U.S. NUCLEAR REGULATORY COMMISSION

Report No. 50-289/84-11

Docket No. 50-289

License No. DPR-50 Priority -- Category C

Licensee: GPU Nuclear Corporation

P.O. Box 480

Middletown, Pennsylvania 17057

Facility: Three Mile Island Nuclear Station, Unit 1

Inspection at: Middletown, Pennsylvania

Inspection conducted: April 10 - May 8, 1984

Inspectors:

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F. Young, Resident Inspector (TMI-1) — May 17, 1984 date signed

W. Baunack
W. Baunack, Project Engineer — 5/21/84 date signed

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Inspection Summary:
Inspection conducted on April 10 - May 8, 1984 (Inspection Report Number 50-289/84-11)
Areas Inspected: Routine safety inspection by resident inspectors of licensee action on previous inspection findings; plant operations (shutdown mode) including review of a radioactive liquid waste discharge, reactor coolant pump repair, and reactor building integrated leakrate test; implementation of

Abnormal Transient Operating Guidelines (ATOG); and modification for additional water storage capacity. The inspection involved 159 inspector-hours.

Results: Of the four areas reviewed, one apparent violation was identified: failure to properly implement written modification instructions (paragraph 4.3). Overall control and maintenance of the plant in a shutdown condition was adequate for the evolutions being conducted. The ATOG program was implemented in a controlled manner with proper emphasis in the area of operator training.

DETAILS

1. Licensee Actions on Previous Inspection Findings

(Closed) Inspector Follow Item (289/84-07-01): Review of Steam Generator Tube Rupture Guidelines. In conjunction with the Abnormal Transient Operating Guidelines (ATOG) Program (see paragraph 3 for details of review) the inspector conducted a review to verify that the licensee commitment requirements as stated in NUREG 1019, NRC Staff Safety Evaluation for TMI-1 Steam Generator Repair, were incorporated into ATOG procedures (previously in Emergency Procedure 1202-5). Abnormal Transient Program (ATP) 1210-5 Tube Leak/Rupture was reviewed. The inspector concluded that the specific guidelines were incorporated in this procedure as noted in NUREG 1019.

(Open) Task Action Plan Item (TAP)(289/I.C.1): Guidance for the Evaluation and Development of Procedures for Transients and Accidents. The licensee program for this item was the Anticipated Transient Operator Guidelines (ATOG). Details of the implementation aspects of this TAP item are in paragraph 3. The NRC's safety evaluation for this item lists a number of questions that remain to be resolved by the licensee. The licensee is in the process of answering these questions.

(Closed) Inspector Follow Item (289/81-33-03): Operator Training before ATOG Implementation. Details are in paragraph 3.

2. Plant Operations During Long Term Shutdown

2.1 Routine Review

The resident inspectors periodically inspected the facility to assess compliance with general operating requirements of Section 6 of Technical Specifications in the following areas:

-- licensee review of selected plant parameters for abnormal trends;

-- plant status from a maintenance/modification viewpoint including plant cleanliness;

-- licensee control of ongoing and special evolutions, including control room personnel awareness of these evolutions;

-- control of documents including log keeping practices;

-- implementation of radiological controls; and,

-- licensee implementation of the security plan including access controls/boundary integrity and badging practices.

The inspectors reviewed the following specific items:

-- Random inspections of the control room during regular and selected backshift hours were conducted which included a review of sections of the shift foreman's log and control room operator's log for the period April 10 - May 8, 1984, and selected sections of other control room daily logs for the period from midnight to the time of review;

-- Inspections of areas outside the control room occurred on: April 9, 10, 12, 13, 15, 16, 23, 24, May 2, 4, and 7, 1984; and,

-- Selected licensee planning meetings.

2.2 Reactor Coolant Pump Repair

2.2.1 Background

The NRC Inspection Report No. 50-289/84-08 documented a review of licensee activities on the Reactor Coolant Pump (RC-P-1B) Repair including the results of licensee inspection of the pump internals. As previously reported, there was excessive erosion on the RC-P-1B impeller and the licensee identified a hairline crack on the shaft at the thermal sleeve retaining pin holes. On April 10, 1984, the licensee submitted a report on RC-P-1B repair to the NRC's Office of Nuclear Reactor Regulation. Early in the inspection period, the licensee completed reinstallation of major components and equipment in the area of the RCP. Testing of the motor under no load conditions was satisfactory. Cold testing, satisfactorily completed as of the end of the inspection period, included: pump control circuit interlock and logic testing, cold balancing of the rotor assembly, and operational test of the pump and motor.

2.2.2 Review

During the inspection period, the resident inspectors reviewed the licensee's report of April 10, 1984. In summary, the report was a justification for continued operation based on the repaired RCP and visual/video observations of the other 3 RCP's (1A, 1C, 1D) installed in the reactor coolant system. In that report, the licensee discussed current and future actions. The inspector reviewed this report to verify the accuracy of the licensee's reported findings on the RCP internals examination.

2.2.3 Findings

The inspector verified that the licensee completed the commitment to provide a report to the NRC on the RCP damage. The information presented by the licensee on the internals examination was accurate based on inspector monitoring of licensee activities in this area since February 1984.

Licensee characterization of the major findings of the RC-P-1B internals inspections are:

-- A shaft crack at the thermal sleeve area of the shaft was apparently due to fatigue failure. The licensee contracted with Babcock & Wilcox to perform a laboratory examination (metallurgical evaluation) to substantiate the failure mechanism. Preliminary results of the analysis were expected by mid-May, 1984 (now mid-June, 1984, based on later discussions with licensee representatives).

-- There was significant degradation of the 1B impeller (apparently not exhibited on the other RCPs) due to erosion and apparently not due to a corrosive attack (which is expected to be substantiated by the laboratory examination noted above). Licensee representatives are continuing their study to understand the significant erosion mechanism on the 1B pump in regard to net positive suction head requirements and pump runout conditions during cold single pump operation.

-- The licensee is relying on a photo-enhancing technique for evaluation of the video inspection of the bottom view of the RC-P-1A, C, D impeller vanes. This technique resulted in a licensee's conclusion that no significant damage occurred to the underside of RC-P-1A, C, and D impellers. The licensee acknowledges the possibility of some superficial cavitation damage to these impeller vanes, but states that confirmation of acceptable pump hydraulic performance for all RCP's will be achieved by flow testing. Specific test details are being finalized.

-- Existing instrumentation (vibration monitors) are adequate to detect vibration changes before radical failure of shaft. Ultrasonic testing techniques used on the pump shafts, developed as a result of the RC-P-1B event, are adequate to detect any similar damage to the RCP's.

The licensee's overall conclusions in the report are:

-- The RCP's with their protection system and associated support systems will withstand a sudden stopping due to seizure after a shaft break or other cause without resulting in a failure of the reactor coolant pressure boundary (references: TMI-2 FSAR Section 15 applicable to TMI-1).

-- With respect to core flow, the pump shaft failure (the onset of such an event will most likely be detected before actual failure) is bounded by the locked rotor safety evaluation (reference: TMI-1 FSAR (updated) Section 10).

-- In light of the above, the pump damage has no safety significance since it is not viewed as a safety concern for cold shutdown operation or future power operation.

The adequacy of the licensee's evaluation and conclusions will continue to be reviewed by NRC staff. The resident inspectors will continue to routinely monitor licensee activities on RCP post repair testing (289/84-11-01).

2.3 Review of Radioactive Liquid Waste Discharge

2.3.1 Event Circumstances

On April 4, 1984, the local Environmental Protection Agency (EPA) Office reported to the NRC onsite staff that EPA sample results for April 1, 1984 at RM-L7 (10pCi/l, CO-60) indicated a slight increase from normal background activity levels.

A review of a radioactive liquid discharge from the plant during this time frame was conducted. Radioactive liquid release Number 22-84-L consisted of 4,231 gallons with a total radioactivity content of 0.0283 curies. Discharge calculations indicated the components to be CO-60 (0.00091 curies); Cs-134 (0.00013 curies); Cs-137 (0.00016 curies); Sb-125 (0.00008 curies); and H-3 (0.0256 curies). Prior to commencing the discharge, a sample of the liquid was required to be analyzed and the administrative requirements require a liquid release permit to be completed. This permit required certain plant parameters to be monitored during the release. The parameters monitored included the flowrate from the tank; Radiation Monitor - Liquid RM-L6, the discharge line monitor; flow recorder for the mechanical draft cooling tower effluent (FR-146), and Radiation Monitor - Liquid RM-L7, the site discharge monitor.

The discharge was initiated at 4:45 P.M. on March 31, 1984. The recorded readings from RM-L6 increased from a normal background reading of 2,000 counts per minute at the start to about 27,000 counts per minute. The alert setpoint was

31,692 counts per minute, and the high alarm was 42,256 counts per minute. At the high alarm, RM-L6 automatically terminates the release by closing WDL-V 257 (plant discharge valve).

Control room operators noted on shift change at 11:00 P.M. March 31, 1984, that RM-L6 was in the alert condition. At about 1:00 A.M. April 1, 1984, RM-L6 alarmed high, and the recorded spike was about 75,000 counts per minute. The high alarm automatically terminated the release.

The monitor (RM-L6) was back flushed to the Auxiliary Building sump; the release was restarted; and RM-L6 immediately went into a high alarm, and terminated the release a second time. Operators performed a second back flush of the monitor and restarted the release. The release was not terminated a third time by RM-L6. The release was manually terminated at 4:20 A.M. on April 1, 1984 at the tank low level. Licensee samples taken at the site discharge point indicated the release had not exceeded the allowable concentrations of Appendix B, 10 CFR Part 20 for water in an unrestricted area.

2.3.2 Scope of Review

In response to inquiries by the local EPA Office, as noted above, the inspector reviewed radioactive liquid waste discharge number 22-84-L (March 30, 1984) to verify that station discharges were being properly performed with respect to criteria contained in:

-- 10 CFR Part 20, Appendix B, "Concentrations in Air and Water Above Natural Background," Table II, Column 2, limit for concentrations in water released to an unrestricted area.

-- 10 CFR 20.106, "Radioactivity in effluents to unrestricted area.

-- 10 CFR 20.201, "Surveys"

-- 10 CFR 20.401, "Records of Surveys, Radiation Monitoring, and Disposal."

The following documents were reviewed:

-- Liquid Release Permit Number 22-84-L, dated March 30, 1984;

-- Radiological Controls Procedure (RCP) 1621, Releasing Radioactive Liquid Waste" Revision 28, dated May 27, 1983;

-- Operation Procedure (OP) 1104-29S, "Transfers from the Waste Evaporator Condensate Storage Tanks," Revision 25, November 10, 1983;

-- Alarm Response Procedure C-2-1, Revision 11, January 5, 1984; and

-- Emergency Procedure 1202-12, "Excessive Radiation Levels," Revision 18, dated March 19, 1984.

2.3.3 Findings

The inspector determined that administrative requirements for performing and monitoring the release parameters were accomplished within the scope of procedures controlling the evolution. However, the inspector identified a problem with licensee management's guidance to the control room operators on the handling of RM-L6 high alarm.

In reviewing the referenced procedures, it was noted that during planned liquid releases, EP 1202-12, is not applicable and that RCP 1621 is to be the controlling procedure. The EP 1202-12 states, in part, that when RM-L6 terminates a release for unknown reasons, the alarm is to be investigated, a new sample drawn and a new release permit issued. Alarm procedure C-2-1 directs basically the same actions to be taken for a high alarm signal from RM-L6. Even though the alarm procedure is applicable, AP 1001G requires, in part, that the control room operator evaluate the required alarms and use appropriate response steps for the circumstances. Historically, because of physical arrangement of the piping and location of the sample chamber liner, RM-L6 frequently becomes contaminated. Plant operations management policy has been that when the contamination collected on the sampling liner for RM-L6 builds up to an alarm condition, the release is halted, a back flush is made through the monitor to the auxiliary building sump until the background is below the alert setpoint, and the release is then restarted. Past practices, which varies from shift to shift, has been to perform as many as three back flushes in order to lower the background activity level of RM-L6 before the release flow could be re-established without RM-L6 immediately retripping WDL-V-257.

The inspector considered the lack of guidance on how many times a backflush could be performed when RM-L6 alarmed high without a resample to be a weakness in the licensee's alarm response procedure. The licensee acknowledged this finding and is revising the alarm response procedure (C-2-1) to address this issue (289/84-11-02).

2.4 Containment Integrated Leakrate Test

Between April 12 and 17, 1984, the resident inspector assisted region based inspectors in the review and monitoring of the Reactor Building (Containment) Integrated Leakrate Test and associated procedures. Resident inspector activities included: witnessing of selected local leakrate tests; verification of the applicable surveillance test procedure implementations including prerequisite completion; proper positions of selected containment isolation valves; 12 psig inspection inside the reactor building; and review of log-keeping practices for the special test. Additional details and conclusions are addressed in NRC Inspection Report 50-289/84-10. The test was satisfactorily completed.

2.5 Based on this sampling review of the various licensee activities noted above, the inspector did not identify any conditions adverse to nuclear safety or regulatory requirements. Personnel stationed in the control room presented a posture of overall control of daily activities. Licensee intermediate managers showed awareness of daily activities including problem areas that needed resolution. The planning meetings indicated an attempt to proceed safely with daily activities and to resolve any inter-department interface problems. Licensee upper management continued their detailed involvement in site activities.

3. TMI-1 Abnormal Transient Operating Guidelines (ATOG) Program and Procedure Implementation

3.1 Background

In accordance with NUREG 0737 (Supplement 1) TMI Task Action Plan (TAP) Item I.C.1, Guidance for the Evaluation and Development of Procedures for Transients and Accidents, licensees of operating plants were to upgrade emergency procedures and conduct appropriate operator retraining prior to implementation. The licensee has developed a group of symptomatic abnormal transient procedures to complement their emergency event-oriented procedures. They based these procedures on the B&W ATOG procedures developed for Oconee Unit 3 (September 19, 1983).

The schedule and review requirements for TAP Item I.C.1 were clarified by Supplement 1 to NUREG-0737, "Requirements for Emergency Response Capability," (Generic Letter 82-33), dated December 17, 1982. In accordance with the above, NRR staff has reviewed the TMI-1 ATOG Plant-Specific Technical Guidelines, Writer's Guide, Program Validation and Training Program Description and found them to be generally acceptable. However, the staff has asked a number of questions of the licensee listed in the staff's safety evaluation report and the licensee is in the process of answering these questions. The purpose of this NRC Region I review was to accomplish the remaining portion of the TMI-1 ATOG program review; that is, a review of the final upgraded program and procedure implementation.

3.2 Scope of Review

The inspector reviewed TMI-1 Abnormal Transient Procedures (ATP) 1210-1 through 1210-10 to determine whether they were technically compatible with plant operational characteristics and technically adequate to accomplish their required purpose. This review included a verification of proper format, step sequence, and ease of comprehension and use. Interviews were held with members of the TMI-1 Operations Engineering staff as well as with selected control room operators (2 SRO's and 2 RO's) to discuss their knowledge of ATOG and their opinions about its approach and usefulness. The inspector also toured the TMI-1 control room for verification of the availability and accessibility of up-to-date ATOG procedures. In addition, on March 5, 1984, the NRC Region I independently conducted walkthroughs of these procedures at the Bellefonte simulator near Chattanooga, Tennessee, with assistance from representatives from the NRC Training Center, IE.

Also, the inspector reviewed the documents and records (noted below) related to the operator training program for TMI-1 ATOG. This information was reviewed to ensure that all operators received and successfully completed the required training.

-- NUREG 0737, Supplement 1, "Requirements for Emergency Response Capability" (Generic Letter No. 82-33), December 17, 1982

-- NUREG/CR-2005, "Checklist for Evaluating Emergency Procedures Used in Nuclear Power Plants," Sandia National Labs, Albuquerque, N.M., May 1981

-- NUREG-0899, "Guidelines for the Preparation of Emergency Operating Procedures: Resolution of Comments on NUREG-0799"

-- TMI-1 Abnormal Transient Procedures ATP 1210-1 through ATP 1210-10

-- Training records and documents for B&W simulator and classroom training and onsite training for ATOG including:

a. Attendance sheets
b. Training schedules
c. Classroom training exams (samples)
d. Classroom training test results
e. Classroom lesson plans
f. ATOG drill guides for simulator
g. Simulator practical exam evaluations
h. GPU management evaluation of B&W instructors
i. Student critiques of training courses
j. Guide for TMI-1 control room walkthroughs

? 3 Findings

3.3.1 Procedure Review

The inspector verified that the up-to-date ATP's were listed on the plant procedure index and available in the control room. The inspector found the procedures to be technically accurate for guidance to performing the functions for which they were intended. There were, however, some phrases in the procedures which either directed operator action or ask for an evaluation of plant conditions for which the inspector needed further clarification as follows.

a. Initiation of High Pressure Injection Flow - A step in several of the ATP's requires injection of full flow from two makeup pumps with a suction from the Borated Water Storage Tank and directs the operator to "Initiate HPI". Since there are two methods to do this (ESAS actuation and individual component actuation), the inspector inquired as to what the operators were trained to do in response to this step and what the preferred method of initiation was. The licensee stated that the most often used method was the ESAS actuate and then re-position the letdown system valves (isolated on actuaction) according to the transient (some require minimizing letdown flow). The component initiation method was presented to the operators as an option to use in a slowly developing transient when more time is available to position the HPI system on a component basis and assure the proper valve lineups. This method precludes unnecessary loading of the diesel generators. The inspector verified that these discussions were presented in the ATOG training program and had no further questions with regard to this item.

b. Definition of "Excessive" Primary to Secondary Heat Transfer - The interviews with the control room operators regarding this ATP step, which assesses plant heatup or cooldown conditions, revealed that all operators had a slightly different view of the definition of "excessive" primary to secondary heat transfer. The confusion seemed to center upon whether this phrase referred to an instantaneous condition, a trending condition, or the initiating event. The inspector was not satisfied that the procedures and related training guidelines provided sufficient information to properly and consistently define this term. The licensee stated that a memorandum would be written to the licensed operators to clarify this term and that training would be altered accordingly.

c. Criteria for Isolation of Core Flood Tanks - During the transient resulting from a reactor trip, when Reactor Coolant System pressure has decreased to a point where it is approaching Core Flood Tank (CFT) injection pressure, if RCS pressure and inventory conditions are generally stable the ATP's instruct the operators to isolate the CFT's. The procedures, however, state simply that the CFT's will be isolated when a subcooling margin exists. Although the experienced operators (who have previously used the old emergency procedures) are familiar with the need to verify RCS pressure and inventory stability, the inspector felt that this should be stated in the procedure step, especially for future operators. The licensee stated that the need to change this procedure step had been recognized during licensee training sessions and that the change was being developed.

The needed clarifications noted above will be reviewed during a subsequent inspection (289/84-11-03).

3.3.2 Operator Acceptance of ATOG

Four control room operators (2 SRO's and 2 RO's) were interviewed separately to determine their opinions about ATOG, their acceptance of its philosophy, and their general knowledge of certain terms used in the procedures. Generally, the operators are receptive to the symptomatic approach of the ATOG procedures and feel that they are easier to follow (much less cluttered) than the previously used emergency procedures. Although the operators do not feel that they are technically doing anything differently than before, they feel that the ATOG procedures are better at treating problems progressively as the abnormal condition develops, rather than having to make decisions on what conditions should receive priority treatment. The operators felt that the training they received was adequate, but that ATOG training for new operators would have to be more extensive since they would not have worked with the older emergency procedures.

Although the ATOG procedures are easier to read and use, the operators did express concern over the definition of some terms that are used to effect operator action or define plant conditions. Of greatest concern was the definition of "excessive" primary to secondary heat transfer. This item and others are discussed in the findings of the procedure review presented above.

3.3.3. Training Verification

Based on the training records and interviews with several reactor operators and actions completed by NRR representative (as noted in the NRC's SER for TAP I.C.1), the inspector determined that all presently licensed TMI-1 Senior Reactor Operators and Reactor Operators have received and successfully completed the TMI-1 ATOG classroom and simulator training conducted at the B&W training center in Lynchburg, Virginia and have successfully completed an ATOG-related TMI-1 control room walkthrough. This completes a condition specified by the TMI-1 Atomic Safety and Licensing Board in its Partial Initial Decision on Licensee Management dated August 27, 1981, at paragraph 583(8) which states that the operators are to be trained in ATOG prior to implementation.

4. Modifications Providing Additional Contaminated Water Storage Capacity

4.1 Background

The modifications are described in a letter from H. Hukill (GPUN) to J Stolz (NRC) dated November 12, 1982, and consist of installing valves from the discharge of the TMI-1 turbine building sump pumps to existing interconnecting piping which leads to the TMI-2 condensate storage tank (CST). These modifications make available a 250,000 gallon additional contaminated water storage at Unit 1. During normal operation, turbine building sump water is discharged to the Industrial Water Treatment System (IWTS). In the event of radioactivity in the turbine building sump, as might be encountered during a steam generator tube rupture event, a radiation monitor will trip the sump pumps. The modification provides for transfer of potentially contaminated water from the turbine building sump to the former Unit 2 CST using a new procedure 1104-29X, "Transfers, Contaminated Water from Turbine Building Sump." In this manner, waste storage capability of Unit 1 is increased by 250,000 gallons. The licensee intends to process the stored water using portable demineralizers which would be brought to the site.

4.2 Review

During April 17-19, 1984 a review was conducted of the licensee's efforts to add additional contaminated water storage capacity to TMI-1. In addition to discussions with personnel and observing the physical modification, the following documentation was reviewed: the completed modification package associated with Task 8 modifications including the safety analysis, the system description and the procedure for the use of the modified system; an analysis of plant radiation releases and its 10 CFR 50, Appendix I conformance for different operating conditions; a TMI-1 primary-to-secondary OTSG leakage evaluation and its onsite/offsite radiological impact; GAI Drawing C-302-159, Revision 1, "Turbine Building Sump Water Storage Flow Diagram"; and Flow Verification and Hydrostatic Test SP 250/3.1. performed May 25, 1983.

Following the review of this material, several areas requiring clarification and/or additional information were identified by the Region I staff. These related to releases from the condensate storage tank vent, status of the plant when the modification would be used, and tank overflow protection. The material necessary to resolve these issues was provided to Region I on April 30, 1984. This material consisted of a "Technical Document Review Regarding Use of Turbine Building Sump Monitor and Discharge Path to the COT-1B (previously Unit 2 CST)". These documents included excerpts from TDR-400, "Guidelines for Plant Operation With Steam Generator Tube Leakage"; TDR-390, "TMI-1 Primary to Secondary OTSG Leakage and Its Onsite/Offsite Radiological Impact"; SDD-232D (Div. II), "TMI-1 Primary to Secondary Leak Contaminated Water Collection/ Processing"; changes to Operating Procedure 1104-29X, "Transfers, Contaminated Water From Turbine Building Sump," dated April 26, 1984; and, Technical Data Report, "Radiological Consequences of Release of 100 Ci of Kr-85."

During this review, the inspector verified by drawing review and physical observation, that all Unit 1/Unit 2 interfaces from the transfer line were isolated, primarily by the use of blank flanges; that expected radionuclide concentrations were within the limits prescribed by the Technical Specifications; that the piping associated with the modification was designed and fabricated in accordance with ANSI B31.1; that flow verification and hydrostatic testing of the modification was performed; and that storage tank level instrumentation and alarms are available. The level indication and alarm are currently in the Unit 2 control room but the licensee's long range plans call for moving this instrumentation to the Unit 1 control room. It was also determined that a procedure has been prepared for the use of the system and, that this procedure clearly specifies the monitoring of the level indication and alarm and that adequate controls are incorporated to prevent a tank overflow. This modification is expected to be used only following the occurrence of significant primary to secondary steam generator leakage which would require a reactor shutdown.

4.3 Findings

During the performance of this inspection, it was noted the Control Room controlled copy of the Turbine Building Sump Water Storage flow diagram C-302-159 depicted a condensate storage tank overflow configuration which differed from that actually present at the tank. In addition, Plant Mod No. Task 8 Mod C contained a job order (A 25A-30377) which specified a change to the tank overflow as part of the total modification package. The change specified the overflow line to remain uncapped and the funnel entrance on the line to the yard drains, to be capped with a welded plate. This yard drain pipe is susceptable to being sprayed by potentially contaminated water from the overflow line. The change which was signed off as having been completed had, in fact, never been made. Had the change been made as specified, in all probability the controlled drawing would have been updated, in accordance with existing controls. The failure to properly implement the design change is an apparent violation of TS 6.8.1 and Administrative Procedure 1043, paragraphs 3.8.5 and 3.8.11 and Job Order 25A-30377 (289/84-11-04).

5. Inspector Follow Items

Inspector follow items are matters that warrant NRC verification of licensee completion as a result of commitments made to the NRC for restart or a matter that warrants NRC followup review to assure compliance with NRC regulations. Inspector follow items are addressed in paragraphs 1, 2 and 3.

6. Exit Interview

Periodically, the inspectors met with licensee representatives to discuss inspection findings. At the conclusion of the inspection on May 8, 1984, the inspectors summarized the inspection scope of review and findings in a meeting with the Operation and Maintenance Director (R. Toole) and a representative from Plant Operations (H. Shipman), Plant Licensing (R. Szczech), Quality Assurance (W. County), Radiological Engineering (S. Williams) and Maintenance and Construction (J. Faulkner).