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

Region I

Report No. 50-293/81-02

Docket No. 50-293

License No. DPR-35 Priority ---- Category C

Licensee: Boston Edison Company

800 Boylston Street

Boston, Massachusetts 02199

Facility Name: Pilgrim Nuclear Power Station

Inspection at: Plymouth, Massachusetts

Inspection conducted: January 5 - 30, 1981

Inspectors: *John D. Johnson*
J. Johnson, Senior Resident Inspector

3/24/81
date signed

date signed

date signed

Approved by: *R. Keimig*
R. R. Keimig, Acting Chief,
Reactor Projects Section No. 1B
Projects Branch No. 1

3-24-81
date signed

Inspection Summary:

Inspection on January 5-30, 1981 (Report No. 50-293/81-02)

Areas Inspected: Routine unannounced safety inspection of plant operations including followup on previous inspection findings, an operational safety verification, followup on events, surveillance activities, licensee status of TMI T.A.P. Category 'B' items, ATWS procedure review, LER followup, a review of organization/personnel changes, and a survey of potential leaking detectors. The inspection involved 92 hours by the resident inspector.

Results: Four items of noncompliance were identified in one area. (Failure to perform required surveillances for ATWS instrumentation, paragraph 3.b.(1); Failure to implement station administrative procedures for the control of Borax, for required log entries and for required valve lineup signature verification, paragraph 3.b.(2), Failure to properly review, approve, and distribute station procedures, paragraph 3.b.(3); and Failure to follow alarm response procedure for deenergizing annunciators, paragraph 3.b.(4).

DETAILS

1. Persons Contacted

r. Famulari, QC Supervisor
E. Graham, Sr. Plant Engineer
R. Machon, Nuclear Operations Manager - Pilgrim Station
C. Mathis, Deputy Nuclear Operations Manager
T. McLoughlin, Sr. Compliance Engineer
P. Smith, Chief Technical Engineer
R. Smith, Sr., Chemical Engineer
R. Trudeau, Chief Radiological Engineer
P. Williard, I&C Engineer
E. Ziemanski, Management Services Group Leader

The inspector also interviewed other members of the health physics, operations, security, maintenance, and technical staffs.

2. Followup on Previous Inspection Findings

(Closed) Noncompliance (293/80-25-01); The licensee reinstructed the personnel involved on leaving valves out of position and the purpose of the shift turnover sheet. Subsequent tours of the control room by the inspector to verify valve and switch lineups following completion of surveillance tests have not identified any similar instances. This item is closed.

(Open) Inspector Follow Item (293/80-21-01); The inspector contacted the NRC:NRR Licensing Project Manager who indicated that the design review of the ATWS RPT/ARI modification had been completed. The licensee has yet to install a backup power supply (inverter). The licensee expects necessary instructions and equipment to be available for implementation in April, 1981 and stated that the completion of this modification will be scheduled for the next outage of sufficient duration prior to the planned refueling outage of September, 1981. This item remains open pending review of the completed modification.

(Open) Deviation (293/80-30-02); The licensee's January 9, 1981 response to NRR concerning the status of the TMI Task Action Plan item III.E.4.2.6 stated that procedural controls would be implemented by January 15, 1981 to meet the previous commitment of limiting containment vent and purge valve operation to 90 hours per year during reactor operation. The inspector reviewed the revised procedure No. 2.2.70 "Primary Containment Atmosphere System," Revision 15, dated January 15, 1981. This item remains open pending a review of the implementation of this procedure change and a review of the justification for not modifying the two remaining 20 inch purge inlet valves.

(Open) Deviation (293/80-30-03); Following receipt of the IAL dated December 28, 1980 (concerning shift staffing and overtime hours) the licensee informed Region I of a disagreement between the current station policy and the written understandings in the IAL. As a result of discussions with the inspector, the licensee responded to both Region I and NRR with a letter dated December 31, 1980 which revised the licensee's commitments and clarified the original commitments.

The current station policy includes the following:

"The Nuclear Operations Manager or his Deputy's approval must be obtained in order to exceed the 12 hours (in the control room performing safety related functions) however, under normal circumstances, an operator shall not exceed 16 hours performing safety related control room functions. Deviation from the above restrictions may be authorized by the NOM or higher levels of management in accordance with published procedures and with appropriate documentation of the cause."

The inspector reviewed entries made in the W.E. instruction log to all shifts and a revised station procedure No. 1.1.17 "Control Room Manning" Revision 9, which include this criteria.

This item remains open pending review of the licensee's response to Inspection Report 50-293/80-30.

3. Operational Safety Verification

a. Scope

The inspector observed control room operations, reviewed selected logs, and conducted discussions with control room operators during the month of January, 1981. The inspector verified the operability of selected emergency systems, and verified the proper return to service of affected components. Tours of the security perimeter, reactor building, turbine building, process building auxiliary bay, control room, and vital switchgear rooms were conducted. The inspector's observation included a review of plant equipment conditions, potential fire hazards, physical security, housekeeping, and the implementation of radiation protection controls.

These reviews and observations were conducted in order to verify conformance with the Code of Federal Regulations, the facility Technical Specifications, and the licensee's administrative procedures.

b. Findings

- (1) During a tour of the control room on January 7, 1981, the inspector questioned the licensee concerning documentation for surveillance of the ATWS instrumentation required to be performed by Technical Specification 4.2.G. The licensee determined that the daily instrument checks were not being performed, immediately verified the operation of these instruments (reactor vessel level and pressure) and took action to revise station procedures to include these checks.

The inspector also reviewed documentation provided by the licensee for the (monthly) functional tests performed on June 19, 1980, July 25, 1980 and December 31, 1980. Documentation of (quarterly) trip unit calibrations performed for the pressure and level instruments on May 11, 1980 and for the level instruments on July 26, 1980, was also reviewed.

Based on this review, the inspector determined that all the functional tests and trip unit calibrations required by T.S. 4.2.G had not been performed since equipment installation in May, 1980. The licensee acknowledged the inspector's statements and stated that the appropriate surveillance procedures would be revised and that the trip unit calibrations would be performed prior to the end of January, 1981 along with the monthly functional test.

Prior to the end of this inspection, the inspector verified that the daily instrument checks were being performed and that the functional tests and trip unit calibrations had been performed satisfactorily on January 30, 1981.

The licensee further stated that a detailed review of all changes required by Amendment No. 42 to the Technical Specifications would be performed to ensure that there were no similar instances of required surveillances not being performed. Failure to perform the surveillances required by T.S. 4.2.G is considered an item of noncompliance (293/81-02-01).

- (2) During facility tours during the month of January, 1981, the inspector identified several cases where the requirements of the licensee's administrative procedures were not being implemented.

-- During a tour of the reactor building on January 9, 1981 the inspector observed a partially used container of Borax which was unsealed and stored under an open stairway near the Standby Liquid Control System (SLCS).

Station procedure No. 1.4.9, Revision 5, "Storage, Handling, and Disposal of Sodium Pentaborate," Section III, states in part that Borax will be stored in the station warehouse and that the containers shall be kept sealed.

This was brought to the attention of station management and actions were taken to seal the partially used container of Borax. The licensee further stated that procedure No. 1.4.9 would be revised to allow storage of partially used containers of Borax and Boric Acid in the vicinity of the SLCS, and to ensure appropriate labeling and controls to prevent misuse.

- During a tour of the main control room on January 13, 1981, the inspector noted that a summary of the overall operation of the plant was not being entered in the Station Operations Log at the end of each shift as required by procedure 1.3.7 Revision 17, "Records," Section III.A.1.a.

The inspector informed the acting Chief Operating Engineer who immediately issued instructions to all shifts to ensure that this requirement was implemented.

- During a review of documentation associated with a liquid radioactive discharge of the 'C' monitor tank on January 20 - 21, 1981, the inspector noted that although the valve lineup had been verified prior to the discharge, the valve lineup check sheet, OPER-28, had not been signed by the on-duty Watch Engineer as required by Section VIII.B. of procedure no. 7.9.2, Revision 9, "Liquid Radioactive Waste Discharge."

The licensee acknowledged the inspector's concerns and stated that appropriate action would be taken to ensure that this requirement was fulfilled.

These three examples of failures to implement station procedures are collectively considered an item of noncompliance (233/81-02-02).

- (3) The inspector reviewed controlled copies of selected station procedures to ensure that the procedures were reviewed, approved, and distributed in accordance with the licensee's administrative controls and regulatory requirements.

- Boston Edison Co. QA Manual Volume II, Operation of Nuclear Power Plants, Section 5 (revised August 6, 1979) required that Station quality assurance program related procedures be submitted to the QA Manager for review and approval prior to implementation. Station Procedure No. 1.3.4, Revision 21, "Procedures," Section III.D., states that each procedure title page contains a space for the signature of the QA Manager when applicable.

On January 23, 1981, the inspector identified that the following station QA Program related procedure revisions (as listed in Exhibit II-5-6 of the QA Manual) had been approved and distributed for use at the station without being approved by the QA Manager.

- 1.2.1, Revision 9, "Operations Review Committee"
- 1.3.4, Revision 21, "Procedures"
- 1.5.3, Revision 13, "Maintenance Request"
- 1.3.8, Revision 24, "Document Control"
- 8.1, Revision 6, "Periodic Surveillance Tests"
- 1.3.9, Revision 22, "Reports"
- 1.4.6, Revision 5, "Housekeeping"

The licensee was unable to provide the inspector with documentation to show that the required revisions and approval had been performed. The licensee stated that these procedures would be immediately sent to the QA Manager for his review and approval, and that an independent QA audit would be performed to ensure that there were no additional procedures which did not have the required review and approval.

- Station Procedure No. 1.3.8, Revision 24, "Document Control," Section III.A, states that controlled copies of selected volumes and individual procedures are maintained in accordance with Attachment 1.3.8 A-1. Attachment 1.3.8 A-1 refers to attachment 1.3.8 E-1 for a list of additional controlled copies of Volume 2.2, system operation procedures, to be provided specifically to the Radwaste Control Room operator.

During a tour of the Radwaste Control Room on January 21, 1981, the inspector identified that the manual of procedures in use

by the Radwaste Operators contained nine (out of eleven) system operating procedures which had been superceded by later revisions:

| <u>Procedure</u> | <u>Title</u> | <u>Rev. In Use</u> | <u>Current Revision</u> |
|------------------|--|------------------------|-----------------------------|
| 2.2.33 | Makeup Demineralizer System | 4 | 5 |
| 2.2.71 | Radwaste Collection System | 4 | 5 |
| 2.2.72 | Clean Radwaste System | 4 | 6 |
| 2.2.83 | Reactor Cleanup System | 7 | 9 |
| 2.2.85 | Fuel Pool Cooling and Filtering System | 7 | 8 |
| 2.2.97 | Condensate Demineralizer System | 10 | 13 |
| 2.9.98 | Ultrasonic Resin Cleaner | 2 | 3 |
| 2.2.116 | Reactor Water Cleanup Sludge Processing | 1 | 2 |
| 2.2.117 | Shipment of Spent Resins from Spent Resin Storage Tank | 1 | 2 |

The licensee immediately replaced the out of date procedures with up-to-date copies and stated that actions would be taken to ensure proper distribution in the future.

These two examples of failure to properly review, approve, and distribute station procedures are considered an item of noncompliance (293/81-02-03).

- (4) Station Procedure No. 2.3.1, Revision 3, "General Action (Alarm Procedures)," Section III, states that a nuisance or malfunctioning alarm may be silenced by pulling the alarm card, provided that a yellow tag is placed on the annunciator window with the following information: date, maintenance request number, and Watch Engineer's name. An entry in the Control Room Log indicating this action is also required. Section III further states that an erratic alarm because of operation at the setpoint does not require a maintenance request number, but is required to be reactivated when the parameter is no longer on the alarm setpoint. An entry in the Control Room Log Book is required any time these actions take place.

During a review of control room annunciators on January 14, 1981, the inspector observed that twenty-two annunciator panel alarms were silenced by pulling the instrumentation card with no evidence of log entries being made in the Control Room Log Book and that sixteen of these had no maintenance request numbers entered on the yellow tag attached to the alarm window.

The licensee stated that a review of all annunciator panels would be performed to identify the deenergized alarms and that maintenance requests would be prepared for necessary repairs by February 15, 1981.

This failure to properly control and document deenergized annunciator alarms is considered an item of noncompliance (293/81-02-04).

- (5) The inspector also discussed the status of main control room annunciators with operators on duty to identify the cause of the alarm, and with licensee management to review actions being taken to eliminate unnecessary alarms in order to provide operators with a "black board" if no problems exist.

During the month of January, 1981 the licensee had taken action to correct three annunciators that had been pulled and to clean ten annunciators that were in the alarm condition.

At the end of this month, however, there were still approximately twenty-one annunciators that were in the alarm condition and twenty-one that had been deactivated with the alarm card pulled because of erratic (nuisance) conditions or because the equipment was not in use.

Although the inspector did not identify any items of non-compliance with the Technical Specification **limiting conditions** for operation for the equipment associated with these annunciators, concerns were expressed to the licensee's management in the following areas:

- several annunciators which were in alarm could mask other problems associated with common inputs.
- several annunciators were normally in alarm during power operation (by design) while no abnormal condition existed.
- several annunciators had their cards pulled because of being close to the setpoint and/or because of inoperability or unused equipment.

The licensee stated that it was also their desire to correct the conditions which caused the annunciators to be in alarm or deenergized, and that they had established a program to review each alarm, determine whether maintenance or a plant design change was needed, and assign the appropriate priorities to effect resolution.

The inspector acknowledged the licensee's statement and stated that progress in this area would continue to be reviewed during further routine inspections.

4. Followup on Events Occurring During the Inspection

a. Main Stack Sample Pump Inoperable on January 7, 1981

The inspector verified that the licensee's reports met the requirements of 10 CFR 50.72 and that the response was in accordance with procedural and Technical Specification requirements. Supplemental radiation monitor recordings for the affected times were reviewed by the inspector. No abnormalities were noted. No items of noncompliance were identified.

b. Spent Resin Spill on January 17, 1981

- Description of Event

On January 17, 1981 at 11:30 a.m., water and about 20 cubic feet of spent resin was accidentally spilled in the Resin Addition Room while auxiliary operators were transferring spent resin from the 'B' Condensate Demineralizer to the Cation Tank for backwashing. About half of the spent resin seeped under a door to the outside area immediately adjacent to the building where it was contained. An operator standing outside the building observed the spill and immediately notified the control room. The leak was immediately isolated; the licensee initiated a Radiation Alert, and notified local, state, and federal agencies.

Station Management responded to the alarm and evaluated/monitored further actions. At 3:00 p.m., after the spent resin had been contained, cleanup was in progress and the licensee determined that no significant personnel exposures or off-site releases had occurred, the Radiation Alert was terminated. The appropriate agencies were notified.

- Findings

The inspector arrived at the site at about 3:00 p.m. to monitor the licensee's actions and determined that:

- The site of the spill had been roped off and barricaded with most of the resin placed in several five cubic feet containers.
- Airborne surveys and radiation surveys in the immediate area outside the building indicated no significant off-site release.
- Discussions with HP supervisors indicated no internal contamination of the Watch Engineer (W.E.) who isolated the spill. Surveys of the W.E. following decontamination (initially externally contaminated to about 2000 cpm) showed background activity.
- Discussions with station management at the Technical Support Center indicated that the cause of the spill was a valve lineup error during the last resin addition, and that actions to preclude recurrence would be taken.
- A review of control room logs and completed Radiation Emergency procedure notification forms indicated that the Radiation Alert was reported as required.

Findings resulting from a subsequent special inspection of this event will be addressed in Report No. 293/81-04.

c. Circulating water Piping Corrosion

On January 18, 1981, the licensee identified a leaking Circulating Water System outlet pipe from the main condenser No. 1-2 water box. Investigation revealed general corrosion of the piping, possibly due to erosion of the internal rubber line. Nondestructive examination of the other three outlet piping sections revealed no similar corrosion. Temporary repairs were made by welding and providing external reinforcement.

The inspector spot-checked the licensee's sea water radioactivity sample results taken in accordance with Temporary Procedure No. 81-04 on January 19, 1981, prior to discharging. All samples were less than minimum detectable activity.

The inspector will follow the licensee's plans for permanent long term repairs.

No items of noncompliance were identified.

d. 'E' Service Water Pump(SWP) Discharge Check Valve

The inspector reviewed the licensee's actions in response to noting that the 'E' SWP discharge check valve failed to close fully following routine system surveillance on January 19, 1981. The check valve was repaired under Maintenance Request No. 81-29-1 and returned to service on January 27, 1981.

No items of noncompliance were identified.

e. Reactor Feed Pump (RFP) Trip on January 22, 1981

The inspector verified that the licensee's actions in response to the trips of 'A' and 'C' RFP were in accordance with station procedures and Technical Specifications. The licensee's investigation revealed conservative suction pressure trip setpoints. The licensee recalibrated the suction pressure trips and control room pressure indication and returned the unit to full power on January 23, 1981.

No items of noncompliance were identified.

f. Inadvertent Plant Trip on January 28, 1981

The inspector reviewed the licensee's actions in response to an inadvertent reactor scram from full power January 21, 1981 to verify that the reporting requirements of 10 CFR 50.72 were met and that requirements of station procedures and the Technical Specifications were met.

The licensee's investigation revealed that an isolated level instrument (used for turbine trip) was returned to service too quickly, momentarily affecting the RPS instruments which share common sensing lines. The inspector reviewed control room indication and verified that actual level remained normal during the transient. The unit was returned to service on January 29, 1981.

No items of noncompliance were identified.

5. Surveillance Observations

The inspector reviewed Technical Specification (T.S.) required surveillance testing in order to verify that testing was performed in accordance with approved station procedures and met the T.S. limiting conditions for operation.

Portions of testing on the following systems were reviewed:

- 'A' Standby Liquid Control System Pump out of service for leaking gasket (redundant equipment testing and return to service testing).
- 'E' Service Water System Pump out of service to repair discharge check valve (redundant equipment testing and return to service testing).

The inspector also observed that several motor operated valves inside containment were backseated due to previous indications of packing leakage. The inspector questioned the licensee concerning assurance that these valves would meet the T.S. required closing times from the backseat position. The licensee stated that a station approved procedure is used to electrically backseat these valves, that all surveillance testing for required closing times is done from the backseat position and results to date have shown acceptable closing times. The licensee agreed, however, to revise the maintenance procedure for electrically backseating motor operated valves to include a record sheet which would be filled out for each valve and to specify that a caution tag be placed on the valve's control switch indicating this condition. The inspector had no further questions.

No items of noncompliance were identified during this review.

6. IE Bulletin Followup

The inspector reviewed the licensee's actions in response to the IE Bulletins listed below to verify that the actions and responses adequately addressed the concerns of the Bulletin.

- IEB 80-21; "Valve Yokes Supplied by Malcolm Foundry Co. Inc." Following a request by the inspector the licensee committed to provide a supplemental response which would address all valve parts and not just yokes as specified in the Bulletin.
- IEB 79-27; "Loss of Non-Class-1-E Instrumentation and Control Power System Bus During Operation." The licensee committed to provide a supplemental response by mid-February, 1981 which would include a schedule for completion of procedure revisions and/or design changes.
- IEB 80-24; "Prevention of Damage Due to Water Leakage Inside Containment." The inspector reviewed the licensee's internal memorandum summarizing a review of records from 1973 to the present for any evidence of leaks inside containment and held discussions with the staff engineer who performed the review. One minor leak from a fan cooler in 1973 was identified.

The inspector also reviewed system drawings to verify that the Reactor Building Closed Cooling Water System is a closed system and that the Service Water and Circulating Water Systems do not penetrate primary containment as open systems. No further information is required and this bulletin is considered closed.

- IEB 80-17; "Failure of Control Rods to Insert During a Scram at a BWR" Supplement 3, Item No. 2 - The licensee modified computer inputs and revised station procedures to implement the acceptance criteria for scram discharge instrument volume limit switch operability as described in the December 5, 1980 letter to Region I. The inspector verified implementation of the procedure changes by observations of a reactor scram on January 28, 1981.

Supplement 4 - The licensee performed single rod scram tests on January 4, 1981 in accordance with Temporary Procedure No. TP 80-87, as required by item No. 2 of the Supplement. Positive indication of level from all 4 transducers was monitored on a CRT scope and videotaped. The test results were discussed in a telephone conversation between the licensee, IE Region I, and HQ personnel on January 5, 1980, and it was concluded that the CMS was considered operable. The inspector also observed the alarm indication in the control room from each of the four transducers following a scram on January 28, 1981.

This bulletin remains open pending review of additional actions required by the licensee including a full test of the CMS, and implementation of periodic surveillance procedures.

No items of noncompliance were identified during the review of these bulletins.

7. Status of TMI Action Plan Category 'B' Items

The inspector reviewed the current status of the licensee's implementation of selected Category 'B' TMI T.A.P. items. This information was provided from a review of the licensee's December 15, 1980 response, a draft version of the licensee's January 1, 1981 response, and discussions with the licensee's station management.

The status of each item as provided to the inspector on January 12, 1981 is described below.

| <u>Item</u> | <u>Remarks</u> |
|--|---|
| I.A.1.1(STA) | Training program has been implemented and degreed (or equivalent) engineers are on shift. |
| I.A.1.3 (Shift Manning) | The licensee has not committed to all the NRC criteria. Partial commitments (as specified in separate correspondence to NRR and IE) will be implemented via station procedures by January 16, 1981. |
| I.A.2.1.(4) (RO/SRO Training Program) | The training program has been implemented |
| I.C.5 (Feedback of Operating Experience) | The licensee has implemented procedures. |
| I.C.6 (Verify Performance of Operating Activities) | The licensee has not yet committed to this item. The licensee plans to review station policy and determine by June, 1981 to what extent the NRC criteria will be implemented. |
| II.E.4.2.(5a) (Containment Pressure Setpoint) | The licensee considers that the current setpoint meets the criteria. |
| II.E.4.2.(6) (Containment Purge Valves) | The licensee had not implemented the "Interim Criteria for Containment Vent and Purge Valve Operation; and committed to have procedures in place by January 15, 1981 to limit operation to 90 hours per year. |
| II.K.3.22a (RCIC Suction) | Procedures to implement this item would be prepared by January 15, 1981 |
| III.D.3.3 (Inplant Rad. Monitors) | Upgrading of Iodine monitoring had been implemented. |

The inspector had no further questions concerning the status request and forwarded the information to NRC:IE HQ for review.

8. Emergency Procedures for Coping with Anticipated Transients Without Scram (ATWS) Events

a. Scope and Acceptance Criteria

The inspector reviewed the licensee's Emergency Procedures describing actions required during ATWS events and other transients resulting in the inability to shutdown with control rods. This review was performed to determine whether the licensee's procedures contained the following items:

- Actions specified in IE Bulletin 80-17, Paragraph 4
- Operator authority, responsibility, and criteria for initiation of the Standby Liquid Control System (SLCS), and
- The requirement for the SLCS key to be readily available.

The following procedures were reviewed:

- 2.1.6 "Reactor Scram," Revision 12
- 2.1.5 "Controlled Shutdown from Power," Revision 19
- 5.3.15 "Reactor Isolation Without Scram or Loss of Offsite Power (ATWS)," Revision 4
- 5.3.2 "Inability to Shutdown with Control Rods," Revision 7
- 2.4.1 "Stuck or Inoperable Control Rod Drives," Revision 3
- 2.4.3 "Rod Drift," Revision 6
- 2.4.4 "Loss of Control Rod Drive Pumps," Revision 3
- 1.1.1 "Station Organization Responsibilities," Revision 7, and
- 2.2.24 "Standby Liquid Control System," Revision 7.

b. Findings

The inspector determined that the licensee's procedures contained the requirements and criteria specified in paragraph a., above, for coping with ATWS related events.

The inspector also discussed these procedures with the Senior Nuclear Training Specialist who stated that criteria for use of the SLCS was included as a routine and continuing part of the licensee's training program.

The inspector has observed the SLCS initiation key readily available on the main control panel (as required by station procedures) during daily tours of the control room.

No unacceptable items were identified during this review.

9. Licensee Event Report Followup

The LER listed below was reviewed to determine the safety significance and whether the reporting requirements of the Technical Specifications were complied with.

- LER 80-94/04T; Anomalous Measurement of Iodine-131 in milk from Plymouth Plantation

The inspector questioned the licensee concerning an apparent error in the event date and justification for the conclusion that the measured concentration was "unquestionably the result of a recent Chinese weapons test." The inspector also stated that the report was about four days late.

The licensee acknowledged the inspector's comments, stated that the event had inadvertently been considered in the category of a 14 day vice 10 day report and that a revised LER would be issued correcting the event date and providing further details justifying the conclusions concerning the cause of the increased iodine concentration.

The inspector reviewed the past seven anomalous measurement reports which had been issued within the required time frame and considered this an isolated case. The inspector also reviewed the revised report LER 80-94/04T-1 and had no further questions.

10. Personnel and Organization Changes

The inspector reviewed the qualifications of personnel recently assigned to both on-site and off-site management positions. This review was performed to determine whether the education, training, and experience described in resumes provided to the inspector by the licensee met the requirements of ANSI N18.1-1971 "Selection and Training of Nuclear Power Plant Personnel."

Positions reviewed included the following;

On-Site

Deputy Nuclear Operations Managers (2)

Staff Assistant - Nuclear Safety

Off-Site

Quality Assurance Manager

Nuclear Engineering Department Manager

Nuclear Operations Support Manager

The inspector determined that the qualifications of the personnel assigned met the requirements of ANSI N18.1-1971 and had no further questions.

11. Survey of Possible Leaking Detector Sources

Because of concerns at another power plant, the inspector was requested to inform the licensee of the possibility of removable contamination on certain detectors manufactured by Ion Track Instruments, Inc.

On January 22, 1981, the licensee performed a leak test of the subject instruments (four of model No. 75, and one model No. 70) with all Ni-63 source smears indicating less than minimum detectable activity (less than 10 pico curies beta/gamma).

The inspector had no further questions and provided this information to NRC Region I personnel.

12. Exit Interview

At periodic intervals during the course of the inspection, meetings were held with senior facility management to discuss the inspection scope and findings.