# U. S. NUCLEAR REGULATORY COMMISSION REGION I

Report No.	50-277/83-20 50-278/83-20 50-277	50-277:	830618 830617 830620 830624
Docket No.	50-278 DPR-44		830626 830629
License No.	DPR-56 Priority	Category	C
Licensee:	Philadelphia Electric Company		
	2301 Market Street		
	Philadelphia, Pennsylvania 19101		
Facility Na	me: Peach Bottom		
Inspection	At: Delta, Pennsylvania		
Inspection	Conducted: July 1 - August 23, 1983		
Inspectors:	M.E. Jripp		8/30/83
1	WA. R. Blough, Sr. Resident Inspector		dáte
/	A.E. Supp		8/30/83
1	62 S. H. WITTAINS, Resident Inspector		date
'	DK Jave hamp		8/31/83
	Dy R. Haverkamp, Reactor Licensing Engineer		date
Approved by	: Jouell E. Jupp		8/31/83
	Lowell E. Tripp, Chief		date
Inspection	Summary:		
July 1 - Au	gust 23, 1983 (Combined Inspection Report 50-2)	77/83-20 ar	d 50-278/83-20

Routine, regular and backshift resident inspection (97 hours, Unit 2;105 hours, Unit 3) onsite, and specialist inspection (4 hours) in-office of: accessible portions of Unit 2 and Unit 3, operational safety, radiation protection, housekeeping, physical security, control room activities, maintenance, surveillance, locked valve control, licensee events, periodic reports, and outstanding items.

Results: Violations: Four (Failure to follow locked valve control procedures, Detail 4; failure to post a notice to workers, Detail 5; failure to post a High Radiation Area, Detail 5; and inadequate compensatory measures, Detail 6).

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Region I Form 12 (Rev. February 1982) DETAILS

### 1. Persons Contacted

- W. H. Alden, Engineer-in-Charge, Nuclear Section
- J. K. Davenport, Maintenance Engineer
- G. F. Dawson, I&C Engineer
- \*R. S. Fleischmann, Station Superintendent
- A. Fulvio, Assistant Maintenance Engineer
- N. Gazda, Health Physics Field Operations Engineer
- A. Hilsmeier, Senior Health Physicist
- J. Mitman, Results Engineer
- F. W. Polaski, Assistant Outage Manager
- S. R. Roberts, Operations Engineer
- D. C. Smith, Assistant Station Superintendent
- S. A. Spitko, Site Q. A. Engineer
- S. Q. Tharpe, Security Supervisor
- A. J. Wasong, Reactor Engineer
- H. L. Watson, Chemistry Supervisor
- J. E. Winzenried, Technical Engineer

Other licensee employees were also contacted.

\*Present at exit interviews on site and for summation of preliminary inspection findings.

# 2. Previous Inspection Item Update

(Closed) Inspector Follow Item (277/82-14-03), full operability of the seismic monitoring system. One of the four accelerometers had been inoperable. This was restored by September 1982; however, the off-line spectrum response analyzer (SRA) experienced intermittent failures. The problem was eventually corrected by replacing some AC-powered auxiliary relays, which had been inducing noise on the DC instrument signal lines, with DC-powered relays. The inspector reviewed the interim (October 25, 1982) and follow-up (July 5, 1983) reports pursuant to Technical Specifications 6.9.3 and 3.15.B, and discussed this item with licensee engineers. The SRA is used for detailed, followup analysis of seismic events and is not needed for initial detection, evaluation, and response. Had a seismic event occurred while the SRA was inoperable, off-site vendor equipment could have been used for spectrum analysis of the magnetic tape recordings generated on-site. The inspector had no further questions.

(Closed) Unresolved Item (277/81-07-11 and 278/81-09-10), adequacy of licensee's IE Bulletin 80-10 review. The inspector reviewed licensee corrective actions for this bulletin in reports 277/82-16; 278/82-16 and 277/82-25; 278/82-24. This item is closed.

(Closed) Inspector Follow Item (277/82-16-04), obtain licensee clarification of IE Bulletin 80-10 response. Licensee clarifications and commitments provided to the inspector are detailed in report 277/82-25; 278/82-24. These items will be reviewed as part of the bulletin close-out.

(Closed) Inspector Follow Item (278/82-16-02), review licensee determination of RHR heat exchanger leak start date. The licensee plotted plant water inventory over an extended time period. During this effort, several deficiencies in water inventory accounting, such as inaccurate tank level-to-volume correlations, were identified and corrected. After reviewing the data, the licensee concluded that the RHR heat exchanger leak rate had been below the detectability of the previous inventory methods. Based on RHR system operating history, the licensee believed the leak had started on October 25, 1982. The inspector had no further questions.

(Open) Unresolved Item (277/82-23-01, 278/82-22-01), documentation inadequacies regarding plant shielding design review. Combined Inspection Report 50-277/82-23 and 50-278/82-22 identified several concerns regarding the licensee's documentation of his plant shielding design review completed in response to NUREG-0737, Item II.B.2. Those concerns were reiterated in a licensee letter (S. Daltroff, PECO, to R. Starostecki, NRC) dated May 13, 1983. Attachments to that letter provided additional information regarding the licensee's plant shielding review, vital area assessment, his determination of projected doses to individuals for necessary occupancy times in vital areas, and his evaluation of the need for certain modifications. Based on review of the detailed information provided by this letter and attachments, the inspector determined that the previous documentation inadequacies had been corrected, and determined the following technical aspects of the licensee's plant shielding design review:

- The vital area assessment included all areas identified for consideration in NUREG-0737, Item II.B.2.
- (2) Projected doses to individuals for necessary occupancy times in vital areas have been calculated.
- (3) Based on symptom-based emergency procedure considerations, licensee evaluation had determined that back-filling reactor vessel instrument lines is not required.
- (4) Based on licensee calculations of projected doses to individuals for access to vital areas, modifications are not required for makeup water to spent fuel pools.
- (5) One additional modification is needed for the dose projections for all vital areas to meet the criteria of NUREG-0737, Item II.B.2. Specifically, due to the high projected doses to health physics personnel working at the Health Physics Operations Support Center (HP-OSC) during the postulated accident, the licensee plans to provide a backup HP-OSC, or install additional shielding to protect the current HP-OSC, in time for the 1984 emergency drill.

The inspector had no further questions regarding the licensee's plant shielding design review, but informed licensee management that this item would remain unresolved pending completion of corrective actions for the HP-OSC. (Open) Unresolved Item (277/83-09-02, 278/83-09-06), acceptability of air sampling system as a backup to sump flow rate measurement for determining coolant leakage. The inspector reviewed the revised FSAR section, issued July 20, 1983, dealing with the drywell air monitoring system as a means of measuring coolant leakage. The licensee's conclusion was that one cannot make a meaningful correlation between detector count rate and coolant leakage rate. The inspector stated that the air monitoring system should therefore not be considered fully redundant to the sump monitoring system. The comments were provided to NRC:Region I management and to the NRC:NRR Licensing Project Manager. The inspector will continue to follow this item until resolved.

(Open) Violation (277/83-16-03, 278/83-16-02), failure to adequately inspect fire barriers. The inspector frequently verified that firewatches were posted as required. Installation of permanent seals is in progress in some areas. Licensee detailed inspections of fire barriers are still in progress. The licensee stated that the inspections had revealed additional small unsealed penetrations in the Computer Room and Diesel Generator Rooms. At an Enforcement Conference on August 11, the licensee indicated that the fire barrier inspection surveillance test had been revised to include more detailed guidance and acceptance criteria. The inspector verified this by reviewing the procedure, ST 16.7, Revision 2, Visual inspection of Fire Barriers, and discussing it with licensee personnel. This item remains open pending licensee completion and NRC review of the licensee's long-term corrective actions (reference Enforcement Conference Report 50-277/83-23; 50-278/83-23).

- 3. Plant Operations Review
  - 3.1 Facility Tours

Daily tours and observations included the Control Room, Turbine Building (all levels), Reactor Buildings (accessible areas), Radwaste Building, Diesel Generator Building, yard perimeter outside the power block, Security Building (including CAS, Aux SAS, and control point monitoring), lighting, vehicular control, the SAS security fencing, portal monitoring, personnel and badging, control of Radiation and High Radiation areas (including locked door checks), TV monitoring capabilities, and shift turnover.

- 3.1.1 Control Room staffing frequently was checked against 10 CFR50.54(k), Technical Specifications, and the NRR letter of July 31, 1980. Presence of a senior licensed operator in the control room complex was verified frequently.
- 3.1.2 Monitoring Instrumentation. The inspector frequently confirmed that selected instruments were operating and indicated values were within Technical Specification requirements. ECCS switch positioning and valve lineups were verified based on control room indicators and plant observations. Observations included flow setpoints, breaker positioning, and radiation monitoring instruments.

- 3.1.3 Off-Normal Alarms. Selected annunciators were discussed with control room operators and supervision to assure they were knowledgeable of plant conditions and that corrective action, if required, was being taken. The operators were knowledgeable of alarm status and plant conditions. Most alarms were attributable to the Cold Shutdown status of both units.
- 3.1.4 Fluid Leaks. The inspector observed sump status, alarms, and pump-out rates, and discussed leakage with licensee personnel. The inspector toured the Unit 3 Drywell on August 9 with the reactor pressurized following hydrostatic testing. No evidence of pipe or weld leakage was noted. Minor leakage from some valve packings and bonnets was noted. The inspector verified that these items had been previously documented by the licensee during his inspections.
- 3.1.5 No significant or unusual piping vibration was found.
- 3.1.6 Environmental Controls. The inspector observed visible main stack and ventilation stack radiation recorders and periodically reviewed traces from backshift periods to verify that radioactive gas release rates were within limits and that unplanned releases had not occurred. The inspector also visited a sampling of weather stations and environmental air sampling stations to verify that equipment was in good working condition and was operating.
- 3.1.7 Fire Protection. The inspector observed control room indications of fire detection and fire suppression systems, spotchecked for proper use of firewatches and ignition source controls, checked a sampling of fire barriers for integrity, and observed fire-fighting equipment stations.
- 3.1.8 Housekeeping. The inspector observed housekeeping conditions, including control of combustibles, loose trash, and debris; and spot-checked on cleanup during and after maintenance. The inspector noted that an area of the Turbine Building 135-foot elevation had been posted "No Combustibles Allowed," in accordance with a licensee commitment to NRC:NRR pending long-term smoke detector and cable routing modifications. However, the inspector noted that (1) a clothing change area was being established in the area, presenting potential for accumulation of combustibles, and (2) a past practice of temporarily staging bagged trash in a portion of the area near the end of shift was being continued. These problems were discussed with licensee management, were promptly corrected, and did not recur.

3.1.9 Equipment Conditions. The inspector verified operability of selected safety equipment by in-plant checks of valve positioning, control of locked valves (see Detail 4), power supply availability and breaker positioning. Selected major components were visually inspected for leakage, proper lubrication, cooling water supply, operating air supply, and general conditions. Systems checked included Unit 3 RHR 'A' and 'C', Unit 3 Core Spray 'A' and 'C', and Unit 2 Standby Liquid Control.

On July 25, 1983, the inspector noted an operating air leak on Unit 2 Containment Ventilation Valve AO-2521A, at a threaded union. The inspector informed licensee personnel and the leak was promptly repaired.

The inspector observed equipment and floor drains in the Unit 2 and 3 Reactor Buildings, Turbine Building, and Radwaste Building. Numerous floor drains were dirty and a large fraction of these appeared to be completely clogged. These findings were discussed with the licensee. The inspector re-inspected floor drains on July 12. All drains inspected had been cleaned out and appeared to be functional.

The inspector reviewed selected blocking permits (tagouts) for conformance to licensee procedures. Breaker, switch and valve positioning was verified. Included were:

Permit No.

### Equipment

2-32-M3-14	2D	HPSW	Pump
2-32-M3-15	2A	HPSW	Pump
2-83-84	2A	HPSW	Pump

No violations were found.

#### 3.2 Logs and Records

The inspector spot-checked logs and records for accuracy, completeness, abnormal conditions, significant changes and trends, required entries, operating and night order propriety, correct equipment and lock-out status, conformance to Limiting Conditions for Operations, and proper reporting. The following logs and records were reviewed: Shift Supervision Log, Reactor Operators Log (Unit 2), Reactor Operators Log (Unit 3), CO Log Book, STA Log Book (sampling), Night Orders (current entries), Radiation Work Permits (RWP's), Maintenance Request Forms (sampling), Ignition Source Control Checklists (sampling), and Operation Work & Information Data, all July 1 - August 23, 1983.

Control room logs were evaluated against Administrative Procedure A-7, Shift Operations. Frequent initialing of entries by licensed operators, shift supervision, and licensee on-site management constituted evidence of licensee review. No unacceptable conditions were identified.

### Locked Valve Control

The inspector checked over 50 locked valves for proper position and locking, and reviewed various administrative aspects of locked valve control. All valves checked were in the proper position, however, administrative problems were noted as follows:

- -- On July 21, the inspector noticed several locked valves in the Unit 3 Standby Liquid Control (SBLC) System out of their normal positions. Licensee personnel indicated that surveillance test ST 13.18, Revision 0, July 20, 1983, Standby Liquid Relief Valve, Injection, and Recirculation Testing was being performed and the SBLC system was out of service. The surveillance test requires the valves to be cycled several times during the test. The inspector verified on a sampling basis that valve positions were consistent with the test procedure. Administrative Procedure A-8, Procedure for Control of Locked Valves, requires all locked valves to be controlled with entries in the Locked Valve Log, indicating valve identification and position. For this test, as well as for other SBLC tests, the log entry was "various SBLC valves." Administrative Procedure A-8 does not provide for such simplified logging of repeated operation of multiple locked valves. The licensee began an investigation of this matter. The acceptability of licensee locked valve logging practices is unresolved. (278/83-20-01).
- -- On July 28, the inspector noted that the Basket Strainer Flush Block Valve on the Diesel Fire Pump Discharge (HV-0421) was unlocked. The valve is listed as locked closed on Locked Valve List Appendix A-8C, Revision 8, June 1, 1983. The valve was closed and did not appear to have been operated recently. There was no recent Locked Valve Log entry for the valve, and no maintenance or operations in progress required the valve to be unlocked or repositioned. When informed, the licensee locked the valve.
- -- On August 16, the inspector noted that SBLC Pump Discharge Drain Hose Connection Valve, HV2-11-32, was not locked. The valve is listed as locked closed on Locked Valve List Appendix A-8A, Revision 8, August 31, 1982. The valve was closed and an in-series valve, also on the Locked Valve List, was locked closed as required. No maintenance or operations in progress required HV2-11-32 to be unlocked or repositioned. A Locked Valve Log entry and surveillance test records indicated that a test involving operation of the valve had been completed August 8. When informed, the licensee locked the valve and began a check of all locked valves.
- -- (1 August 18, the inspector reviewed Locked Valve Log entries for consistency with plant status. The log indicated that numerous Unit 3 ECCS room Emergency Service Water (ESW) cooler inlet and outlet valves had not been restored from outage-related maintenance. The inspector reviewed the associated Local Permits (tag-outs) and determined that ESW inlet and outlet valves had actually been restored to their normal (open) positions, without completion of the "restored section" of the locked valve log, as follows:

	ECCS Room	Cooler	Date Restored
3A	Core Spray	Room - both coolers	5-16-83
3C	Core Spray	Room - both coolers	5-16-83
3A	RHR Room -	both coolers	5-20-83
30	RHR Room -	both coolers	5-20 & 21-83
3B	Core Spray	Room - both coolers	4-20-83

When informed, the licensee updated the Locked Valve Log. The inspector checked a sampling of ECCS room cooler inlet and outlet valves in-plant; all those checked were properly positioned and locked.

Technical Specification 6.8 and Regulatory Guide 1.33 (November 1972) require implementation of procedures for equipment control. Administrative Procedure A-8, Revision 5, March 14, 1983, Procedure for Control of Locked Valves, requires that valves on Locked Valve Lists be locked unless maintenance or operations in progress requires otherwise. When a valve previously unlocked for maintenance or operations is restored to the normal condition and locked, procedure A-8 requires that the restored section of the Locked Valve Log be completed. Failure to follow procedure A-8 is a Violation (277/83-20-01, 278/83-20-02). The inspector stated that these deficiencies indicated lapses in attention to detail and presented potential for loss of equipment control, even though in this case no valves were improperly positioned.

## 5. Radiation Protection

During this report period, the inspector examined work in progress in both units, including the following:

- a. Health Physics (HP) controls
- b. Badging
- c. Protective clothing use
- d. Adherence to RWP requirements
- e. Surveys
- f. Handling of potentially contaminated equipment and materials

More than 60 people observed met frisking requirements of Health Physics procedures. A sampling of high radiation doors was verified to be locked as required.

Compliance with RWP requirements was verified during each tour; special emphasis was placed on RWP adherence in work associated with the Unit 3 outage. About 20 RWPs were checked. Line entries were reviewed to verify that personnel had provided the required information and about 40 people working in RWP areas were observed to be meeting the applicable requirements.

On July 27 and 29, the inspector spot-checked radiological measures associated with radiography in the Unit 3 Torus Room. No inadequacies were noted. About 4:00 p.m., on August 12, the inspector observed the licensee's bulletin board used for posting of notices to workers. A Notice of Violation involving radiological working conditions, dated July 20, 1983 (reference inspection report 277/83-16; 278/83-16), had not been posted. When informed the licensee promptly posted the notice. Licensee records indicated that the notice had been received on August 1, 1983. 10 CFR 19.11, Posting of Notices to Workers, requires any Notice of Violation involving radiological working conditions to be posted within two days of receipt from the Commission. Failure to post notices as required is a Violation (277/83-20-02, 278/83-20-03).

While observing activities on the Unit 3 Refuel Floor about 2:40 p.m., on August 18, the inspector noted that an accessible area associated with temporary storage of underwater lights near the cask loading hatch was not posted as a High Radiation Area. The radiation survey, dated August 17, associated with Refuel Floor RWP 3-94-0587, indicated that (1) general area gamma radiation levels were 200 milliroentgens per hour (mr/hr) in the vicinity of the lights; and (2) the area was posted. Thus, a person in this area could receive a dose of 200 millirems to a major portion of the body in one hour. Health Physics technicians indicated that the area had been properly posted the previous day, but the rope and sign had apparently been removed. Also, large cables had been moved into the area. Health Physics technicians re-surveyed and re-posted the area. 10 CFR20, paragraphs 20.202 and 20.203, require High Radiation Areas i.e., areas accessible to personnel in which a major portion of the body could receive a dose in excess of 100 millirems in one hour, to be conspicuously posted with a radiation caution symbol and the words, "Caution--High Radiation Area." Failure to post a High Radiation Area is a Violation (278/83-20-04). The inspector noted that the High Radiation Area was within a Radiation Area, which was properly posted and required an RWP for entry. Thus, access control, although not the same degree as for a High Radiation Area, was in place during the time the High Radiation Area signs were missing.

6. Physical Security

#### 6.1 Routine Operations

The inspector spot-checked compliance with the accepted Security Plan and implementing procedures, including: operations of the CAS and SAS, over 20 spot-checks of vehicles onsite to verify proper control, observation of protected area access control and badging procedures on each shift, inspection of physical barriers, checks on control of vital area access and escort procedures. No violations were identified. THIS PAGE, CONTAINING SAFEGUARDS INFORMATION, NOT FOR PUBLIC DISCLOSURE, IS INTENTIONALLY LEFT BLANK

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# 7. Surveillance Testing

The inspector observed surveillance to verify that testing had been properly approved by shift supervision, control room operators were knowledgeable regarding testing in progress, approved procedures were being used, redundant systems or components were available for service as required, test instrumentation was calibrated, work was performed by qualified personnel, and test acceptance criteria were met. Parts of the following test were observed:

-- ST 13.18, Revision 0, dated July 20, 1983, "Standby Liquid Relief Valve, Injection and Recirculation Testing," performed July 21 on Unit 3.

The following tests were reviewed:

- -- ST 13.9, Revision 7, dated May 16, 1983, "Secondary Containment Capability Test," performed July 11 and 12 on Unit 2.
- -- ST 9.1.2, Revision 25, dated June 22, 1982, "The Surveillance Log," performed June 30 on Unit 2.
- -- ST 9.1-3, Revision 28, dated June 17, 1982, "The Surveillance Log," performed July 10 on Unit 3.
- -- ST 9.3, Revision 5, dated April 11, 1983, "Manual Scram," performed May 7 on Unit 2.
- -- ST 7.5.4, Revision 4, dated February 12, 1979, "Determination of Airborne Particulate Activity in Areas Contributing to Unmonitored Releases," performed June 20.

No violations were observed; an unresolved item regarding locked valve logging in ST 13.18 is discussed in Detail 4.

### 8. Maintenance

The inspector spot-checked administrative controls, reviewed in-process documentation, and observed portions of maintenance activities associated with Unit 3 reactor vessel closure, drywell head closure, and refuel floor restoration. The inspector verified that work performed was in accordance with the following documents:

- -- Maintenance Request Form 3-18-M3-25, March 3, 1983, Reactor Vessel (closure of);
- -- M4.3, Revision 11, April 2, 1982, Closing the Reactor Vessel, including a Temporary Change, dated June 21, 1983, to allow temporary installation (untensioned) of the head; and

-- M4.66, Revision 5, August 5, 1983, Installation of Drywell Head.

The inspector observed portions of post-maintenance testing of the Unit 3 RCIC overspeed trip device, per 5.3.5.K, Revision 0, June 17, 1983, RCIC Overspeed Test, in progress on July 28. The test could not be completed as initially written because a higher than anticipated reactor water level was causing closure of the steam supply line. A temporary change was obtained to defeat the high water level closure and the test was subsequently completed successfully. The inspector reviewed the completed procedure and discussed the test with licensee personnel.

The inspector observed post-maintenance functional testing of the Unit 3 'B' CRD pump. No problems were noted.

The inspector reviewed completed Local Permits (tagouts) associated with Unit 3 ECCS room cooler maintenance to verify that the maintenance was properly considered as Technical Specification-related and that sequencing of cooler maintenance was consistent with ECCS operability requirements. Included in this review were Local Permits 3-40M3-43 through 3-40M3-58.

No violations were identified.

# 9. Review of Licensee Event Reports (LERS)

# 9.1 In-office Review

IPD No /

The inspector reviewed LERs submitted to NRC:RI to verify that the details were clearly reported, including the accuracy of the description and corrective action adequacy. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite followup. The following LERs were reviewed:

LER Date/ Event Date	Subject
2-83-15/3L 7-11-83 6-18-83	Reactor Water Cleanup isolation valve failed to close during surveillance due to controller circuit contact failure. The redundant valve was kept shut during repairs.
2-83-16/3L 7-13-83 6-17-83	Oxygen analyzer isolation valve failed to fully close during surveillance. The redundant valve was kept shut during re- pairs.
2-83-17/3L 7-20-83 6-20-83	Off-site power supply transformer relief device failed and was replaced. The re- maining off-site power source and all four emergency diesels were operable during re- pairs.
2-83-18/3L 7-11-83 6-24-83	HPCI failed to operate during surveillance due to a failed resistor in the governor. Redundant equipment was operable during re- pairs.
2-83-19/3L 7-12-83 6-26-83	SBGT Train 'A' outlet valve failed to open during surveillance due to a sticking solenoid. The valve was opened by removing its air supply to maintain system operabil- ity during repairs.
2-83-20/3L 7-29-83 6-29-83	Fire barrier inadequacies. See Detail 2, Items 277/83-16-03 and 278/83-16-02.

### 9.2 LER System Changes

The inspector discussed with the licensee changes to 10 CFR50.72 and 10 CFR50.73 that become effective January 1, 1984. These regulations change event reporting requirements to standardize reporting thresholds among licensees and to make reports more useful to NRC evaluations of the nuclear safety implications of reactor events. The regulations will supercede the appropriate sections of Technical Specifications and will necessitate major changes in the licensee report procedures and format.

No unacceptable conditions were identified.

## 10. In-Office Review of Periodic Reports

# 10.1 Monthly Operating Report

Peach Bottom Atomic Power Station Monthly Operating Reports listed below were reviewed pursuant to Technical Specifications and verified to determine that operation statistics had been accurately reported and that narrative summaries of the month's operating experience were contained therein.

Report

Date

June	1983	July 15, 1983
July	1983	August 15, 1983

# 10.2 Safety-Relief Valve Challenge Report

The inspector reviewed the 1982 Annual Report on Safety-Relief Valve Challenges, dated June 27, 1983, pursuant to TMI Action Plan Item II.K.3.3. The report indicated that no challenges had occurred in 1983.

No unacceptable conditions were identified.

### 11. Unresolved Items

Unresolved items are items about which more information is required to ascertain whether they are acceptable, violations, or deviations. An unresolved item is discussed in Detail 4.

### 12. Management Meetings

## 12.1 Preliminary Inspection Findings

A summary of preliminary findings was provided verbally to the Station Superintendent at the conclusion of the inspection. During inspection, licensee management was periodically notified verbally of the preliminary findings by the resident inspectors.

# 12.2 Attendance at Management Meetings Conducted by Region-Based Inspectors

The resident inspectors attended entrance and exit interviews by region-based inspectors as follows:

Date	Subject	Report No.	Reporting Inspector
July 18 (Entrance) July 22 (Exit)	Health Physics	277/83-19 278/83-19	J. White
August 17 (Entrance)	IE Bulletin	277/83-25	S. Reymolds
August 19 (Exit)	83-02	278/83-25	
August 15 (Entrance)	Containment Leak	277/83-24	W. Rekito
August 23 (Exit)	Rate Testing	278/83-24	

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