced. Wear of the control rod sheath and fuel channels was measured on tests conducted for the designed 20 year life cycle. Based on the results of these tests and of the reinspection performed on April 10, 1979, the control rod blades presently supplied to the Zimmer Station are considered to be satisfactory.

During the discussion with the General Electric company personnel it was stated that for BWR's 5 it is recommended that the fuel channels be rotated during each refueling outage. Since this is new information and since it was not clear how and when the channels are to be rotated the inspector requested that the licensee obtain written clarification of General Electric's position regarding the desirability or need for channel rotation. This is an unresolved item (358/79-06-10) pending further review of this matter by the licensee and the inspector.

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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. Unresolved items disclosed during the inspection are discussed in Paragraphs 5.b, 6.a, 6.b, 6.d, 6.e, 9.b, and 10.

12. Exit Interview

The inspectors met with licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection on March 23, and April 11, 1979. The inspectors summarized the purpose and the scope of the inspection and the findings. In response to certain of the items discussed by the inspector, the licensee representatives:

Acknowledged the statements by the inspector with respect to the items of noncompliance (Paragraph 7, 8, 9 and 10).

Stated the SAD covering "Work Requests" would be completed by March 31, 1979 (Paragraph 4).

Objected to the inspector's position regarding the three core support plate pins (Paragraph 2).

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