

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

Region I

Report No. 50-289/79-21
50-320/79-29

Docket No. 50-289'
50-320

License No. DPR-50 Priority -- Category c
DPR-73 c

Licensee: Metropolitan Edison Company
100 Interpace Parkway
Parsippany, New Jersey 07054

Facility Name: Three Mile Island Nuclear Station, Units 1 and 2

Inspection at: Middletown, Pennsylvania

Inspection conducted: October 23 - November 27, 1979

Inspectors: *D. R. Haverkamp* 12/20/79
D. R. Haverkamp, Reactor Inspector date signed
R. J. Conte 12/20/79
R. J. Conte, Reactor Inspector date signed
G. P. Greger 12/20/79
L. R. Greger, Senior Radiation Specialist date signed
G. P. White 12/20/79
J. R. White, Senior Radiation Specialist date signed
G. P. Yunas 12/20/79
G. P. Yunas, Senior Radiation Specialist date signed
Approved by: *E. C. McCabe, Jr.* 12/20/79
R. W. McGaughy, Acting Chief, Site Operations date signed
Section, TMI Site Office

Inspection Summary:

Inspection on October 23 - November 27, 1979 (Combined Report Nos. 50-289/79-21;
50-320/79-29)

Areas Inspected: Special inspection by NRC TMI Site staff of: licensee action on previous inspection findings (Units 1 and 2), new and revised procedures (Unit 2); plant operations including shift activities as monitored by NRC shift inspectors (Units 1 and 2); fire drill at radwaste storage area (Unit 2); EPICOR II operating experience and health physics practices (Unit 2); and, in-plant health physics including documentation, posting and labeling reviews (Units 1 and 2). The inspection included continuous shift coverage by NRC Inspectors.

Results: Of the six areas inspected, one item of noncompliance was found in one area (Infraction - failure to store and control licensed materials in unrestricted areas, Paragraph 8.c).

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DETAILS

1. Persons Contacted

Licensee Representatives

Principal licensee and contractor personnel contacted during this inspection are identified in Paragraph 10.

NRC Inspection Participants

The following personnel participated in this inspection.

J. Baird, IE:RV, October 23 - November 6, 1979
C. Cain, IE:RIV, November 27, 1979
J. Carlson, IE:RV, October 30 - November 13, 1979
R. Conte, IE:RI, October 23 - November 27, 1979
H. Crocker, IE:RI, November 19 - November 27, 1979
N. Dubry, IE:RIII, November 13 - November 27, 1979
S. Ewald, IE:RII, October 23 - October 29, 1979
E. Flack, IE:HQ, November 27, 1979
L. Greger, IE:RIII, October 23 - October 30, 1979
A. Hardin, IE:RII, October 23 - October 30, 1979
D. Haverkamp, IE:RI, October 23, - November 27, 1979
G. Kalman, IE:RI, November 1 - November 27, 1979
D. Kelley, IE:RIV, November 13 - November 27, 1979
H. Kister, IE:RI, October 23 - October 24, 1979
B. Little, IE:RIII, November 27, 1979
R. McGaughy, IE:RI, October 25 - November 20, 1979
D. Miller, IE:RIII, October 30 - November 13, 1979
W. Millsap, IE:RII, October 30 - November 13, 1979
R. Nimitz, IE:RI, October 23 - October 30, 1979
W. Raymond, IE:RI, October 23 - November 17, 1979
D. Sly, IE:HQ, November 20 - November 27, 1979
R. Thomas, IE:RV, November 6 - November 20, 1979
J. White, IE:RI, October 30 - November 4, 1979 and November 20 -
November 27, 1979
J. Wray, IE:RII, November 13 - November 27, 1979
G. Yuhas, IE:RI, November 5 - November 20, 1979

2. Licensee Action on Previous Inspection Findings

(Closed) Inspection Finding (320/79-17-03): RCS Leakage Calculations. Procedure Change Request No. 2-79-131 dated August 21, 1979 was issued for TMI 2 Surveillance Procedure 2301-3D1, RCS Inventory, to correct RCS leakage calculations involving operator induced level changes to the reactor coolant drain tank and the make up tank during leak rate measurements. The inspector verified that revised Data Sheet 1 (used when the plant computer is operational) and Data Sheet 2 (used when the computer is unavailable) of the procedure correctly adjusts level changes to "equivalent RCS conditions." This item is closed.

The inspector noted that TMI Unit 1 Surveillance Procedure SP 1303-1.1 incorrectly accounts for operator induced changes to the make up tank, as identified in Inspection Report No. 50-320/79-17. As

of November 16, 1979, this procedure was not reviewed and revised by the Unit 1 operating staff. This item was discussed with a member of the licensee management staff, who stated that the leak rate procedure would be revised by December 31, 1979. This item is considered unresolved pending completion of the licensee operating staff review and revision of SP 1303-1.1 (289/79-21-01).

3. Facility Procedure Review (Unit 2)

Operating Procedures (OP), Emergency Procedures (EP), Surveillance Procedures, and Special Operating Procedures (SOP), including subsequent revisions, were reviewed by the NRC on site staff during this inspection.

Procedure review included both health physics and operations aspects with consideration of the following: (1) the procedure, when implemented, would not degrade the containment of radioactive material, jeopardize core cooling, or result in excessive personnel exposure; (2) the procedure conforms to the general criteria of TS 6.8, "Procedures", TS 6.11, "Radiation Protection Program," and, ANSI N-18.7, 1976; and, (3) the technical content of the procedure is adequate to perform the intended evolution.

The procedures reviewed included approximately: 38 Operating and Special Operating Procedures; 5 Emergency Procedures and 50 Surveillance Procedures. Further, 26 Temporary Changes to the above types of procedures were also reviewed.

Composite NRC comments on procedures were forwarded to the licensee. No instances of failure to resolve NRC comments were identified.

4. Review of Plant Operations (Units 1 and 2)

a. Unit 1

(1) Shift Logs and Operating Records

The inspector reviewed the following logs and records:

- Shift Foreman Log and Control Room Operator Log Books from May through July 1979;
- Control Room Operator's Log Sheets, Primary Auxiliary Operator's Log-Tour Readings, Primary Auxiliary Operator's Log-Liquid Waste Disposal Panels, Secondary Auxiliary Operator's Log Sheets, and Auxiliary Operator Log Sheets-Out-Building Tour from October 1 through November 4, 1979;
- Shift and Daily checks from October 1 through November 4, 1979;
- Jumper, Lifted Lead, and Mechanical Modifications Log (active and cleared) from March to November 1979;

- Fire System Removal from Service Notification Log from August to November 1979;
- ISI Tag Book from March to November 1979;
- Do Not Operate and Caution Tag Log from March to November 1979;
- Transient Cycle Log Book from March to November 1979; and,
- Unit #1 Operations Department Memo 79-2.

The logs and records were reviewed to verify the following items:

- Logkeeping practices and log book reviews are conducted in accordance with established administrative controls;
- Log entries involving abnormal conditions are sufficiently detailed;
- Operating orders do not conflict with Technical Specifications (TS);
- Jumper log and tagging log entries do not conflict with TS; and,
- Jumper, Lifted Lead and Mechanical modification and tagging operations are conducted in conformance with established administrative control.

Acceptance criteria for the above review included inspector judgement, applicable Technical Specifications, and the following procedures:

- Administrative Procedure (AP) 1002, "Rules for the Protection of Employees Working on Electrical and Mechanical Apparatus;"
- AP 1010, "Technical Specification Surveillance Program;"
- AP 1012, "Shift Relief and Log Entries;"
- AP 1013, "Bypass of Safety Functions and Jumper Control;"
- AP 1016, "Operations Surveillance Program;"
- AP 1033, "Operating Memos and Standing Orders;"
- AP 1037, "Control of Caution and DNO Tags;" and,

- Operating Procedure (OP) 1104-45, "Fire Protection System."

No items of noncompliance were identified.

(2) Plant Tour

At various times between October 23 and November 27, 1979, the inspectors conducted tours of the following accessible Unit 1 areas: Auxiliary Building; Turbine Building; Fuel Handling Building; Reactor Building; Control and Service Building; Control Room; Switchgear rooms; and, Inverter and Battery rooms.

The following observations/discussions/determinations were made:

- Control room recorders and monitoring instrumentation for various process parameters were observed;
- Radiation controls established by the licensee, including the posting of radiation and high radiation areas, the condition of step-off pads, and the disposal of protective clothing, were observed. Radiation Work Permits used for entry to radiation and controlled areas were reviewed. Actual radiation levels were measured and compared with posted values throughout the plant;
- Plant housekeeping, including general cleanliness conditions and storage of materials and components to prevent safety and fire hazards, were observed;
- Systems and equipment in all areas toured were observed for the existence of fluid leaks and abnormal piping vibrations;
- Selected piping snubbers/restraints were observed for proper fluid level and condition/proper hanger settings;
- The indicated positions of selected electrical power supply breakers, control board equipment start switches and remote-operated valves and the actual positions of selected manual-operated valves were observed;
- Selected safety-related instruments/gauges were observed for proper calibration interval;
- Selected equipment lockout tags, caution tags, and do-not-operate tags were observed for proper posting and the tagged equipment was observed for proper positioning, where applicable;

- Selected jumper and lifted lead markers were observed for proper identification and the affected wiring changes were observed for proper completion;
- The Control Board was observed for annunciators that normally should not be lighted during the existing plant conditions. The reasons for the annunciators were discussed with the control room operator;
- Control Room manning was observed on several occasions during the inspection, and a shift turnover was observed to verify that continuity of system status was maintained;
- Selected fire extinguishers were observed for unobstructed access and adequate pressure and/or level;
- Selected fire alarm reporting stations were observed to verify that the stations were clearly identified and unobstructed;
- Battery Room ventilation system was observed for proper operation;
- Selected areas were observed to verify that designated "no smoking" areas did not exhibit evidence of smoking; and,
- Battery power supplies for selected emergency fire protection and lighting equipment were observed for proper operability.

Acceptance criteria for the above items included inspector judgment and requirements of 10 CFR 50.54(k), Regulatory Guide 1.114, applicable Technical Specifications, and the following procedures:

- AP 1002, "Rules for the Protection of Employees Working on Electrical and Mechanical Apparatus;"
- AP 1003, "Radiation Protection Manual;"
- AP 1008, "Good Housekeeping;"
- AP 1009, "Station Organization and Chain of Command;"
- AP 1028, "Operator at the Controls;"
- AP 1037, "Control of Caution and DNO Tags;" and,
- AP 1050, "Control of High Radiation Areas."

No items of noncompliance were identified.

(3) Status Meetings

NRC personnel attended licensee meetings to observe and ascertain additional plant status information. The meetings attended included those listed below, and involved discussions of: plant status; specific system operation; pending or planned maintenance and construction activities; radioactive waste management and plant radiological status; and Restart actions status.

- Unit 1 Plan of the Day/Maintenance Review
- Unit 1 Restart Modification/Startup Testing Management Review

b. Unit 2(1) Daily Surveillance Reviews

Shift inspectors reviewed items listed in Paragraph 5 to ascertain plant status and monitor licensee performance in the Operations and Health Physics areas.

(2) Status Meetings

NRC personnel attended licensee meetings to observe and ascertain additional plant status information. The meetings attended included those listed below, and involved discussions of: plant status; specific system operation; pending or planned construction activities; radioactive waste management and plant radiological status.

- Daily Plant Status Meetings
- Standby Pressure Control Meetings (Weekly)
- Mini-Decay Heat Removal Meetings (Weekly)
- Weekly Planning Meeting
- Technical Working Group Meeting (Weekly)
- Monthly Technical Meeting
- Biweekly Containment Purge Task Force Group Meeting
- Biweekly Containment Entrance Task Force Group Meeting
- Radwaste Operations Meeting (Twice/Week)

(3) Findings

No items of noncompliance were identified, however, the following unresolved item was noted.

On November 7, 1979, the licensee measured Reactor Building water level at 290.54 feet (8.04 feet above the building floor). A limit of 290.5 feet, and increasing, was administratively set by the licensee for the plant operators to immediately notify upper management and the NRC. This was not accomplished until several hours after the measurement was known by the control room operators.

Subsequent review of this event indicated that the limit of 290.5 feet was specified on data sheets used by the plant operators but not specifically addressed in the associated procedure, R-2-79-034, Reactor Building Sump Level Measurement, Revision 0, July 2, 1979. The licensee representative indicated the limit appears outdated since it was established at a time when sump level was approximately 280 to 285 feet.

Further, the individual operators and intermediate managers reviewed this event with upper management and were appropriately counseled.

Further, the licensee representative stated that an evaluation of the 290.5 feet limit would be made and a revised limit, if necessary, for proper notification including the NRC would be specified in R-2-79-034. This is unresolved pending completion of action by the licensee as stated above and subsequent NRC review (320/79-29-01).

5. Shift Inspection Reviews (Units 1 and 2)

a. Plant Tours

On a daily basis three shift inspectors completed a general plant tour including all control points and selected radiologically controlled areas. Observations included:

- Cleanliness and housekeeping conditions;
- Fire protection measures;
- Construction status and startup testing progress;
- Access control to radiologically controlled areas;
- Use of survey meters including personnel frisking techniques;
- Proper use of respiratory protection equipment;

- Adherence to Radiation Work Permit (RWP) requirements;
- Various logs/records to ascertain current licensee actions/evaluations/problem areas; and,
- Adherence to Health Physics and Operating Procedures.

b. Procedural Implementation/Significant Evolutions Witnessed

A fire drill was observed to verify compliance with procedural requirements, the use of properly approved procedures and the proper use of administrative controls for procedural changes.

The fire drill was conducted at an interim radwaste storage area (Paint Shed) on November 8, 1979 (see Paragraph 6).

c. Measurement Verifications

The below listed measurements were independently obtained to verify the quality of licensee performance in these selected areas:

- Radioactive Material Shipping; and,
- Radiological Control Radiation and Contamination Surveys.

No items of noncompliance were identified during shift inspection reviews.

6. Fire Drill at Radwaste Storage Area (Unit 2)

On November 8, 1979, NRC personnel observed a fire drill at a low level radwaste storage area (Paint Shed) on site. The following observations were made:

- There was excessive delay in personnel response to the area;
- There was inadequate equipment in the near vicinity of the area to fight the fire. As an example, the nearest fire hydrant was an excessive distance from the scene.
- There was inadequate radiation monitoring and protection equipment to handle potential radiological consequences;
- Basic fire fighting techniques were implemented, however, the approach to the scene of the fire was downwind implying personnel were potentially contaminated and/or exposed;
- The Paint Shed area is a remote section of the site. There was no installed instrumentation for fire detection and remote readout capabilities;
- When personnel arrived at the scene there was no thorough and aggressive assessment of the scene from a radiological standpoint.

The licensee's critique of the drill was monitored by the NRC staff. The following short term measures were planned and implemented as of November 13, 1979.

- An adequately equipped fire truck was located near the Unit 2 Administration Building;
- A van equipped with radiacs, scott air packs and additional fire fighting equipment was located near the Unit 1 process center; and,
- Fire brigade training of the installed equipment was completed.

Long term fire protection measures are being developed. This is unresolved pending NRC review of these long term measures (320/79-29-02).

7. Operating Experience and Health Physics Practices Associated with the EPICOR II System (Unit 2)

During the initial one month of EPICOR II operation the below listed items were reported by the licensee to the NRC staff. Associated licensee action to resolve outstanding issues in these areas were also monitored by NRC staff.

- On or about October 25, 1979, during the refill of filter overflow loop seal line, fill water (approximately 3,000 gallons) was inadvertently discharged into the building sump rather than back into one of the filters.

The licensee representative stated that this was attributed to operator error. The individual was counseled.

- During the period October 27-31, 1979, the Motor Operators (MOV) for ALC-V43 and ALC-V86 were incorrectly installed resulting in a misalignment of valve position indicator versus actual valve position (e.g., indicated open while valve was actually closed). This was not discovered until November 1, 1979, when operators tried to conduct system line flushes.

A review of the maintenance package indicated that the procedure was adequate to preclude the incorrect replacement of the MOV. Further, based on discussions with an operator who was on duty at the time, it was stated that specific directions were given to the maintenance technicians to keep track of valve positions for alignment purposes. It appeared the tracking method for MOV alignment versus valve actual position was inadequately handled.

The licensee representative stated that the need to check out the position by the valve was not adequately passed on to or known by the crew who eventually started the system. Future plans for similar type of maintenance include the use of match marks or other control methods. Further, operators reviewed the circumstances of this event.

- On November 18, 1979, during the installation of filter F-1 a quick disconnect connection of the influent process line was uncapped while pressurized by approximately 80 psig air (with a small amount of water in the line). This resulted in a discharge of an air mist into plastic bags, which ripped, and spread contamination in the area around the filter. Initial review of the incident indicated that apparently an upstream valve in one or two air supply lines (for water blowdown) leaked while downstream isolations in the process line were inadvertently left open.

The applicable procedure for the filter installation assumes the proper completion of the filter removal procedure, which requires both isolation valves to be shut. The completed procedure and operator statements indicate that both upstream and downstream valves were last known to be shut. After the incident, the downstream valves were found to be open.

Licensee action included the following. The liner installation procedure (OP 2104-4.9) was revised to verify bounding valve lineup and verification of line depressurization and liquid venting prior to reconnecting the process hoses. The entire Chemical Cleaning Building (CCB) was decontaminated to clean area levels.

- The use of standing RWP's for specific work activity does not meet the intent of HPP 1613. For example, the uncapping of the influent process line for filter replacement (November 18, 1979, Contamination Incident) was conducted under a Standing RWP #7980411.

The RWP's in use at EPICOR II were reviewed and revised. Further review of plant-wide RWP's is ongoing and associated Health Physics procedure changes were initiated. This area continues to be monitored by the NRC staff.

- Resin traps were allowed to accumulate in the EPICOR II area contributing to excessive background radiation area.

Three resin traps have been removed. Further a lead lined storage cask has been procured and is intended to be used for temporary storage of traps in the CCB. This cask is expected to significantly reduce the area radiation levels during temporary storage.

Further, an ALARA engineering survey of the facility will be performed during the next planned outage.

The NRC staff had no further comments in these areas.

8. In-Plant Health Physics

a. Unit-2 Air Sampling Program

The inspector reviewed the licensee's air sampling program against the requirement of Health Physics Procedure 1616.4, "Implementation of Air Sample Counting, Handling and Actions." Procedure steps 3.8 through 3.11 require the licensee to submit selected samples for Sr-89 and Sr-90 activity analysis on a weekly basis to ascertain the current ratio of strontium activity to Cs-137. Such evaluation allows the licensee to progress with recovery efforts while awaiting the results of the analysis for Sr-89 and Sr-90 (analytical process that may take as long as 15 days).

Though the procedure was first implemented on October 9, 1979, the licensee has failed to submit air samples for the strontium evaluation though such requests were made in accordance with procedure 1616.4. Further review indicates that the licensee is utilizing ratios (Sr-89 and Sr-90 to Cs-137) that were developed from air samples taken August 5 and August 28, 1979. These samples showed that Sr-90 was 0.19 of the Cs-137 activity; and Sr-89 was 13 times the Cs-137 activity. Since it is expected that this ratio would diminish with time, no health and safety problem is apparent. However, the licensee is taking action to assure that the procedural specifications are adhered to. This will be monitored by the NRC staff pending completion of licensee efforts in this area (320/79-29-03).

In the course of this review it was additionally determined that the Cs-137 analyses which were being performed with SAM-2 instrumentation were showing results significantly below (by as much as a factor of 2) the results that were later reported by the licensee's Geli instrumentation. As a result of this variation, utilization of the SAM-2 equipment was curtailed, but no change to 1616.4 was made to provide directions in the interim period.

As of December 4, 1979, the licensee initiated actions to review Health Physics procedure 1616.4 to assure that the procedure is workable and provides adequate directions; and the licensee has initiated re-evaluation of counting equipment calibration technique and efficiency determination. This will be monitored by the NRC staff pending completion of the licensee's efforts in this area (320/79-29-04).

b. Personnel Exposure Control

- (1) In reviewing portions of the licensee's program regarding personnel exposure it was determined that the licensee had not fully implemented a new regulation, 10 CFR 20.102, "Determination of prior dose," which states in paragraph (a):

- "Each licensee shall require any individual, prior to first entry of the individual into the licensee's restricted area during each employment or work assignment under such circumstances that the individual will receive or is likely to receive in any period of one calendar quarter an occupational dose in excess of 25 percent of the applicable standards specified in § 20.101(a) and § 20.104(a) to disclose in a written, signed statement, either (1) that the individual had no prior occupational dose during the current calendar quarter, or (2) the nature and amount of any occupational dose which the individual may have received during that specifically identified current calendar quarter from sources of radiation possessed or controlled by other persons. Each licensee shall maintain records of such statements until the Commission authorizes their disposition."

On November 2, 1979, an NRC inspector determined that the licensee was not requesting a written signed statement from individuals in accordance with the regulatory requirement. Upon notification, the licensee initiated action to revise the personnel dosimetry processing procedure to include such written statements as is required.

This will be monitored by the NRC staff pending completion of the licensee's effort in this area (289/79-21-02; 320/79-29-05).

- (2) The licensee determined on October 31, 1979, that four extremity monitoring devices (TLD finger rings) that were issued and subsequently used by two individuals between October 29 and October 30, 1979, did not contain any TLD elements resulting in unmonitored exposure to the individuals. Follow-up investigation by the licensee revealed the seventy-four additional TLD finger rings that were available for personnel (but not used) also did not contain TLD elements. All devices were removed from service.

An investigation of this event revealed that Harshaw TLD finger rings are normally forwarded to TMI in a pre-packaged state that allows them to be issued to personnel without any additional assembly or preparation. On October 29, 1979, a dosimetry technician was preparing a package of TLD extremity devices (rings) for issuance but failed to realize that no TLD element was included in the ring when placing the Harshaw logo over the cavity that houses the element.

According to the licensee, a discussion between several dosimetry technicians on October 31, 1979, concerning the proper practice for assembling the TLD rings lead to the

realization that the TLD rings prepared on October 29, 1979, may have been improperly handled. An immediate recall of all TLD rings began and an inspection of the issued rings lead to the following evaluation:

- Babcock and Wilcox Company was issued 14 TLD rings - all without chips;
- Unit II Health Physics was issued 60 rings - all without chips; and,
- Unit I Health Physics was issued 30 rings - all with chips.

Of the 74 rings that were issued without chips, only two personnel actually wore the rings before the recall occurred. Six other personnel were issued TLD rings but never wore them prior to recall.

The licensee evaluated the exposure to hands of the two individuals who were subject to exposure in the course of their work assignment and determined the following:

- Individual A - 532.5 mrem (right and left hands)
- Individual B - 264 mrem (right and left hands)

It was brought to the licensee's attention that this incident was an example of failure to implement adequate management controls and could have resulted in a much more serious situation had the error gone unnoticed.

Upon determination of this incident the licensee initiated action to revise the applicable procedure and instruct personnel in the proper method for dosimeter preparation.

This item will be monitored by the NRC staff pending completion of the licensee's efforts in this area (320/79-29-07).

c. Radioactive Material Accountability and Control

The licensee's program for shipping radioactive material was reviewed against the requirements of 10 CFR 20.207, "Storage and Control of Licensed Materials in Unrestricted Areas," which states,

"(a) Licensed materials stored in an unrestricted area shall be secured from unauthorized removal from the place of storage. (b) Licensed materials in an unrestricted area and not in storage shall be tended under the constant surveillance and immediate control of the licensee."

On November 15, 1979, at least seven drums of dry waste material which were at that time thought to be non-radioactive were turned over to a vendor to be transported for disposal at the Harrisburg city refuse dump. The material was refused by the operator of the facility on the grounds that the dump was not suited to dispose of steel drums. The vendor transported the drums to his warehouse in Elizabethtown, PA, for overnight storage, and returned the material to the Three Mile Island facility of November 16, 1979. Subsequent surveys by the licensee revealed that two of the drums had radiation levels on the external surface of 3 mR/hr and 0.5 mR/hr, respectively.

Further investigation by the licensee and an NRC inspector indicated that the drums were not identified as containing radioactive material however, one drum had a "LSA" (low specific activity) stencil painted over and the other had portions of a radioactive material sticker affixed.

The inspector indicated that contrary to 10 CFR 20.207 this licensed material was permitted to be stored in an unrestricted area without adequate control and surveillance by the licensee.

This item constitutes noncompliance with 10 CFR 20.207 (320/79-29-06).

Upon discovery the licensee initiated immediate action to better control the handling of material that is normally collected as trash to prevent recurrence of this type of incident. A letter to the senior Metropolitan Edison staff from the Vice-President and Radiological Controls Manager details the actions that were taken by the licensee in immediate response to the event. Further, a Licensee Event Report (LER) was initiated on this event.

9. Unresolved Items

Unresolved items are findings about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. Unresolved items disclosed/reviewed during this inspection are discussed in paragraphs 2, 4, 6, and 8.

10. Exit Interviews

Meetings were held with licensee management to discuss inspection findings and concerns as noted below.

Meeting on November 21, 1979

Licensee Representatives

G. Kunder, Supervisor Technical Specification Compliance
 J. Logan, Superintendent, Unit 2
 B. Marshall, Radwaste Engineer

NRC Representatives

R. Conte, Reactor Inspector
H. Crocker, Acting Chief, Site Operations Section
J. White, Senior Radiation Specialist

Findings on EPICOR II operating experience and health physics practices were discussed.

Meeting on November 30, 1979Licensee Representatives

J. Barton, Manager Site Operations (Unit 2)
J. Chawastyk, Operations Supervisor (Unit 2)
R. Harding, Supervisor of Licensing
J. Herbein, Vice-President-Nuclear Operations (Unit 1)
R. Heward, Manager Radiological Controls (Unit 2)
R. Wilson, Director TMI-2

NRC Representatives

J. Collins, Deputy Director, TMI Support
R. Conte, Reactor Inspector (Unit 2)
H. Crocker, Acting Chief, Site Operations Section
D. Haverkamp, Reactor Inspector (Unit 1)
J. White, Senior Radiation Specialist

Scope and findings in the operations and health physics areas for the inspection period were discussed.