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50293-830310
50293-830402
50293-830403
50293-830405
50293-830413
50293-830416

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-293/83-07

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: March 22, 1983 - April 18, 1983

Inspectors: Jon R Johnson — 4/22/83
J. Johnson, Senior Resident Inspector — date

Jon R Johnson, for — 4/22/83
H. Eichenholz, Resident Inspector (April 4-18, 1983) — date

_____ — _____
date

Approved by: T. C. Elsasser — 4/28/83
T. Elsasser, Chief, Reactor Projects Section No. 1B, Projects Branch No. 1 — date

Inspection Summary:
Inspection on March 22 - April 18, 1983 (Report No. 50-293/83-07)
Areas Inspected: Routine unannounced safety inspection of plant operations including followup of previous findings, an operational safety verification, followup of events, trips and LER's, a review of surveillance and maintenance activities, and a review of actions in response to the Performance Improvement Program. The inspection involved 111 inspector-hours by two resident inspectors.
Results: One violation was identified (Failure to implement a station procedure for inspection and cleaning of the Standby Gas Treatment System inlet plenum, Paragraph 3.B).

Region I Form 12
(Rev. February 1982)

DETAILS

1. Persons Contacted

J. Aboltin, Sr. Reactor Engineer
J. Ballentine, Vice President - Operations
N. Brosee, Assistant Chief Maintenance Engineer
A. Caputo, Fire Prevention and Protection Engineer
B. Damon, Q.A. Records Manager
W. Deacon, Project Manager
R. DeLoach, Group Leader - Operations QC
J. Dwyer, Q.C. Engineer
G. Fiedler, Watch Engineer
J. Frazer, I&C Supervisor
W. Harrington, Sr. Vice President - Nuclear
R. Kennedy, Sr. Project Engineer
J. Keyes, Licensing Engineer
G. LaFond, I&C Supervisor
R. Machon, Director of Outage Management
P. Mastrangelo, Chief Operating Engineer
C. Mathis, Station Manager
J. McCann, Watch Engineer
J. McEachern, Security Supervisor
P. Moraites, I&C Supervisor
A. Morisi, Nuclear Operations Support Manager
L. Olivier, Watch Engineer
L. Oxsen, Director of Nuclear Operations Review
J. Peters, Sr. Construction Engineer
K. Roberts, Chief Maintenance Engineer
J. Seery, On-Site Safety and Performance Group Leader
P. Smith, Chief Technical Engineer
R. Smith, Sr. Chemical Engineer
K. Taylor, Watch Engineer
S. Wollman, Shift Technical Advisor
E. Ziemianski, Management Services Group Leader

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

2. Followup on Previous Inspection Findings

(Closed) Infraction (80-20-01). Performed repairs/adjustments to containment penetrations after the initiation of the primary containment integrated leak rate test (PCILRT) procedure. The licensee had taken steps to revise the PCILRT procedure (8.7.1.4) and upgrade administrative controls as described in their July 15, 1980 response. However, these actions were not effective in preventing a recurrence of this event. This item is closed for record purposes. Comments relating to the repetitive event are addressed below.

(Open) Violation (82-11-01): Performed repairs to containment after the initiation of the PCILRT. The licensee's response dated April 26, 1982 describes corrective actions. In addition to counseling personnel involved, the licensee stated that procedure No. 8.7.1.4 would be revised by July 7, 1982 to emphasize administrative control requirements in place during the test. The inspector reviewed the current procedure, 8.7.1.4, PCILRT, Revision 9, dated June 24, 1982. Attachment A, Sections 4.5.1-4.5.3, 5.3.13, and 5.3.15 contain precautions, prohibitions, and responsibilities. The procedure requires briefing, questioning, and witnessing by the PCILRT Test Director and test/inspection personnel of leakage assessments to ensure that no repairs or adjustments are made without proper authorization. This procedure also requires that all related Maintenance Requests initiated after the start of the test be reviewed by the PCILRT Test Director prior to approval by the Watch Engineer. The inspector verified that the licensee had made procedure changes as described in the April 26, 1982 response. However, the inspector questioned the licensee as to the statements in Attachment A, Section 5.3.15(d) and 12.3 regarding the results of Local Leak Rate Tests performed on penetrations found to be leaking which were subsequently isolated during the PCILRT. It was not clear from the procedure how this "as found" local leak rate test data would be used in acceptance criteria for the PCILRT. The licensee acknowledged the inspector's comments and stated that these Sections would be reviewed. Pending verification of implementation of these procedural controls during a future PCILRT, this item remains open.

(Closed) Follow Item (80-27-01): Review system for initiating and review of Failure Malfunction Reports (FMR). The inspector has observed the licensee's activities over the past year with respect to initiating and review of FMR's. Several comments have been made to the licensee's staff with regard to the need for initial review responsibilities (prompt - 24 hour reporting if applicable) and followup review responsibilities (14 day or 30 day). The licensee has made several changes resulting in a close relationship between the Watch Engineer adn the Station Manager for initial reporting determinations. The inspector reviewed the current governing procedure, 1.3.24, Failure and Malfunction Reports, Revision 7, dated January 24, 1983, and determined that it provided acceptable guidance, review criteria and requirements. Implementation of this procedure will continue to be reviewed during routine inspections of the facility. This item is closed.

(Closed) Follow Item (83-03-09): Revise Nuclear Watch Engineer (NWE) Training qualification form. The licensee's Emergency Plan specifies that the on-watch NWE is the station's Emergency Director at the onset of an accident until relieved of those duties by the Station Manager (or other designated personnel). The NWE qualification form (03B) did not require completion of the Emergency Director qualification form (S-1). On April 12, 1982, the inspector verified that the licensee has approved and issued a change to both the Nuclear Operating Supervisor (NOS) qualification form (03A) and the NWE qualification form (03B) requiring, as a prerequisite, the completion of the Emergency Director qualification (S-1). This item is closed.

(Closed) Deviation (80-30-03) Licensee did not implement an October 15, 1980 commitment to NRR concerning limiting staff working hours (overtime). Previous followup of this item is described in NRC report No. 81-02. The licensee clarified their position on overtime commitments in two letters dated December 31, 1980 to the NRC (NRR and Region I). The licensee's response to this Deviation, dated June 3, 1981, states that these overtime limitations will be incorporated into station procedures by July, 1981. The licensee's additional response, dated August 12, 1981, described a computer tracking system to be used to capture future commitments.

Additional previous NRC review of the licensee's overtime policy and implementation is described in NRC Reports 81-07 and 81-12.

The inspector reviewed the licensee's current procedure governing this area, 1.3.34, Conduct of Operations, Revision 2, dated March 30, 1983. This procedure incorporates the licensee's latest commitment to the NRC (December 31, 1980 letter). In addition, the inspector has verified implementation of this policy. This Deviation is closed.

During the review of this item the inspector noted that the licensee's latest policy for limiting overtime was not in full conformance with the NRC's latest policy as stated in a letter (Generic letter No. 82-12) from NRR to all operating plants dated June 15, 1982. This NRC letter forwarded revised pages to NUREG 0737, item I.A.1.3. The inspector discussed the licensee's deviations from Generic letter No. 82-12 with the facility management who stated that an additional evaluation of these deviations would be performed.

The inspector will follow the licensee's actions to evaluate overtime policy with respect to the NRC's Generic letter No. 82-12 in a future inspection (83-07-01).

(Closed) Violation (82-29-02) Failure to follow procedure for setting Main Steam Safety Valve (SV). The licensee's response dated February 4, 1983 stated that immediate corrective actions consisted of the following: the reactor was shutdown, personnel were counseled, temporary changes were made to the procedure adding cautions, and the valve was replaced with a spare safety valve. NRC Report No. 82-29 documents verification of these actions. The licensee's response also stated that procedure No. 3.M.4.7 would be revised to clarify the intended test method (nitrogen pressures vs. steam pressures). The licensee also subsequently informed the NRC that revision of this procedure would not be completed by the anticipated March 1, 1983 date. On April 13, 1983 the inspector reviewed this completed revision and determined that the licensee's corrective actions were satisfactorily completed. Station procedure No. 3.M.4-7, Main Steam Safety Valve, Revision 6, dated March 30, 1983, provides a clear description of the correlation between nitrogen and steam lift set pressures, specifies the unique valve serial numbers and nameplate data, and provides adequate cautions to ensure that the required steam set point will be demonstrated by testing at ambient conditions with nitrogen. This item is closed.

3. Operational Safety Verification/Emergency Safeguards System Walkdown

A. Scope and Acceptance Criteria

The inspector observed control room operations, reviewed selected logs and records, and held discussions with control room operators. The inspector reviewed the operability of the Anticipated Transient Without Scram (ATWS) Recirculation Pump Trip (RPT) and Alternate Rod Insertion (ARI) system. Tours of the reactor building, turbine building, station yard, switchgear rooms, SAS, diesel generator rooms, cable spreading room, auxiliary bay, intake structure, and control room (daily) were conducted. Observations included a review of equipment conditions, control room annunciators, potential fire hazards, physical security, housekeeping, radiological controls, and equipment control (tagging); in addition, records of radioactive liquid and gaseous releases from the station and sampling of the Standby Liquid Control System boron concentration were reviewed.

These reviews were performed in order to verify conformance with the facility Technical Specifications and the Licensee's procedures.

B. Findings

(1) At 9:30 am on March 30, 1983, the inspector noted that the control room operator was hanging equipment control red tags on the Standby Gas Treatment System (SGTS) fan, inlet, and outlet damper control switches on panel C7. The tags had the words "men in duct" written on them. The control room operators stated that station personnel were performing routine monthly ventilation duct inspection/cleaning because of previous problems with spent resin in the duct work.

The inspector subsequently toured the SGTS room and observed several personnel dressed in anticontamination clothing inspecting and cleaning the SGTS inlet plenum. The SGTS room door was held open and the workers had opened the SGTS inlet plenum sheet metal access door for cleaning with a vacuum cleaner. In this condition the SGTS train would not be capable of drawing a vacuum in the reactor building because of the open path to the turbine building corridor outside of the SGTS room.

Procedure TP 82-43, Resin Removal from the Reactor Building Vent Duct, Revision 2, dated June 25, 1982, required that the redundant SGTS train, in this case the 'A' train, be demonstrated operable prior to removing the 'B' train from service. A QC verification is also required to ensure that the plenum filter housing seals were not damaged. The inspector determined that the required operability checks were not performed on the 'A' SGTS train before the 'B' train was removed from service.

The inspector discussed concerns related to the authorization, and control of these activities with the station operation management personnel. Following the licensee's review, the inspector was informed that a station procedure had previously been approved for the control of this activitiy, had been implemented in the past but had not been followed in this case. The licensee immediately counseled the personnel involved for failing to implement the requirements of Procedure TP 82-43.

The inspector verified that the requirements of T.S. 3.7.B.1.a were met (with both SGTS trains inoperable the reactor must be shutdown in 36 hours) in that inspection, cleaning, and testing were completed by about 3:00 p.m. on March 30, 1983.

The failure to follow Procedure TP 82-43 is a violation (83-07-02).

(2) On March 24, 1983 and again on March 31, 1983, the inspector held discussions with licensee management personnel relating to the administration of compensatory measures for various fire protection equipment degradation. Items discussed related to shared responsibilities for security and fire patrols and overview of all areas and equipment in a degraded mode to ensure that the compensatory measures required by the Technical Specifications were being implemented. Because the NRC regulations regarding upgrading of areas (10 CFR 50, Appendix R), the licensee initiated additional fire patrols for four areas on March 31, 1983. This was in addition to already degraded equipment/barriers (CO_2 tank, auxiliary boiler room door, SGTS sprinkler system, steam tunnel barrier, intake structure fire pump room and salt service water pump rooms).

No violations were identified, however, the inspector will continue to review the licensee's actions in this area during future routine inspections of the facility.

(3) On April 8, 1983, the inspector observed that a contractor had brought a one gallon plastic container of combustible cutting oil into the reactor building 51' elevation. Following discussions with the contractor, the inspector determined that the worker was unaware of the licensee's requirements in administrative procedures for the control of combustibles. The oil was immediately removed from the area and returned to an outside storeroom.

The licensee's construction management personnel and fire prevention officer held discussions with the contractor management personnel describing the licensee's requirements. The contractor established administrative controls on April 8, 1983 for the storage, use, and control of combustible and flammable liquids. These controls were discussed in a personnel safety meeting on April 11, 1983.

The inspector determined that this item was an isolated event for which immediate and responsive corrective action was taken. The inspector had no further questions but will continue to observe fire protection measures during future routine inspections.

4. Followup on Events; Trips, and Licensee Event Reports (LER's)

A. Events/Plant Trips

(1) On April 2, 1983, at 3:48 pm, the reactor scrammed from full power because of main turbine stator cooling problems. The inspector discussed this event with operations and maintenance personnel, reviewed control room logs, recorders, and reviewed the process computer printout. The scram was caused by an automatic high neutron flux spike which was in turn, caused by a turbine runback signal which closed the main turbine control valves. Maximum reactor coolant system pressure reached was about 1070 psig (below the high pressure scram and safety-relief valve setpoints).

The licensee's investigation determined that the method of routine equipment rotation (changeover of stator cooling pumps) and a long system response time of the heat exchanger temperature control bypass valve resulted in transient high generator cooling water temperatures and a runback.

The licensee restored normal stator cooling temperatures and commenced a reactor startup on April 3, 1983. No violations were identified.

(2) Following the reactor scram described above, at 5:30 pm on April 2, 1983 the licensee was unable to open the main steam line drain valve No. 220-2 (a containment isolation valve). This valve was declared inoperable and the series valve No. 220-2 shut and red-tagged. The valve stem was lubricated, the valve exercised, and post maintenance testing performed. At 1:30 am on April 3, 1983 the valve was declared operable and the drain system returned to normal. No violations were identified.

(3) On April 3, 1983, while the reactor was shutdown because of the scram described above, the licensee decided to perform preventive maintenance on the Recirculation Pump Motor Generator (MG) Set generator brushes. At 00:40 am, on April 3, 1983, the 'B' MG Set

was secured by control room operators (this should have tripped the generator field breaker). At about 1:00 pm on April 3, 1983, plant personnel smelled smoke in the MG Set room and noted that the field breaker had not opened and that the normal shunt trip coil had burned out.

Maintenance personnel found mechanical binding of the breaker unit which required partial disassembly to operate. The licensee replaced the trip coil, removed the breaker, and exercised it several times during bench testing and following reinstallation.

Following discussions with NRC:Region I personnel on April 3, 1983 the licensee's On-site Review Committee (ORC) was convened and reviewed this event. No definitive cause was determined for the binding but the ORC determined that repairs and testing were adequate to insure proper breaker function. The reactor was taken critical at 6:37 pm on April 3, 1983 and normal operations resumed.

The licensee made a prompt report (LER No. 83-13) to the NRC describing this event.

NRC findings and evaluation of this event will be described in a separate report.

(4) At 1:05 pm on April 5, 1983, with the reactor at full power, the control room operators received several alarms indicative of a main turbine runback due to stator cooling problems. The plant had been in steady state and no specific evolutions were in progress prior to receipt of the alarms. The operators reduced reactor power to about 45% by manually decreasing the speed of the recirculation pumps and control rod insertion. The main turbine runback signals cleared, and, following verification of normal system status, routine power operations were resumed.

The inspector reviewed this event including logs, records, control room recorders and indications and held discussions with licensee personnel.

No specific cause of the stator cooling runback signals was identified. The licensee performed trouble shooting of stator cooling temperature, pressure, and current-to-flow comparator processing equipment and alarms. No equipment malfunction was found.

The licensee installed additional monitoring equipment including continuous strip chart recorders to assist in future problem identification following recurrence.

The inspector determined that actions taken were in accordance with station procedures and the facility Technical Specifications. No violations were identified.

(5) At 9:15 pm on April 13, 1983, the licensee declared the Reactor Core Isolation Cooling (RCIC) system inoperable. The outboard. steam isolation valve No. 1301-17 would not close properly during surveillance testing being performed prior to taking the High Pressure Coolant Injection (HPCI) system out of service (to fix a steam leak).

The inspector verified that the series containment isolation valve, No. 1301-16, was shut and red-tagged, and that alternative testing of the HPCI pump and valves was performed in accordance with T.S. Sections 3.5.D, and 3.7.D requirements. Repairs to the 1301-17 valve motor were performed, the valve was repacked and tested satisfactorily. At 8:55 pm on April 15, 1983, the RCIC system was declared operable.

No violations were identified during this review, however, the inspector expressed concern to the station operations management personnel relating to the degree of details entered in the control room operations log. The licensee acknowledged the inspector's concerns and stated that actions would be taken to improve the details of log entries. The inspector had no further questions.

(6) At 10:55 am on April 16, 1983, while at full power, the control room operators received a trouble alarm on control room panel C7 indicating problems with the main stack dilution fans. The on-line ('B') fan indicated operating status but the standby fan ('A') also came on automatically. An operator was immediately dispatched to the main stack building (outside the protected area) to investigate.

Failure and Malfunction Report, dated April 16, 1983, states that local flow indication was 12,000 SCFM versus a normally expected 15,500 SCFM dilution flow.

A blown power supply fuse had caused the fan discharge dampers to close, restricting flow. The licensee manually opened one discharge damper and dilution flow increased to about 16,000 SCFM.

The inspector reviewed station records and discussed the event with the Watch Engineer. The Watch Engineer stated that the applicable T.S. and station procedures were implemented. T.S. 3.8.B.4 requires the minimum dilution flow be maintained during releases of gaseous wastes. Procedure No. 2.1.15, Daily Surveillance Log, Rev. 48 specifies the minimum dilution flow as 12,000 SCFM. Station abnormal procedure 2.4.45, Loss of Dilution Fans at Off-Gas Building, Rev. 4 specifies actions to take.

The inspector reviewed the main stack release rate recorder chart and noted that the reduced dilution flow was returned to normal in about 45 minutes and during this time the instantaneous radioactivity release rate was well within T.S. limits.

No violations were identified. The inspector had no further questions at this time.

B. Review of LER's

(1) LER's submitted to the NRC:RI were reviewed to verify that the details were clearly reported and that the corrective actions were adequate. The inspector also determined whether generic implications were involved and if onsite followup was warranted. The following LER's were reviewed:

LER No.	Subject
*83-10	Core Spray test valve 1400-4A found with missing hold down bolts
*83-11	'B' Standby Gas Treatment System charcoal filter wetted by fire suppression water
*83-12	ATWS trip indicating lights inoperable
*83-13	Recirculation Pump MG Set field breaker not operable

(2) For the LER's selected for onsite review (denoted by asterisks), the inspector verified that appropriate corrective actions were taken or responsibilities were assigned and that continued operation of the facility was conducted in accordance with the Technical Specifications.

- LER 83-10; Followup is described in NRC Report No. 83-03. The inspector is following the licensee's actions to determine whether the Core Spray valve 1400-4A would have remained closed with the missing bolts found on February 21, 1983. No information has been received from the licensee to date. This is being tracked via unresolved item No. 83-03-07.

- LER's 83-11, 83-12; Followup is described in NRC Report No. 83-06.

- LER 83-13; NRC followup of this event and findings will be described in a separate report.

5. Surveillance Activities

A. The inspector reviewed the licensee's actions associated with surveillance testing in order to verify that the testing was performed in accordance with approved station procedures and the facility Technical Specifications.

Portions of the following tests were reviewed/observed:

- routine operability testing of RCIC valves on March 28, 1983
- routine logic functional testing of the 'A' Core Spray system on March 31, 1983
- routine pump flow rate test of the HPCI system on April 7, 1983
- alternative testing of the HPCI system on April 14, 1983 due to an inoperable RCIC steam isolation valve 1301-17, and
- routine weekly battery cell specific gravity checks on April 14, 1983.

The inspector also performed a review of the licensee's procedures and activities which implement the requirements of T.S. 3.4.C and 4.4.C for Sodium Pentaborate Solution in the Standby Liquid Control (SBLC) system tank. This review included a technical evaluation of procedure adequacy, a review of sampling records, and the witnessing of a sample analysis (boron concentration titration) an March 28, 1983.

The inspector also reviewed the licensee's program for testing equipment included in the Anticipated Transient Without Scram (ATWS), Recirculation Pump Trip (RPT) and Alternate Rod Insertion (ARI) system. NRC inspection findings resulting from this review will be included in a separate inspection report.

B. Findings

(1) Following the observation of SBLC tank boron analysis on March 28, 1983, the inspector reviewed the licensee's concentration calculations. The licensee determines boron concentration via titration

with NaOH solution following the addition of mannitol to release the boron atoms in solution as an acid. The "Boron Equivalency" of the NaOH is determined by titration of a boron standard in accordance with procedure 7.1.19, Sodium Pentaborate, Revision 8.

The inspector identified a minor mathematical error in the licensee's calculated value of boron standard concentration (mg/gm) which resulted in an error in the final reported Sodium Pentaborate concentration of less than .1%. The correct value was verified to be within the limits of the T.S.

The inspector determined that the licensee had established and implemented procedures relating to the requirements of T.S. 3.4.C and 4.4.C for Sodium Pentaborate concentration limits. No violations were identified.

(2) During the performance of procedure 8.M.2.2.10.1-6, Auto Start of Core Spray Pump 'A' Logic System Functional Test, Revision 6, on March 31, 1983, the licensee identified a descrepancy between the performance of the equipment and the procedure. The I&C technicians immediately reviewed the system logic diagrams, determined that there was a typographical error in the procedure, initiated a procedure change and completed the test. The logic system was demonstrated to operate properly. No violations were identified.

6. Maintenance/Modification Activities

The inspector reviewed the licensee's actions associated with maintenance and modification activities in order to verify that they were conducted in accordance with station procedures and the facility Technical Specifications. The inspector verified for selected items, that the activity was properly authorized and that the appropriate radiological controls, equipment control tagging, and fire protection were being implemented.

The items/documents reviewed included the following:

- Maintenance Request (M.R.) 83-9-11; Repair nitrogen supply valve - did not meet closing time requirements
- M.R. 82-13-22; Repack RCIC valve 1301-17
- M.R. 83-99; Repair RCIC valve 1301-17 - did not go closed fully during testing, and
- M.R. 83-92; Repair main steam line drain valve 220-2.

No violations were identified during this review.

The inspector also reviewed the modification activities (Plant Design Change Request 79-25) performed in 1980 and recent maintenance on the Anticipated Transient Without Scram (ATWS) Recirculation Pump Trip (RPT) equipment ('B' MG Set field breaker). Details of this review and associated findings will be described in a separate NRC Report.

7. Performance Improvement Program (PIP) Implementation

A. On April 6, 1983, the inspector met with licensee representatives to review the status of PIP (Rev. 1 and Rev. 2) milestones planned for completion in March, 1983. These items are described below.

II.4.3 Final Completion of MAC Action Plan - Reorganize the Nuclear Engineering Department. NED memo 83-223, dated March 24, 1983, provides details of closeout actions and accomplishments achieved. Areas of improvement include reduction in use of contractors, evaluation of personnel attrition, improved analytical skills, and clarification of authorities and responsibilities. Improved communications with the station for immediate engineering needs has been accomplished. However, following the move to Braintree, Mass., the Site Engineering Group concept was abandoned.

II.5.3 Final Completion of MAC Action Plan - Reorganize the Nuclear Operations Department (Station). The Station implemented a reorganization in September, 1981. Department goals have been identified. Personnel hiring is receiving senior corporate management support in order to fill open help requisitions, especially with the on-site technical group.

II.6.3 Final Completion of MAC Action Plan - Reorganize the Quality Assurance Department. Memo VPNE 83-52, dated March 21, 1983, provides details of closeout actions and accomplishments in the Q.A. Department. Reorganization has established four groups: Operations QC, Inservice Inspection, Q.A. Auditing, and Quality Engineering. Continued effort is ongoing to hire and retrain personnel to maintain the required staff which is presently judged sufficient.

II.7 Reorganize the Nuclear Operations Support Department. Memo NOS 83-313, dated April 1, 1983, describes the current NOSD organization including recent changes in the Regulatory

Affairs and Programs Management Group. Additional changes deemed necessary by corporate management will be described in the final completion report planned for completion at the end of April, 1983.

III.1.D.3 Review Sample of IE Bulletins to Confirm Conformance with Correspondence. The NED selected eleven IEB's to review based upon written criteria specified in Work Instruction 267 dated November 16, 1982. Those selected were the following: 75-03, 76-04, 78-08, 79-12, 79-15, 79-19, 79-23, 80-01, 80-09, 81-02, and 81-03. The correspondence review was performed by a consultant (EDS Nuclear Inc.), in accordance with a written procedure and transmitted to the licensee in a report dated January, 1983. The licensee's summary report, NED 83-221 dated March 23, 1983, concludes that in general, BECo's responses have been accurate and complete. Discrepancies were identified with respect to an inaccuracy in seismic description of ADS pneumatic supply lines (IEB 80-01) and with respect to commitments made to install soft seat check valves (IEB 80-01) and to implement training programs for radwaste shipping (IEB 79-19). The licensee plans to inform the NRC:Region I of these discrepancies in a future letter. The licensee is also evaluating the need to review all previous commitments made to the NRC via IEB responses.

III.3.F.3 Complete Implementation of PM Program for Mechanical Equipment. The licensee has approved procedure 1.8.2, PM Tracking Program, dated February 1, 1983. The licensee representative stated that this program has been implemented for mechanical equipment. Additional NRC review of this area will be performed during routine inspection of the facility.

III.3.D.3 Perform the Modification Management Scope of Review for 1980 Outage PDCR's and Fire Protection Modifications. Memo NOS 83-232, dated March 10, 1983, describes the review of training, drawing update, postwork testing, procedure and T.S. changes resulting from seventy-six (76) previously implemented plant design changes (PDCR's). Deficiencies noted have been identified and are being tracked to completion.

III.3.D.3 Assess the Results of the Modification Management Review. Memo NOS 83-299, dated March 31, 1983, describes this assessment. Deficiencies fell mainly into the areas of updating procedures and training. Under a separate PIP milestone (III.3.D) NED is reviewing past PDCR's for design document update in conjunction with a procedure update program. The licensee concluded that no significant safety issues were identified and that identified deficiencies in procedures and training are being tracked to completion.

The inspector also reviewed two milestones carried over from February, 1983:

II.2.3 Implement Improvements in Safety Review and Assessment. The licensee is still in the process of establishing schedules for completion of the improvements identified.

III.1.B.3 Develop Procedures for Regulatory Requirements Analyses. This milestone has been completed via establishment of NOSD procedures 16.05, Commitment Completion Compliance Evaluation, and 16.06, Implementation of Regulatory Requirements Analysis Process.

The inspector determined that the licensee had met the March, 1983 milestones as committed in PIP Rev.1 and Rev. 2. Item II.2.3 is considered to remain open pending review of the licensee's schedule for completion.

8. Unresolved Items

Areas for which more information is required to determine acceptability are considered unresolved. An unresolved item is discussed in Paragraph 4.B.(2) with regard to an operability determination of the Core Spray valve (1400-4A) on February 21, 1983.

9. 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.