

U.S. NUCLEAR REGULATORY COMMISSION

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Report No. 50-239/84-17

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: June 5 -- July 3, 1984

Inspectors:

F. Young  
 F. Young, Resident Inspector (TMI-1)

July 12, 1984  
 date signed

W. Baunack  
 W. Baunack, Project Engineer

7/16/84  
 date signed

R. Conte  
 R. Conte, Senior Resident Inspector (TMI-1)

July 12, 1984  
 date signed

Approved by:

W. Baunack for  
 E. Conner, Chief, Reactor Projects  
 Section No. 3B, PB No. 3

7/16/84  
 date signed

Inspection Summary:

Inspection conducted on June 5 -- July 3, 1984 (Inspection Report Number 50-289/84-17)

Areas Inspected: Routine safety inspection by resident and region-based inspectors of licensee action on previous inspection findings; plant operations (shutdown mode) including OTSG tube repair, inadvertent partial ESAS actuation, and selected maintenance activities; onsite follow up of licensee event reports; and restart valve lineups. The inspection involved 203 inspector-hours.

Results: No conditions adverse to nuclear safety or regulatory requirements were identified. Overall control and routine maintenance of the shutdown plant were good. The licensee had proper system valve lineups to support system operations. Licensee corrective action in response to LER's was generally adequate and complete.

## DETAILS

### 1. Licensee Action on Previous Inspection Findings

(Closed) Inspector Follow Item (289/82-BC-12): Verification of system valve lineups. See paragraph 4 for details.

(Closed) Unresolved Item (289/83-08-02): Review Licensee's actions following the leakage of the waste gas decay tank discharge valve WDG-V30. Plant incident reports 1-83-07 and 1-83-08 were reviewed. These reports described the two events and recommended the corrective actions to be taken. The actions recommended were (1) change I & C Procedure 1313-4.15 to provide dual valve protection during testing (2) perform tests on diaphragm valves to determine the proper sequence for adjusting mechanical stops and (3) provide training for maintenance people. The inspector verified surveillance procedure 1303-4.15 was changed to provide dual valve protection. In addition, a memorandum dated March 25, 1983, from the Preventive Maintenance Manager to the Manager Plant Operations described the corrective actions taken in response to the plant incident reports. This memo states that bench testing was performed and the desired position for the valve travel stops were determined, and that mechanical maintenance personnel have been instructed in the method to be used for setting travel stops. Preventive Maintenance Procedure M-151, "Disassembly, Inspection and Parts Replacement of Grinell Diaphragm Valves and Operators," was revised to include the proper method for setting valve travel stops.

(Closed) Inspector Follow Item (289/83-24-01): Licensee to evaluate spent fuel pool leakage and establish leakage acceptance criteria. The licensee performed a 24 hour leakage check on October 19, 1983. During this check, leakage from each of the telltale pipes of the leakage detection system was monitored for a 24 hour period. Zero leakage was detected from each telltale. In addition, the licensee's leakage detection surveillance procedure was changed to require the telltale leakage to be recorded daily. A licensee representative stated that any identified leakage greater than zero would be evaluated.

(Closed) Inspector Follow Item (289/83-32-01): Verify surveillance requirements included in License Amendments 87 through 90 have been included in surveillance procedures. The inspector verified the new surveillance requirements contained in License Amendments 87 and 88 have been incorporated into facility surveillance procedures. Amendments 89 and 90 incorporated no new surveillance requirements.

(Closed) Inspector Follow Item (289/83-32-06): Licensee to revise Loss of Coolant Accident (LOCA) and Station Blackout Emergency Procedures (EPs). During the review of licensee consultant reports, documented in NUREG 0680 Supplement 4, the NRC staff identified weaknesses in the Loss of Coolant Accident (LOCA) Emergency Procedure (EP) 1202-6B and Station Blackout EPs (1202-2 and 2A). Specifically, extraneous information was in the immediate action sections making it long and cumbersome. By letter, dated September

23, 1983, and as noted in NUREG 0680, Supplement 4, (p. 3-14), the licensee committed to simplify the subject procedures immediate action sections by eliminating excessive or unnecessary wording, notes, or precautions or by placing them in the followup action section.

The inspector verified the completion of this commitment by review of Revision 13, dated December 22, 1983, to EP 1202-2, "Station Blackout" and of Revision 11, dated December 22, 1983, to EP 1202-2A, "Station Blackout With Loss of Both Diesel Generators." The licensee replaced EP 1202-6B with the issuance of ATOG (Anticipated Transient Operating Guidelines) procedure series 1210-1 to 1210-10 (re: Inspection Report 50-289/84-11).

All of the above revised procedures use the immediate actions of the ATOG procedure series which is a symptomatic approach used by operators in protecting the reactor in case of emergencies. A positive licensee initiative noted by the inspector was that the followup action sections of the EP's start off with objectives to help the operator keep in mind the purpose of followup actions during the various emergencies. It was also noted that the stated objectives were oriented toward reactor safety. The inspector concluded that the above noted commitments were met.

(Closed) Inspector Follow Item (289/83-32-07): Licensee to improve the quality of Special Temporary Procedures (STPs). During the review of licensee consultant reports documented in NUREG 0680, Supplement 4, the NRC staff identified a need for the licensee to improve the quality, legibility and understandability of STPs. By letter dated September 23, 1983, and as noted in NUREG 0680 Supplement 4 (p. 3-15), the licensee agreed to make these improvements.

The inspector verified completion of this commitment by review of the active STP Book in the Control Room. The licensee purged the book of old STPs and only 5 STP's remained effective. The index accurately reflected the effective STP's. These STP's appeared to be current for the present plant conditions. Only typed STP's were in the book making them legible and understandable. The inspector concluded that the quality of the STP's improved and that the above noted commitment was met.

The inspector noted other positive initiatives on the part of the licensee. An internal memorandum dated September 21, 1983 from the Operations and Maintenance Director required all personnel, including procedure reviewers and Plant Review Group members, to be more responsive in assuring the quality of STP's. The licensee issued Revision 5, dated January 5, 1984, to Administrative Procedure 1001A, "Procedure Review and Approval," which requires that changes (with the exception of notes) to STP's are made only by issuing a new STP with a new number and the old STP is to be cancelled.

(Closed) Inspector Follow Item (289/83-32-08): Licensee to implement a cognizant engineer concept. The NRC staff documented in NUREG 0680, Supplement 4 (pp. 5-5 to 5-7) various improvements being implemented by the licensee

with respect to Technical Function Division (TFD) performance. Inspection Report 50-289/83-32 identified a need for further review on one of these improvements; that is, the action to get TFD personnel more knowledge of "day-to-day" problems at the operating units -- Cognizant Engineer Concept.

These actions included:

- Major Engineering tasks were to be contracted to outside groups providing more time for TFD primary responsibilities for developing design specifications and independent engineering and safety review;
- Identify cognizant engineering sections and responsible section engineers for each of the plant systems; and,
- Responsible engineers are to provide bimonthly status reports to TFD Management on their respective systems.

The inspector discussed these actions with the Director of Engineering and Design (E&D) at the Corporate Offices in Parsippany, New Jersey. Related documents reviewed were:

- Licensee Internal Memorandum, No. E&D/M-1672, dated March 15, 1984, D. Chroerberger to Distribution, "Engineering Responsibility List" -- this assigns the cognizant engineers to specific plant systems at TMI-1 and Oyster Creek;
- Licensee Internal Memoranda Nos. E&D TMI/OC-1644, 1698 and 1753 dated May 25, 1983 respectively, "E&D Bi-Monthly Status Report on Assigned Systems, Components, or Structures for TMI-1/OC" -- These constitute a summary of the cognizant engineer bimonthly reports;
- "E&D Bi-Monthly Status Report on Assigned Systems, Components or Structures" for the period March-April 1984 -- backup information to the above summary report; and,
- EP 027, Revision 4, May 1, 1982, "Plant Operating/Emergency Procedure Review," establishes cognizant sections over certain procedures for review.

The inspector had the following observations.

The cognizant engineer listing is a very detailed listing of plant systems, components or structures for which cognizant engineers are assigned. The cognizant engineer bimonthly reports (backups to the management summary reports) are detailed enough to understand system status or the problem described. On a sampling basis, the inspector noted that these reports reflect good knowledge of the cognizant engineers on their assigned system, component or structure and that there was an obvious interface with site personnel. The inspector frequently observed various members of TFD at the site (at least every two weeks).

The E&D management summary (composite) reports are to highlight to upper management the status or problems for each of the plant systems, components or structures. The Director of E&D stated that upper management usually calls him for more details on some of the highlights; this is indicative of upper management's interest in this area and usefulness of the system.

The inspectors concluded that the above stated improvements are being implemented.

(Closed) Inspector Follow Item (289/83-32-09): Licensee to improve vendor information handling. During the review of licensee consultant reports documented in NUREG 0680, Supplement 4, the NRC staff identified that, prior to startup, it would inspect to assure adequate provisions existed to handle vendor information.

The inspector reviewed this area through discussions with the Plant Analysis Section, TFD, the Licensing Section, TFD, and personnel at the corporate office in Parsippany, New Jersey, and reviewed the following documents:

- Engineering Procedure (EP) 017, Revision 4, December 31, 1983, Review of Industry/GPUN Operating Experience;
- 5000-ADM-7316.03 (EP-021), Revision 1-00, January 15, 1984, Technical Manuals;
- GPUSC Action Item List-Task Records, Plant Analysis Section (TMI-1), dated June 14, 1984;
- INPO SER (Significant Event Report) Log; and,
- INPO SOER (Significant Operating Experience Report) Log.

The licensee incorporated the review of vendor service bulletins into the program for review of operating experience as noted in EP-017. The Plant Analysis Section, TFD, is the initial reviewer of this type of information with appropriate followup action documented and computerized using the Plant Analysis Task Record. The outstanding action list indicated that action was taken or planned for a number of different regulatory/industry documents such as INPO SERs or SOERs, NRC AEOD reports, B&W Service Bulletins, and Power Reactor Events. This review program includes safety and non-safety equipment. Procedure EP-021 controls the review and approval of technical manuals. This procedure further assures that copies of vendor service bulletins are sent by the vendor to the Plant Analysis Section for the above noted review.

The inspector concluded that adequate measures exist to handle vendor information and that the program is being implemented.

(Closed) Violation (289/84-02-02): Licensee failed to specify stroke times for Reactor Building Purge Isolation Valves in inservice testing (IST) procedure. The licensee has specified the stroke times for the Reactor Building

Purge Isolation Valves in Surveillance Procedure 1300-3Q. The valves have been tested to verify performance within the acceptance criteria. The licensee has also reviewed the IST valve testing program to insure stroke times are specified where required. All valves have maximum stroke times listed, including two recently added valves. The stroke times for these valves are identified in a procedure change to Surveillance Procedure 1303-R which is currently in review. The reason for the previous test failure was that the valve was not properly restricted to a maximum 30° open setting during a previous maintenance evolution.

## 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 the 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 back shift hours were conducted which included the selected sections of the shift foreman's log and control room operator's log for the period June 5 - July 3, 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 June 7, 11, 12, 13, 14, July 2, 3; and,
- Selected licensee planning meetings.

## 2.2 Surveillance

During this report period, the inspector verified that the Seismic Monitor Instrumentation was calibrated within required frequency and that data met the test acceptance criteria. Data taken on February 2, 1984, and May 15, 1984, were reviewed for Surveillance Procedure 1302-3.2, Revision 6, February 6, 1983, Strong Motion Accelerometer Calibration, (Quarterly Technical Specification Table 4.1-1 Item 36). No discrepancies were identified.

## 2.3 Steam Generator Abnormal Leakage

During the week of June 18, 1984 and subsequent to the reactor coolant system (RCS) fill, vent and repressurization to approximately 300 psig, the licensee received positive indications of abnormal primary to secondary steam generator tube leakage. The key chemical parameter indicators were increasing cesium, tritium and boron concentrations accompanied by a slight decrease in pH in the "B" OTSG (Once Through Steam Generator). Preliminary calculations by the licensee indicated a leak rate of 1.5 gph (gallons per hour) at an RCS pressure of 300 psig and a projected leak rate to hot conditions of less than 7.0 gph administrative limit (Technical Specifications limit is 1.0 gpm - gallon per minute - or 60 gph). On June 23, 1984 at approximately 12:45 P.M., the Director of TMI-1 reported this information to the Senior Resident Inspector and indicated that preparations were being made to depressurize and drain down the RCS for Bubble and Drip Testing for both OTSGs to substantiate specific tube leakage problems.

During the week of June 25, 1984, bubble and drip testing was completed. Results of these tests, as reported in a licensee letter to NRC dated June 27, 1984, Hukill, GPU, to Stolz, NRC, indicated that one tube in the B OTSG (No. 80-45) was the primary source of this abnormal leakage. Later fiberoptic examination by the licensee revealed a crack 360° around the top of the tube above the Kinetically expanded qualified portion of the new tube to tube sheet joint. The licensee decided to plug the tube. Fourteen (14) other tubes in A and B OTSG's (7 in each) were characterized by the licensee as having faint, visible, very slight bubble formations. This indication was seen on previous bubble tests after which hot functional testing indicated a baseline leakage of approximately 1 gph, not unexpected for mechanical joints such as with the kinetic expansion joint or the mechanical plug to tube joint. Eddy current testing was planned on selected tubes. The licensee is in the process of evaluating this data to determine if additional tube repairs are necessary.

A followup report on further testing, examination and evaluation is planned. This area will continue to be routinely followed in subsequent inspections.

## 2.4 ESAS Actuation

On June 3, 1983 at 11:53 A.M., a partial actuation of the Engineering Safeguard Actuation System (ESAS) occurred. The partial actuation was due to routine electrical maintenance being performed on the B train of ESAS with two unknown failed relays in that same train. The de-energization of this portion for maintenance gave the required 2 out of 3 logic to start only the components in the failed relay circuits. This included the starting of the B Diesel Generator, stopping B Spent Fuel Pool pump and cycling three plant valves. Actuation of these components had no adverse effect on the plant.

The inspector reviewed the applicable Job Ticket JT-CE-005 to obtain a better understanding of what caused the partial actuation of ESAS. In addition, the inspector reviewed MP 1420-Y-11 "ESAS Channel Relay Failure or Incorrect Indication" Revision 4 dated November 15, 1983 that was performed as part of JT-CE-005. The procedure did not require the technician to check the status of other ESAS relays prior to removing one train of ESAS circuitry for maintenance. The inspector noted this to the licensee and the licensee is in the process of adding a precautionary note to address this.

The cause of failures of these relays was discussed with the Plant Engineering Staff. The licensee representative indicated that the preliminary cause was the magnetic coils within the relays were failing. The inspector questioned the reliability of this relay in light of so many failures. The licensee acknowledged the inspector's concerns and stated that corporate engineering was working on a long term solution (i.e. possible replacement with electronic circuitry). For interim correction, the licensee plans on replacing the relay with the same relay and also attempting to obtain a safety grade coil with better current and heat rejection capacity. Evaluation of the root cause and final solution will be addressed further in a Licensee Event Report to be submitted to NRC. The item will be reviewed in subsequent NRC inspection in conjunction with the review of the LER. (289/84-LO-02)

## 2.5 Building Spray Pump Maintenance

Completed maintenance documentation associated with Building Spray Pump 1B was reviewed to verify that quality work was performed, necessary tests had been performed, and that the pump had been properly returned to service. The inspector reviewed Corrective Maintenance Ticket CC-650. This work package required that the pump be disassembled and rebuilt. The disassembly and reassembly was performed in accordance with Maintenance Procedure (MP) 1410-P-7 "Assembly and Disassembly of Centrifugal Pumps," Revision 2 dated February 17, 1983. In addition, the inspector reviewed the ALARA review performed to support this work. The work was determined to be performed in accordance with the applicable procedures. Review of spare parts used demonstrated that there was QA/Engineer involvement to ensure proper replacement parts were used. Re-



test and return of the pump to service was accomplished by Surveillance Procedure 1300-3A (A) "Reactor Building Spray Pump Functional Test Recirculation Mode and Reactor Building Spray System", Revision 11, dated May 7, 1984. Review of surveillance procedure data disclosed no adverse findings. In general, no discrepancies were identified.

## 2.6 Summary

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, 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. Licensee Event Report In-Plant Review

The inspector reviewed the below listed Licensee Event Reports (LER's) to verify whether the corrective actions described in the reports have been taken and that these actions are appropriate to correct the cause of the event, that the report clearly described the conditions of the event, and that reporting requirements have been met. The licensee's required review of reportable events was the subject of a previous violation. Currently, the required independent safety reviews are scheduled and tracked as Technical Functions Action Items. The requested completion date for these reviews is June 30, 1984.

- LER 83-004/03L-0: Failure of the Hays Gas Analyzer due to condensation that collected in the analyzer when a drain valve failed to open. Licensee records show that long term corrective action described in the report has been taken; replacement of the solenoid drain valve every six years has been added to the preventive maintenance schedule.
- LER 83-007/03L-0: The alarm and trip for minimum dilution flow failed to activate during a plant liquid effluent release. Records show the licensee performed testing to determine the cause of the relay failure. No obvious problem was identified. All moveable parts were cleaned and lubricated and the relay tested 10 times. Transient dirt was suspected to be the cause of the relay failure. To prevent recurrence, Procedure RCP 1621 has been revised by Revision 28 to include a low flow interlock check prior to each release.
- LER 83-012/03L-0: Failure of a hydraulic snubber. Licensee records show that in accordance with Technical Specification requirements, 10 additional snubbers were tested satisfactorily. The snubber with the piston seal-ring installed backwards was rebuilt in 1975. Since that time, training had been given to maintenance personnel who now perform

snubber repairs. Records show training was given to maintenance personnel on January 9, 1981, February 11, 1981 and again on April 16-17, 1984. The training in 1984 was given by ITT Grinnell instructors.

- LER 83-014/03L-0: Liquid radioactive effluent monitor was found inoperable. Testing was performed. However, no cause for the failure could be determined. The recorder charts for the radiation monitoring system are monitored each shift as required by the CRO Log Sheet (AP 1016). Any failures of the monitor would be identified in this way and investigated.
- LER 83-016/03L-0: Liquid effluent radiation monitor RM-L7 was discovered, during routine surveillance, to have no sample flow through the monitor. The licensee has installed a new monitoring system to replace RM-L7 on the IWTS/IWFS discharge line RM-L12 to provide greater monitoring reliability and sensitivity. The new monitor was verified to be operating. (See LER 83-017/03L-0 below).
- LER 83-017/03L-0: Liquid effluent radiation monitor RM-L7 discovered with no sample flow. It was not certain if the lack of flow was due to a closed valve or clogging with foreign material since the piping was heavily corroded inside. The licensee's long term corrective action was described as (1) Install a new monitoring system RM-L12; (2) Replace RM-L7 carbon steel pipe with stainless steel tubing; and, (3) Revise the grab sample procedure to require verification of sample flow to RM-L7 upon completion of a grab sample. The new RM-L12 has been installed (See LER 83-016/03L-0 above). New stainless steel piping has been installed per DRF 5944 and J. O. #A25A-V1041. Due to a failure to prepare a technical functions action item requiring the grab sample procedure change, the commitment to revise the grab sample procedure was not accomplished until the end of the inspection.
- LER 83-026/01T-0: While testing main steam safety valves, 17 of 18 valves were found with setpoints above the allowed tolerance. The cause was found to be due to a deficient procedure which required the installation of the test pressure gauges at a location which did not accurately reflect the main steam header pressure. The licensee's corrective action consisted of providing training relating to the problems resulting from improper procedure change review. The training was verified to have been conducted for Engineering Projects Department Personnel, Maintenance Department Personnel and Operations Personnel. Also, Surveillance Procedure 1303-11.3, Main Steam Safety Valves, Revision 11, dated May 17, 1984 was verified to have been revised to specify the correct location for the installation of the pressure test gauge.

#### 4. Restart Valve Lineups

A requirement of NUREG 0680, TMI-1 Restart Evaluation (page C2-6) was that the NRC staff will independently verify the position of safety-related valves (289/82-BC-12). On a sampling basis, inspectors, with the aid of Licensee

Auxiliary Operators to locate plant valves as necessary, verified the position of valves as specified by the following System Operating Procedures (OP):

- OP 1102-14, Reactor Building Purging & Venting, Revision 16, dated April 5, 1983
- OP 1104-4, Decay Heat Removal System, Revision 43, dated March 19, 1983
- OP 1104-11, Nuclear Services Closed Cooling, Revision 18, dated March 19, 1984
- OP 1104-19, Control building Ventilation System, Revision 19, dated September 16, 1983
- OP 1104-27, Gaseous Waste System, Revision 24, dated February 4, 1984
- OP 1104-29, Liquid Waste Disposal System, Revision 25, dated April 27, 1984
- OP 1104-43, Nuclear Plant Sampling, Revision 24, dated February 15, 1984
- OP 1104-46, Electrical Heat Tracing, Revision 21, dated March 14, 1983
- OP 1104-55, RB Atmosphere Cleanup Systems, Revision 7, dated February 20, 1981
- OP 1104-62, Hydrogen Recombiner, Revision 10, dated April 4, 1984
- OP 1105-1, Nuclear Instrumentation, Revision 7, dated October 16, 1981
- OP 1105-2, Reactor Proledion System, Revision 19, dated January 13, 1984
- OP 1105-3, Safeguards Actuation System, Revision 14, dated October 22, 1983
- OP 1105-6, Non Nuclear Instrumentation, Revision 12, dated March 19, 1984
- OP 1105-8, Radiation Monitoring System, Revision 22, dated March 19, 1984
- OP 1105-14, Loose Parts Monitor System, Revision 11, dated March 8, 1984
- OP 1105-18, Containment Hydrogen Monitor, Revision 1, dated May 9, 1984
- OP 1106-6, Emergency Feed, Revision 35, dated March 25, 1984
- OP 1107-2, Emergency Electrical System, Revision 38, dated April 4, 1984

-- OP 1107-3, Diesel Generator, Revision 25, dated February 28, 1984

In performing these valve lineup verifications, no major inconsistencies were noted. In general, valve lineups were complete and accurate. Valves were found in the position prescribed by the current valve lineup sheet or repositioned due to current plant conditions. The inspector did note that there were a large number of Permanent Change Requests (PCR's) outstanding to update valve lineups. The majority of the PCR's were submitted to change valve lineup sheets to more accurately reflect the operational alignment of the system. The licensee acknowledges this fact and is working to issue these PCR's.

In some instances, some valve lineups were organized well from the perspective of listing the valves in the order they were physically located in a space. To what extent this had been done varied from lineup to lineup. The licensee representative stated that he was aware of this and will consider this in subsequent changes to the procedures. The inspector did not consider this to be an adverse condition, but an efficiency problem. The inspector did, however, note a weakness in the licensee instruction on documenting discrepancies on valve lineups. At present, if the individual performing the valve lineup determines a problem with a certain valve, he is only required to record this on a discrepancy sheet. No initials are required to be placed in the area designated for signoff on the valve lineup checklist. From an auditability point of view, it would be impossible to determine if a valve with an outstanding discrepancy was checked without using the discrepancy sheet. The licensee acknowledged this and is in the process of formalizing steps to ensure the above situation is addressed.

Based on this review and previous reviews, this item is considered closed. Further sampling of valve lineups will be done as part of the Region I Inspection Program for TMI-1.

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. Inspector follow items are addressed in paragraphs 1 and 2 or preliminary reviews requiring final review.

6. Exit Interview

The inspectors met periodically with the licensee representatives to discuss the inspection scope and findings. At the conclusion of the inspection on June 5, 1984, the inspector summarized the inspection findings to the following attendees:

- C. Hartman, Lead Electrical Engineer, TMI-1 Division (TMI-1)
- C. Inorvate, Quality Assurance (QA) Auditor, Supervisor Nuclear Assurance Division (NAD)

- S. Otto, Licensing Engineer, Technical Functions Division
- H. Hukill, Director and Vice President, TMI-1
- R. Toole, Operations and Maintenance Director, TMI-1
- M. Nelson, Plant Review Group Chairman, TMI-1
- H. Shipman, Engineer Senior-II, TMI-1