

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Docket No.: 50-293
Report No.: 50-293/92-01
Licensee: Boston Edison Company
800 Boylston Street
Boston, Massachusetts 02199
Facility: Pilgrim Nuclear Power Station
Location: Plymouth, Massachusetts
Dates: January 1 - February 3, 1992
Inspectors: J. Macdonald, Senior Resident Inspector
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Approved by: *John Rogge* 2/14/92
J. Rogge, Chief, Reactor Projects Section 3A Date

Inspection Summary:

Areas Inspected: Safety inspection of plant operations, radiological controls, maintenance and surveillance, security, safety assessment and quality verification, and engineering and technical support.

Results: Inspection results are summarized in the Executive Summary.

EXECUTIVE SUMMARY

Pilgrim Inspection Report 50-293/92-01

Plant Operations: Control room personnel continued to maintain excellent communications and control of routine operations and surveillance evolutions. Determinations of equipment operability and availability were appropriate. Overtime practices continued to be controlled in accordance with approved station procedures.

Radiological Controls: The licensee continued efforts to address the presence of noble gasses within the process buildings. General housekeeping and radiological postings were appropriate.

Maintenance and Surveillance: Routine surveillances were conducted in a safe and controlled manner.

Security: On January 23, a contractor security force sergeant failed a randomly administered fitness for duty (FFD) test. The licensee determined by extrapolation that the individual's blood alcohol concentration (BAC) at time of entry into the protected area exceeded the regulatory FFD limit of .04 BAC. Licensee immediate actions and intense followup investigation demonstrated strong commitment to the purpose of the FFD program. In addition, staffing levels and contingency planning for contractor strikes were determined to be outstanding.

Safety Assessment and Quality Verification: Licensee event and special reports were detailed and submitted in a timely manner. Two previously unresolved items were reviewed. These items regarded development of a technical definition for the term "Firefighting Activity" and corrective actions to address personnel contaminations which had occurred during refueling floor activities. Licensee corrective actions appropriately addressed both items.

Engineering and Technical Support: Reactor water cleanup (RWCU) system pipe replacement activities were well coordinated and implemented with proper consideration of correct work controls, ALARA principles, and the establishment of acceptable bases for future inspection activities. A minimal impact upon the continued safe operation of the plant was observed during the RWCU system isolation and repair work because of effective planning and preparation and evidence of a conservative safety philosophy during work progress.

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DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

At the start of the report period Pilgrim Nuclear Power Station was operating at approximately 100 percent power.

On January 3, the station blackout diesel generator was declared inoperable due to lockout relay A801 being found tripped during a daily surveillance. A trending program revealed no cause for the relay trip and the station blackout diesel generator was declared operable on January 14, 1992.

The "C" salt service water pump was returned to service on January 14, following a several week maintenance period for modifications.

On January 23 at 1:45 pm, a contractor security force sergeant failed a random fitness for duty test for alcohol. The licensee determined by extrapolation that the individual's blood alcohol concentration (BAC) at time of entry into the protected area exceeded the regulatory limit of 0.04 BAC.

On January 26, the reactor water cleanup (RWCU) system was isolated to conduct the replacement of one section of temporarily repaired regenerative heat exchanger piping. New pipe and weld installation was accomplished utilizing remote welding equipment. Radiographic inspection and ultrasonic testing of the welds was completed and found acceptable. The system was returned to service on February 2.

On January 27, the "B" emergency diesel generator (EDG) failed the monthly surveillance test and was declared inoperable due to setpoint drift of the starting air compressor start switch. During a subsequent EDG load test, reactive load (KVAR) oscillations were observed. The voltage regulator motor operated potentiometer was replaced and the "B" EDG was successfully returned to service on January 29.

On January 29 at 2:31 am, reactor power was reduced to approximately 40 percent and the "A" recirculation pump motor generator (M-G) was secured to facilitate replacement of the generator end brushes. Following M-G brush replacement the "A" recirculation pump was restored to service and power was restored to 100 percent. On January 30 at 2:20 am, reactor power was reduced to 45 percent to install a temporary modification on the brush rigging of the "A" recirculation pump M-G. The temporary modification was completed on January 31 and power was restored to 100 percent.

The reactor plant was operating at 100% of rated power at the conclusion of the report period.

2.0 PLANT OPERATIONS (71707, 40500)

2.1 Plant Operations Review

The inspector observed plant operations during regular and backshift hours of the following areas:

Control Room	Fence Line
Reactor Building	(Protected Area)
Diesel Generator Building	Turbine Building
Switchgear Rooms	Screen House
Security Facilities	

Control room instruments were observed for correlation between channels, proper functioning and conformance with Technical Specifications. Alarms received in the control room were reviewed and discussed with the operators. Operator awareness and response to these conditions were reviewed. Operators were found cognizant of board and plant conditions. Control room and shift manning were compared with Technical Specification requirements. Posting and control of radiation, contamination and high radiation areas were inspected. Use of and compliance with radiation work permits and use of required personnel monitoring devices were checked. Plant housekeeping controls, including control of flammable and other hazardous materials, were observed. During plant tours, logs and records were reviewed to ensure compliance with station procedures, to determine if entries were correctly made and to verify correct communication of equipment status. These records included various operating logs, turnover sheets, tagout and lifted lead and jumper logs. Inspections were performed on backshifts including January 3, 6-9, 14-17, 21, 22, 24 and 28-30.

Pre-evolution briefings were noted to be thorough with appropriate questions and answers. Operators demonstrated good knowledge of plant conditions. No unauthorized reading material was observed. Food, beverages and hard hats were kept away from control panels.

2.2 Inoperable Equipment

Actions taken by plant personnel during periods when equipment was inoperable were reviewed to verify that: technical specification limits were met; alternate surveillance testing was completed satisfactorily; and equipment was properly returned to service upon completion of repairs. This review was completed for the following items:

<u>Date Out</u>	<u>Date In</u>	<u>System</u>
1/03	1/14	Station Blackout Diesel Generator
1/11	1/15	High Pressure Coolant Injection Room Area Cooler
1/14	1/17	"A" Reactor Building Closed Cooling Water Pump
1/21	1/23	"A" Salt Service Water Pump

<u>Date Out</u>	<u>Date In</u>	<u>System</u>
1/22	1/27	"A" Advanced Offgas System Hydrogen Analyzer
1/22	1/24	Station Blackout Diesel Generator
1/27	1/29	"B" Emergency Diesel Generator
1/29	1/31	"A" Recirculation Pump Motor Generator Set

2.3 Personnel Overtime Practices

The inspector reviewed station overtime procedures and practices. A sampling of employee records were examined in the operations and radiation protection areas. All overtime was within limits or had proper prior authorization in accordance with the licensee procedure. No discrepancies were observed. Overtime policies were determined to be in agreement with regulations. The plant was well staffed in these safety-related areas which precluded the necessity of excessive overtime.

3.0 RADIOLOGICAL CONTROLS (71707)

The inspector observed radiological control practices and radiological conditions throughout the plant. General housekeeping and radiological postings were good. The inspector noted an apparent increase in the concentration of noble gasses present in the plant. The noble gas concentration was believed to result in part from the occurrence of a single fuel element failure during the last operating cycle in conjunction with current minor steam leaks. While the personnel radiation exposure consequence was minimal, personnel have experienced significant delays at the exit control points of the radiological controlled area. Licensee actions to address the presence of noble gasses included: a more aggressive program to identify and correct minor steam leaks within the plant, use of paper coveralls or static guard spray for personnel entering the process buildings and development of additional engineering controls to minimize the localization of noble gasses. The inspector determined that these actions were appropriate.

4.0 MAINTENANCE AND SURVEILLANCE (37828, 61726, 62703)

4.1 Routine Surveillances

The inspector observed portions of surveillances to verify proper calibration of test instrumentation, use of approved procedures, performance of work by qualified personnel, conformance to limiting conditions for operation (LCO), and correct system restoration following testing. The following surveillances were observed:

Procedure 8.M.1-32.5, "Analog Trip System - Trip Unit Calibration Cabinet C2233A, Section A," revision 11, observed January 23, 1992.

Analog trip system components are contained in cabinet C2233A - Section A which monitor drywell pressure and reactor water level. The performance of this surveillance verified the accuracy of these components and functionality to initiate relay logic for the emergency core cooling system. Communications were properly established between control room operators and technicians at the testing cabinet within the plant. The technicians demonstrated excellent procedural compliance and teamwork throughout the surveillance.

Procedure 8.M.2-2.1.10, "4160 Volt Emergency Buses A5 and A6 Loss of Voltage and Degraded Voltage Relays," revision 20, observed January 23, 1992. This surveillance was performed to verify proper relay sequencing of the loss of voltage and degraded voltage relays by simulating undervoltage conditions on 4160 volt emergency buses. Technicians were alert and detected several administrative errors which had inadvertently occurred during a recent procedure revision. The technicians brought these errors to the attention of the Nuclear Watch Engineer for correction prior to performing those portions of the surveillance. The inspector discussed the procedure in detail with the technicians and found their level of knowledge to be good.

5.0 SECURITY (71707)

5.1 Fitness for Duty (FFD) Event

On January 23, 1992 at approximately 1:45 pm, the licensee revoked the unescorted site access of a contractor security force sergeant who failed a randomly administered FFD test. The actual blood alcohol content (BAC) of the individual at the time of the tests as indicated by breathalyzer and blood test was below the regulatory limit of 0.04 BAC. However, extrapolation of the individual's BAC back to the time of entering the protected area (7:32 am), in accordance with the licensee FFD program, resulted in a BAC in excess of the regulatory limit. The licensee notified the NRC of this FFD event in accordance with 10 CFR 26.73 reporting criteria. This individual had been selected for random FFD testing on two previous occasions, with negative results. As a result of the positive test for alcohol, the contractor terminated this individual's employment.

The licensee conducted a thorough investigation of this event. A search of the protected and vital areas for alcohol and other contraband was conducted. No unauthorized substances nor evidence of alcohol consumption while within the protected or vital areas were found. A detailed review of the security force sergeant's activities while within the protected area revealed no abnormal occurrences or behavior. The licensee determined that the physical security of the station had not been compromised. The investigation identified potential for further improvements regarding behavioral observation of personnel and the process by which contracted security personnel communicate FFD concerns to licensee FFD representatives. Supplementary training has been scheduled to address these areas. The inspector determined that the licensee investigation was outstanding and actions taken regarding this FFD event were appropriate. The licensee continued to place strong emphasis on the fitness for duty of personnel within the protected area.

5.2 Security Force Contract Review

The inspector reviewed the current status of security force contracts. The security force personnel contract between the licensee and their contractor, the Wackenhut Corporation, was agreed upon in August 1991 and will remain in effect until August 1993. However, security management informed the inspector of a dispute between Wackenhut Inc. and their subcontractor, the United Plant Guard Workers of America (UPGWA), regarding ratification of their subcontract. Local 540 of the UPGWA contended that their current contract was not fully ratified, pending resolution of several disputed issues.

The security manager discussed licensee readiness and contingency planning to fully staff the security force in the event of a strike by the UPGWA. Discussions included level of training, security force responsibilities and fire brigade response. The number of available licensee and Wackenhut trained security specialists were more than sufficient to meet all security needs. At the close of this reporting period management representatives of the Wackenhut Corporation and UPGWA Local 540 came to agreement and ratified their subcontract. The licensee monitored the progress of negotiations closely. Security staffing levels and contingency planning by the licensee were determined to be appropriate.

5.3 Compensatory Measures for Area Access Control

The inspector noted the implementation of acceptable compensatory measures by site security personnel for specific degraded equipment conditions. These situations involved the stationing of guards to monitor inoperable vital area doors, guard response to door alarms and the direct visual monitoring of protected area boundaries where security systems were not operable because of maintenance activities. In all cases observed by the inspector, security personnel were attentive and knowledgeable of their duties relative to the identified equipment which was out of service.

6.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (92700, 92701)

6.1 Licensee Event Report (LER) and Special Report Review

6.1.1 LER 91-23

LER 91-23, "Loose Drywell Head Bolts Discovered During An Integrated Leak Rate Test (ILRT)," describes the discovery of 11 loose drywell head bolts and associated washer failures, which resulted in a failed ILRT on July 28, 1991. The failed washers and ILRT were documented in NRC Inspection Report 50-293/91-17. An Unresolved Item (50-293/91-17-02) was issued to review and assess licensee root cause analysis and corrective actions related to the procurement and cause of the drywell head washer failures. Twenty-two sets of drywell head washers were subsequently found to be cracked or broken. Root cause analysis determined the primary cause of the failed washers to be use of incorrect material. Metallurgical examination identified the failed washer material to be AISI 8620, case hardened to Rockwell C62. The as

found material was more brittle than that specified for this application (AISI 4140 with Rockwell hardness of C32). A contributing cause to washer failure was the improper installation of washers in an inverted orientation. The LER addresses the root cause of the washer failure in excellent detail. Corrective actions discussed contained within the LER were appropriate. However, licensee review of the procurement and installation of incorrect washers was not complete when this LER was submitted. Inspector review of this issue and licensee implementation of corrective action will be tracked via the existing unresolved item. This LER is closed.

6.1.2 LER 91-24

LER 91-24, "Loss of Preferred and Secondary Offsite Power Due to Severe Coastal Storm While Shutdown," describes events which caused and station response to the October 30, 1991, loss of all offsite power. The event is documented in NRC Inspection Report 50-293/91-24. The LER correctly addressed the reporting criteria. This LER is closed.

6.1.3 LER 91-25

LER 91-25, "Reactor Core Isolation Cooling (RCIC) System Became Inoperable Due to Overspeed Trip and Inverter Trip," describes an unsuccessful attempt to place the RCIC system in service for reactor vessel water level control during the October 30, 1991, loss of offsite power event. The event is documented in NRC Inspection Report 50-293/91-24. The LER accurately detailed the event, cause contributions and corrective actions. This LER is closed.

6.1.4 LER 91-26

LER 91-26, "Automatic Actuations of Primary Containment System Group 6 Isolation Valves," describes two actuations of the reactor water cleanup (RWCU) portion of the primary containment isolation system (PCIS) which occurred on October 30 and 31, 1991. Licensee root cause evaluation was thorough. Improvements to procedure 2.2.83 "Reactor Water Cleanup System" and an Engineering Department evaluation of high flow design setpoints and system design to enhance leak detection capability without unnecessary isolations were initiated. This LER correctly addressed the reporting criteria. This LER is closed.

6.1.5 Special Report - Inoperable Electric Fire Pump

On January 13, 1992, in accordance with Technical Specification 3.12.B.a, the licensee submitted a special report to the NRC documenting that the motor driven fire pump of the fire suppression system was inoperable for a period of more than seven days. The pump had been declared inoperable on December 14, 1991 following an electrical fault in the motor controller circuitry which precluded automatic actuation. Controller repair and replacement lead time precluded immediate return to service. In the interim, the licensee implemented a temporary modification to the circuitry which enabled manual starts to be accomplished, however the pump

remained technically inoperable pending restoration of automatic start capability. This issue was previously documented in NRC Inspection Report 50-293/91-29. The special report fulfilled Technical Specification requirements.

At the conclusion of this inspection period, the motor driven fire pump remained inoperable. The diesel driven fire pump was unaffected by this event and remained operable.

6.2 Followup of Previously Identified NRC Items

6.2.1 UNR (Closed) 91-02-03, Development of Technical Definition for the Term "Firefighting Activity"

During review of the January 11, 1991 smoldering turbine building roof event, the inspector expressed concern that the lack of a clear definition of what constitutes fire fighting efforts as it related to emergency action level (EAL) entry conditions had the potential to cause confusion and therefore had the ability to affect timely classification determinations. Specifically, section 7.2.1.1 EAL procedure EP-IP-100 directed that a Notification of Unusual Event (NOUE) be declared for a fire within the protected area lasting greater than ten minutes from the time fire fighting efforts began. However the procedure did not define fire fighting efforts nor did it detail who would be recognized as conducting such efforts.

In response to this concern the licensee revised the applicable entry condition of EP-IP-100 (revision 3) to direct an NOUE to be declared for a fire within the protected area lasting greater than ten minutes from the time fire brigade fire fighting efforts begin. Additionally by footnote, firefighting efforts have been defined as having begun when the fire brigade first applies fire fighting agents on the fire. The inspector confirmed the adequacy of the changes with the cognizant NRC Region I Emergency Preparedness specialist and verified that the revised procedure was properly implemented. This item is closed.

6.2.2 UNR (Closed) 91-12-01, Review of Corrective Actions Following Personnel Contamination Events

On June 27 and 28, 1991, three personnel contamination events occurred during refuel bridge mast repairs. Inspector review of the events identified the following concerns: 1) lack of clearly stated procedural guidance to establish the process by which workers would be required to exit contaminated areas, conduct personnel monitoring, and don personnel clothing; 2) lack of control of face shields in contaminated areas; and 3) effectiveness of hot particle control zone (HPCZ) training implementation.

On June 28, 1991 immediately following these events the licensee conducted a critique. The final critique report issued November 1, 1991 established action items to address each issue above. The initial revision of procedure 1.3.106, "Conduct of Radiological Operations," which was under development previous to these events included direction that personnel exiting contaminated areas must clear a portal monitor prior to donning personnel clothing. By

radiological section standing order 91-24, effective November 29, 1991 face shield controls were established such that shields were required to be used for one entry into contaminated areas only. The order required shields to be deposited in controlled containers upon exiting contaminated areas and to be decontaminated and surveyed prior to reissue. Finally, procedure 6.1-016, "Hot Particle Contamination Control Program," revision 5, dated January 8, 1992 provided instruction to ensure completion of hot particle qualification training and hot particle/small source pre-job briefings for all individuals requesting access to hot particle control zones.

The inspector concluded licensee corrective actions to the weaknesses observed regarding contaminated area and material controls and practices were appropriate. This item is closed.

7.0 ENGINEERING AND TECHNICAL SUPPORT

7.1 Reactor Water Cleanup System Pipe Replacement

As documented in NRC Inspection Report No. 50-293/91-29, the reactor water cleanup (RWCU) system piping had been restored to service on December 27, 1991 after the installation of a clamp to temporarily repair a through wall leak. These repair activities, conducted in accordance with Temporary Modification 91-63, re-established piping integrity to allow for continued operation of the RWCU system while permanent pipe replacement preparations were in progress.

On January 26, 1992, the RWCU system was again isolated to conduct the planned pipe replacement activities. The system tagout (T 92-18) was coordinated and implemented to effect RWCU maintenance work in conjunction with the pipe repairs. A contractor, Welding Services Incorporated (WSI), was retained by the licensee to provide both the equipment and personnel required for remote machine welding of the replacement spool piece into the piping section between the first two heat exchanger stages. The utilization of automatic welding techniques was determined to be the most effective means of performing a qualified welding operation, while minimizing the worker exposure to radiation.

The inspector examined the automatic welding machine and checked its certification prior to its use in the RWCU heat exchanger room. The inspector also interviewed some of the WSI workers regarding the conduct of pipe cutting activities, as well as the qualification and use of the automatic welding machine. A health physics (HP) briefing of workers was conducted on January 27, 1992, to ensure personnel entry into the high radiation work area and commencement of the initial cutting of the existing pipe with the temporary clamp installed. The inspector reviewed the Radiation Work Request (RWP 92-042) and the ALARA Work Request Review Document (WR 19105228), to ensure the appropriate radiation survey data, as well as establishment of hold points as specific control checks. The inspector discussed the control of the ALARA plan with cognizant personnel.

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On January 26, 1992, the RWCU system was again isolated to conduct the planned pipe replacement activities. The system tagout (T 92-18) was coordinated and implemented to effect other RWCU maintenance work in conjunction with the pipe repairs. A contractor, Welding Services Incorporated (WSI), was retained by the licensee to provide both the equipment and welding operators required for remote machine welding of the replacement spool piece into the piping section between the first two heat exchanger stages. The utilization of automatic welding machine techniques was determined to be the most effective means of performing a qualified welding operation, while minimizing the worker exposure to radiation.

The inspector examined the automatic welding machine and checked its certification prior to its set-up in the RWCU heat exchanger room. The inspector also interviewed some of the WSI operators regarding the conduct of pipe cutting activities, as well as the qualification and use of the welding machine. A health physics (HP) briefing of workers was conducted on January 27, prior to personnel entry into the high radiation work area and commencement of the initial cut of the existing pipe with the temporary clamp installed. The inspector reviewed the Radiation Work Permit (RWP 92-042) and the ALARA Work Request Review Document (WR 19105228), noting the appropriate radiation survey data, as well as establishment of hold points as specific work control checks. The inspector discussed the control of the ALARA plan with cognizant HP personnel.

After completion of all welding on January 28, the new pipe welds were radiographically examined with satisfactory results. Ultrasonic examination (UT) of the welds, to establish baseline data for future inspection of this piping intended to satisfy licensee commitments relative to NRC Generic Letter 88-01, was delayed after the RWCU system was filled because of pipe temperature constraints. On January 31, the affected piping was drained to allow for cooldown, the welds were subsequently ultrasonically inspected and accepted, and the RWCU system was filled and vented in preparation for restoration to service. On February 2, the RWCU system was placed in operation and has remained operable through the end of this inspection period.

The inspector evaluated the interdepartmental coordination and control of contractor activities which were implemented with regard to the RWCU system pipe replacement/welding work. Effective communications and liaison were observed, along with the establishment of work controls evidencing ALARA considerations. The overall engineering, technical and operations support, as well as QA verification activities, for the actual pipe replacement work were instrumental in causing minimal impact upon continued safe plant operation during the RWCU system piping replacement. The management decision to conduct UT of the new pipe welds, despite the resulting delay in the return of the RWCU system to service, was a conservative decision reflecting an appropriate safety philosophy which considered future inspection activities.

8.0 NRC MANAGEMENT MEETINGS AND OTHER ACTIVITIES (30702)

8.1 Routine Meetings

At periodic intervals during this inspection, meetings were held with senior plant management to discuss licensee activities and areas of concern to the inspectors. Following completion of the inspection period, the resident inspector staff conducted an exit meeting with BECo management summarizing inspection activity and findings for this report period. No proprietary information was identified as being included in the report.

8.2 Management Meetings

On January 8, 1992 NRC Management Meeting Number 91-172 was conducted at the Chiltonville Training Center to present the NRC Systematic Assessment of Licensee Performance (SALP) for the period August 16, 1990 to September 28, 1991. The NRC assessment was presented for licensee comment and discussion. Senior licensee management attended and provided detailed discussion regarding their plans for continued safe facility operation and future initiatives. The final SALP Report was issued January 31, 1992.

8.3 Licensee Senior Management Changes

On December 31, 1991, Mr. Ralph G. Bird retired as the Executive Vice President (EVP). Effective January 1, 1992, Mr. George W. Davis, the Senior Vice President Nuclear, succeeded Mr. Bird as EVP and Mr. Roy A. Anderson, Vice President of Nuclear Operations and Station Director (VP-NO/SD) succeeded Mr. Davis as (SVP-N). On January 24, 1992 the licensee announced that E. Thomas Boulette, Phd., of the Maine Yankee Power Company, was selected to succeed Mr. Anderson as VP-NO/SD.