

U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-277/84-24 and 50-278/84-20

Docket No. 50-277 and 50-278

License No. DPR-44/DPR-56 Priority -- Category C

Licensee: Philadelphia Electric Company

2301 Market Street

Philadelphia, Pennsylvania 19101

Facility Name: Peach Bottom Atomic Power Station Units 2 and 3

Inspection At: Delta, Pennsylvania

Inspection Conducted: July 16 - August 31, 1981

Inspectors: Robert M. Gallo FOR 10/12/84
A. R. Blough, Senior Resident Inspector date

Robert M. Gallo FOR 10/12/84
J. H. Williams, Resident Inspector date

Approved by: Robert M. Gallo 10/12/84
R. M. Gallo, Chief date
Reactor Projects Section 2A

Inspection Summary: July 16, - August 31, 1984 (Combined Inspection Report
No. 50-277/84-24 and 50-278/84-20)

Areas Inspected: Routine, onsite regular and backshift resident inspection (52 hours - Unit 2; 97 hours - Unit 3) of accessible portions of Unit 2 and Unit 3, operational safety, radiation protection, physical security, control room activities, licensee events, surveillance testing, refueling activities, Unit 2 pipe replacement, maintenance, and outstanding items.

Results: Except as follows, activities appeared to be conducted safely and in accordance with regulations: (1) failure to perform a written safety evaluation as required by 10 CFR 50.59 for operation with inoperable minimum flow valves in the RHR system is a violation, Detail 3.1.10; (2) Calibration of Main Steam Line Radiation Monitors is unresolved, Detail 6.

DETAILS1. Persons Contacted

J. K. Davenport, Maintenance Engineer
G. F. Dawson, I&C Engineer
*R. S. Fleishchmann, Station Superintendent
A. Hilsmeier, Senior Health Physicist
F. W. Polaski, Outage Manager
S. R. Roberts, Operations Engineer
D. C. Smith, Assistant Station Superintendent
S. A. Spitko, Site Quality Assurance Engineer
J. E. Winzenried, Technical Engineer

Other licensee employees were also contacted.

*Present at exit interviews onsite and for summation of preliminary inspection findings.

2. Previous Inspection Item Update

- 2.1 (Closed) Unresolved Item (278/84-16-01), receipt and review of C.O.L S11.2.BB for start-up of offgas radiation monitors. The licensee provided, and the inspector reviewed, the subject check-off list, dated June 20, 1984. No inadequacies were noted.
- 2.2 (Closed) Inspector Follow Items (277/82-16-06, 277/82-16-07, 277/82-16-08), various SALP commitments to stress supervisory responsibilities and accountability. The inspector verified that these items, including (1) a Vice President's letter to all supervisors and (2) program changes to improve supervisory accountability for housekeeping and radiation protection, had been done. Supervisory accountability has been improved, in part, to a revised deficiency reporting system under procedure A-86. The most recent SALP concluded that housekeeping and radiation protection are somewhat improved. The inspector has no further questions at this time.
- 2.3 (Closed) Inspector Follow Item (277/84-20-05), review welder qualification records. Some welders had requalified on May 31, 1984, and this training had not been entered into the computer data file as of June 7, when the fuel pool gate weld repairs were done. The computer file has since been updated. The inspector reviewed the updated records for each welder involved; no discrepancies were noted. This item is closed.

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 and power block control points, 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 CFR 50.54(k), 10 CFR 50.54(m), Technical Specifications, and the NRR letter of July 31, 1980. Presence of a senior licensed operator in the control room complex was verified frequently.

On August 24, 1984, the inspector noted that the on-going day shift reactor operator at Unit 3 had worked 20 of the previous 36 hours. By working his shift he would exceed the NRC staff working hour guidelines of 24 hours in any 48 hour period. The licensee promptly evaluated the matter and approved a staffing deviation per his administrative procedures, thus avoiding a literal violation. The inspector stated that the intent of the guidelines is to provide prior management review of potential unusual working hours so that such situations can be avoided if at all possible. This issue was discussed with plant management. Operator working hour controls will continue to be evaluated during routine resident inspections.

- 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, PCIS status, 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. Examples of specific alarms discussed during the report period were Moisture Monitoring System Trouble; Area temperatures for HPCI, RCIC and Main Steam Lines; and RBM inoperable.

The operators were knowledgeable of alarm status and plant conditions.

- 3.1.4 Fluid Leaks. The inspector observed sump status, alarms, and pump-out rates, and discussed leakage with licensee personnel. During the inspection numerous sensors of the Moisture Monitoring System were inoperable at Unit 3. The inspector verified that hourly pump-out calculations were being performed.
- 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. On the morning of August 29 1984, while backwashing the 3B RWCU demineralizer on Unit 3 an unplanned release of about 3% of the technical specification instantaneous release limit occurred. The Unit 3 Reactor Building became contaminated with airborne radioactive material and was evacuated. Later in the day the inspector noted that the Reactor Building was still contaminated and questioned the Senior Health Physicist about the situation. The licensee determined the problem was caused by a leaking relief valve (12-58) and ventilation system alignment problems. The licensee gave whole body counts to persons in the Reactor Building who might have obtained internal exposures. No significant internal exposures were detected. The inspector had no further questions at this time.
- 3.1.7 Fire Protection. The inspector observed control room indications of fire detection and fire suppression systems, spot checked for proper use of fire watches and ignition source controls, checked a sampling of fire barriers for integrity, and observed fire-fighting equipment stations. The inspector also verified test engineering and administrative controls were being used to preclude accumulations of acetylene in the drywell.
- 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 licensee's QC group has been given responsibility for on-going housekeeping evaluation and appeared to be effective in early identification and resolution of housekeeping discrepancies.
- 3.1.9 Equipment Conditions. The inspector verified operability of selected safety equipment by in-plant checks of valve positioning, control of locked valves, 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.

During this inspection period an ESF System Walkdown for the Core Spray System was completed on Unit 3. Electrical and mechanical lineups were reviewed for accuracy and consistency. The inspectors confirmed that system lineup procedures matched plant as-built drawings. The following drawings were reviewed:

- M362 Sheets 1 and 2, Revision 22
- M-1-S40 Sheet 1, Revision 37
 - Sheet 1A, Revision 33
 - Sheet 2, Revision 34
 - Sheet 3, Revision 37
 - Sheet 4, Revision 35
 - Sheet 5, Revision 33
 - Sheet 6, Revision 33
 - Sheet 7, Revision 32
- E 363 Sheets 1 and 2, Revision 16

Various completed surveillance tests were reviewed, as detailed in paragraph 6 of this report. Core Spray System operating procedures reviewed included the following:

- S.3.4.A, Revision 4, 8/29/79, "Setting Up The Core Spray System For Auto Operation";
- S.3.4.E, Revision 1, 4/2/73, "Normal System Set-up For Automatic Operation";
- S.3.4.F, Revision 2, 11/22/82, "Filling and Venting the Core Spray Loop Discharge Piping"; and
- S.3.4.D, Revision 3, 9/20/83, "Manual Operation of Core Spray System in Support of Full Flow Testing Through Test Valve 14-26(A)(B)"
- Check Off List (C.O.L) Revision 7, 11/8/83, "Core Spray Set-up for Automatic Operation, Flow From Torus, to Reactor Vessel", completed November 27, 1983 for Unit 3. Several items on the C.O.L were marked with changes. These changes involved violation of locked valves, capped lines, and equipment locations and did not involve mis-positioned valves. The inspectors discussed the changes with the licensee who indicated that the C.O.L would be corrected as necessary and verified with the implementation of the Critical Equipment Monitoring System. The C.O.L. would not be used as presently exists.

Accessible portions of the Core Spray System were inspected for valve lineups, instrument operation and housekeeping. In addition Technical Specification requirements and FSAR description were examined. No system line problems were found, but the following items were noted:

-- Drawings M-362, sheets 1 and 2 showed the minimum flow valves in the incorrect position. Also, the schematics mounted in the control room as operator aids showed the valves in the incorrect position. This was brought to the licensee's attention and the control room schematics were corrected within a few days.

-- The minimum flow valves for HPCI, RCIC, and RHR were also checked for accuracy of the PID's. The valve position was incorrect on M-361, sheets 1 and 2, RHR P&ID. This was brought to the licensee's attention.

The inspector will review M-362 and M-361 when new revisions are issued for proper minimum flow valve positions.

3.1.10 Operational Safety during Equipment Outages. Based on information obtained from another BWR site, the inspector reviewed the licensee's practices regarding minimum flow protection of ECCS pumps. These pumps are provided with minimum flow valves, which recirculate a small amount of flow to the suppression pool when low flow is sensed, to preclude pump overheating or damage from pumping against a shutoff head. Minimum flow protection is described in the FSAR discussions for the following systems:

-- High Pressure Coolant Injection, (HPCI), FSAR Section 6.4.1;

-- Residual Heat Removal, (RHR), FSAR Section 4.8.6; and

-- Core Spray, (CS), FSAR Section 6.4.3

Through review of logs, maintenance records and inspection notes, the inspector determined that minimum flow valves had been deactivated in the closed position with the reactor operating and the associated ECCS loop being considered operable as follows:

-- Unit 3 'D' RHR pump minimum flow valve, April 27, 1982

-- Unit 3 'A' RHR pump minimum flow valve, June 22-25, 1984

The inspector asked if the licensee had evaluated these temporary system changes per 10 CFR 50.59. The licensee was unable to locate any written safety evaluation. The licensee believes an informal evaluation was done by plant personnel and discussed at plant staff meetings in 1982. The licensee agreed to complete a written safety evaluation, and include a summary in their response to the violation. In the interim, operations personnel were instructed not to deactivate the minimum flow valves when system operability is required.

10 CFR 50.59, Changes, Tests and Experiments, allows licensees to make changes to the facility as described in the FSAR without prior Commission approval, unless the change involves a revision to the technical specifications or an unreviewed safety question. The licensee is required to maintain records of such changes, including a written safety evaluation which provides the basis for the determination that the change does not involve an unreviewed safety question. Failure to maintain a written safety evaluation is a violation. (278/84-20-01)

3.2 Follow-up on Events Occurring During the Inspection

3.2.1 HPCI System Pipe Hanger Failure

At 7:05 p.m. on August 1, the licensee declared HPCI inoperable for Unit 3 when a pipe hanger (S-4) was found loose. The NRC was notified via the ENS and the licensee performed the required tests on the Core Spray, RCIC, and ADS systems. The licensee also inspected all hangers on the HPCI line. Problems had been identified earlier with two hangers on the Unit 3 HPCI steam line and steps were being taken to modify the pipe supports for:

(3) 23-DBN-S3

(3) 23-HB-H623

Hanger S-4 was repaired and the system returned to service at 5:55 p.m. on August 3, 1984. The inspector reviewed and discussed the following materials with the licensee:

-- Operator Logs

-- MRF-8405203

-- MOD-1402

-- Technical Specification Requirements

The inspector also reviewed drawings M-2060, HISO-2351 and HISO-2352. No unacceptable conditions were identified. The inspectors will follow work on the MOD package as it develops.

3.2.2 Unit 3 Reactor Scram - August 21, 1984

About 2:00 p.m., August 21, 1984, a reduction in flow from all three feedwater pumps resulted in a reactor low water level scram. Reactor level shrink from the scram caused a Group I Primary Containment Isolation System (PCIS) actuation and HPCI and RCIC initiations at double-low water level. Operators restored level control and reopened Main Steam Isolation Valves (MSIV's) before pressure reached relief valve setpoints. The licensee informed the NRC Headquarters Duty Office via the Emergency Notification System, (ENS), phone. The inspector observed follow-up actions in the control room; no inadequacies were noted. During preparation for restarting the 'B' recirculation pump, its discharge valve tripped when operators attempted to close it. A problem in the motor operator was later identified and repaired. Licensee investigation and troubleshooting concluded that the transient was caused by a Feedwater Control System malfunction, but the specific malfunction could not be identified or repeated. Prior to startup, all feedwater control system components that could have caused the malfunction were replaced. The inspector observed the PORC meeting on August 22, 1984, at which the PORC reviewed the scram and approved both the post-scram review measures and the corrective actions.

No violations were identified.

3.3 Logs and Records

The inspector spot-checked logs and records for accuracy, completeness, abnormal conditions, significant operating changes and trends, required entries, operating and night order propriety, correct equipment and lock-out status, jumper log validity, conformance to Limiting Conditions for Operations, and proper reporting. The following logs and records were reviewed: Shift Supervision Log, Reactor Engineering Log (Unit 3), Reactor Operators Log (Unit 2), Reactor Operators Log (Unit 3), CO Log Book, and STA Log Book (sampling), Night Orders (Current Entries), Radiation Work Permits (RWP's), Maintenance Request Forms (sampling), Ignition Source Control Check lists (sampling), and Operation Work & Information Data, all during July 16 - August 31, 1984.

Control room logs were compared 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.

Upon review of the plant logs on August 13, 1984, it was noted that the STA log indicated MSIV 86B did not give a $\frac{1}{2}$ scram on partial closure during Surveillance Test (ST) 9.7. The inspector questioned the STA about the log entry. It was determined that the 86B valve did give a $\frac{1}{2}$ scram signal, but it came about 6 seconds after the double indication lights (valve open - red and valve closed - green). The $\frac{1}{2}$ scram from MSIV 86B was within the test requirements. The inspector reviewed the completed ST. All steps were completed satisfactorily. The inspector had no further questions.

The inspector reviewed plant procedure CA-72, Revision 2, March 10, 1983, Routine Chemistry Sampling, and the technical specification requirements. The inspector also reviewed the standard technical specification in the area of coolant chemistry. The actions taken by the licensee where the coolant conductivity recorder is out of service were discussed with operation and chemistry personnel. The licensee's procedure complies with the technical specification for the areas inspected. The inspector had no further questions.

No unacceptable conditions were identified.

4. Review of Licensee Event Reports (LERs)

4.1 In-Office Review

The inspector reviewed LER's 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 follow-up. The following LER's were reviewed:

<u>LER No./LER Date/Event Date</u>	<u>Subject</u>
2-84-10/July 30, 1984/June 7, 1984	Jet Pump Instrumentation Line Crack
2-84-11/July 9, 1984 and August 6, 1984/June 8, 1984	Acetylene Leak In Drywell
2-84-12/July 27, 1984/June 28, 1984	Inoperable Fire Damper and PBAPS Cable Spreading Room
2-84-13/July 13, 1984/June 29, 1984	Inoperability of Diesel and Motor Driven Fire Pumps
2-84-14/July 19, 1984/August 17, 1984	Cable Spreading Room Cardox System Out-of-Service Without Continued Fire Watch

2-84-15/August 20, 1984/July 15, 1984	Smoke Detectors Removed From Service Without A Continuous Fire Watch
3-84-8/July 9, 1984/June 10, 1984	Jet Pump Instrumentation Line Crack Indications

4.2 Reportability Determinations

The inspector reviewed the licensee's reportability determinations for selected events, based on research by the NRC Office for Analysis and Evaluation of Operational Data (AEOD). AEOD had compared (1) NRC:HQ Duty Officer (10 CFR 50.72) Notifications, (2) NRC Regional Office Morning Reports, and (3) LERs for consistency with NRC reporting requirements. For Peach Bottom, two discrepancies (i.e., cases where a LER appeared to be required, yet no LER was issued) were identified: (1) Unit 3 manual scram on January 14, 1984, following flooding of the condensate pump room; and (2) Excessive scram time for one control rod during the January 14, 1984 scram.

The inspector reviewed the above events relative to reporting requirements. The licensee had determined that the slow scram time was reportable. Because the event was related to a November 17, 1983 event, the licensee reported it as an update to the applicable LER, 3-83-18/3L. The excessive scram times were reviewed extensively in inspection 84-03 and were the subject of enforcement action.

Regarding the manual scram reportability, the licensee had evaluated the event and concluded it was not reportable. 10 CFR 50.73 requires a report of, "Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, including the RPS, that resulted from and was part of the preplanned sequence during testing or reactor operation need not be reported."

In the January 14, 1984 event, the condensate pump room flooded about two hours before the scram. After the flooding the licensee developed a plan by which it would proceed with a normal shutdown, but would scram if the operating condensate pump bearing temperature rose sharply. Therefore, when the licensee scrambled in response to a bearing temperature increase, the licensee considered it part of a preplanned sequence of events. The inspector informed the licensee that the NRC disagreed with this assessment -- the "sequence of events" in this case began with the unplanned flooding of the condensate pump room. Further, the manual scram was taken, in part, to avoid an impending plant transient and automatic scram from loss of the condensate system. The inspector stated that an LER would be expected for any similar future events.

The inspector reviewed the licensee's log of "Suspected Licensee Event Reports" and did not identify any other failures to submit an LER. Because this particular event is an isolated case, caused by licensee misinterpretation of a new rule, (10 CFR 50.73 was effective on January 1, 1984) no Notice of Violation is issued.

5. Maintenance

For the following maintenance activities the inspector spot-checked administrative controls, reviewed documentation and interviewed cognizant engineers and supervisors.

<u>Maintenance Request Number</u>	<u>Equipment</u>	<u>Date</u>
MRF 8405203	HPCI Pipe Hangers	8/6/84

Documents reviewed included maintenance request, welder qualification, weld information data sheets, and field inspection reports.

No unacceptable conditions were identified.

6. 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 tests were observed:

- ST8.1, Revision 17, dated 7/4/84, "Diesel Generator Full Load Test" performed on the E3 Diesel Generator on August 10, 1984;
- ST9.12B, Revision 2, July 8, 1981, Reactor Coolant Temperatures, for recirculation pump start at Unit 3 on August 23, 1984;
- ST4.6.1, Revision 1, July 2, 1976, Main Steam Line Radiation Monitor Source Calibration, completed August 22, 1984, following replacement of the 'A' detector at Unit 3; and
- ST6.7.1, Revision 7, July 25, 1984, Daily Core Spray "B" System and Cooler Operability, performed August 24, 1984, at Unit 3.

The inspector reviewed completed documentation for the following tests:

- ST1.5, Revision 10, September 23, 1982, Core Spray "B" Logic System Functional, completed January 27, 1984, for Unit 3;

- ST6.7F, Revision 1, July 2, 1984, Core Spray "B" Pump, Valve, Flow, Cooler completed August 7, 1984, for Unit 3;
- ST6.6.1, Revision 5, February 23, 1984, Daily Core Spray "A" System and Cooler Operability completed August 7, 1984, for Unit 3;
- ST6.7.1, Revision 6, February 23, 1984, Daily Core Spray "B" System and Cooler Operability completed August 6, 1984, for Unit 3;
- ST12.15.2-3, Revision 1, March 21, 1984, Core Spray Contaminated Piping Inspection completed July 5, 1984, for Unit 3;
- ST13.2, Revision 3, September 18, 1974, MSIV Position Switch Calibration, completed August 23, at Unit 3;
- ST3.1.3, Revision 5, October 29, 1983, SRM Functional and Calibration Checks completed August 22, 1984, at Unit 3;
- ST9.12B, Revision 2, July 8, 1981, Reactor Coolant Temperatures, completed for recirculation pump start at Unit 3 on August 22, 1984;
- ST6.15, Revision 7, July 9, 1984, Recirculation Pump Valve Operability, completed at Unit 3 on August 23; and
- ST2.16.08C, Revision 4, September 28, 1981, Calibration Check of PT/PISH/PSL3-2-3-55C, completed at Unit 3 on August 22, 1984

No violations were identified.

One unresolved item was identified regarding ST4.6.1, Main Steam Line Monitor Source Calibration. The test acceptance criteria for the detector is merely that it exhibits linear response, since the alarm and trip set points are based on normal full power background. Thus, a newly installed detector could have a significantly lower amplitude response than the previously installed one, yet pass the test (so long as its response was linear). In this case a significantly lower full power reading would result. Under current procedures new alarm and trip settings would not be established until the reactor reaches full power and the new lower radiation monitor reading is actually observed. The licensee is reviewing this issue; this item is unresolved (278/84-20-02). In the specific case of the August 22, 1984, replacement of the 3A detector, the new detector response amplitude was similar to that of the old one.

7. 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 25 people observed met frisking requirements of Health Physics procedures. A sampling of high radiation doors verified the doors to be locked as required.

8. Physical Security

The inspector spot-checked compliance with the accepted Security Plan and implementing procedures, including: operations of the CAS and SAS, 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.

On August 6, 1984, the inspector received anonymous allegations that the CAS attendants were being assigned so many ancillary tasks that the primary function of alarm response was being jeopardized. The inspector observed CAS operations on August 7, 1984, and interviewed CAS operators and security management. Although the inspector confirmed that many tasks unrelated to alarm responses were being assigned to the CAS, no specific interference with alarm response was noted. On August 13, 1984, the licensee informed the resident inspector that a computer terminal in the AUX SAS, whose inoperability had necessitated using the CAS terminal for certain routine administrative functions, had been repaired. On August 16, 1984, NRC Region I sent a letter to the licensee requesting licensee evaluation of this issue.

No violations were identified.

9. Review of Potential Generic Issue

An inspection of the core spray full flow test isolation signal was conducted as a result of a problem identified at another BWR site. According to the Technical Specifications and FSAR, the core spray full flow test isolation valves 14-26A and B should close on Reactor Vessel low level or high drywell pressure at the plant where the problem was identified. The valve actually closes only on low water level. This disagreed with both the Technical Specifications and the FSAR for that particular BWR site. The inspector reviewed the Peach Bottom FSAR, Technical Specifications and As-Built drawings M-362 and M-1-S-40. The as-built drawings show the valves isolating on either signal (high drywell pressure or low water level). The inspector concluded that Peach Bottom does not have the problem identified at the other plant.

10. Outage Activities - Unit 2

10.1 Recirculation Riser Safe-end Examinations

The inspector discussed the status of safe-end examinations with licensee personnel. Dye penetrant testing of the nozzles to thermal sleeve weld, during the week of July 30, 1984, revealed indications in two safe-ends (270° and 330° azimuth). The licensee attempted to take replicates, and also took a boat sample of the 270° safe-end indication. G.E. analysis of the boat sample indicated that the cracking was intergranular stress corrosion cracking (IGSCC), and that the area around the indication had probably been cold-worked (with a grinder) during original fabrication. Analysis also confirmed that the safe-end is of low carbon (about 0.02%) stainless steel -- IGSCC is therefore of particular concern since low carbon stainless steel has been previously accepted as non-susceptible to IGSCC. Subsequent UT examinations revealed indications in the crevice area behind the safe-end-to-thermal sleeve weld. This area is not inspectable visually or by PT. The safe-end cracking was the subject of a meeting in Bethesda on August 30, 1984, among NRC:NRR, General Electric Company, and the licensee. As of the end of this inspection, the licensee had not decided upon a course of corrective actions and was attempting to radiograph the areas of interest. The NRC will review the licensee's disposition of this issue prior to restart (277/84-24-01).

10.2 Outage Meetings

On August 15, 1984, the inspector observed the bi-weekly pipe replacement project review meeting among PECO and the various project contractors. Items discussed included the status in-plant work, procedures and safety evaluations to support upcoming work, and NDE plans. Also discussed were the design and procurement status for pipe supports, ECCS section strainers, and jet pump seal penetrations. ALARA recommendations, relative to unexpectedly high post-decontamination radiation levels at spots near the recirculation pumps, were discussed at length. The inspector also observed three of the daily outage meetings conducted by the plant staff. Within the scope of these observations, no violations were identified.

11. In-Office Review of Monthly Operating Report

Peach Bottom Atomic Power Station Monthly Reports for June and July 1984, transmitted July 13 and August 15, 1984, respectively, 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.

No violations were identified.

12. Inspector Follow Items

Inspector follow items are items for which the current inspection findings are acceptable, but due to on-going licensee work or special inspector interest in an area, are specifically noted for future follow-up. Follow-up is at the discretion of the inspector and regional management. An inspector follow-up item is discussed in Detail 10.1.

13. 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 6.0.

14. Management Meetings

14.1 Preliminary Inspection Findings

A verbal summary of preliminary findings was provided to the Station Superintendent at the conclusion of the inspection. During the inspection, licensee management was periodically notified verbally of the preliminary findings by the resident inspectors. No written material was provided to the licensee during the inspection.

Attendance at Management Meetings Conducted by Region-Based Inspectors

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

<u>Date</u>	<u>Subject</u>	<u>Inspection Report No.</u>	<u>Reporting Inspector</u>
July 16 (Entrance) July 27 (Exit)	U/2 Pipe Replacement	277/84-22	A. Gody
July 23 (Entrance) July 24 (Exit)	T.S. Amendment Request Reviews	277/84-23 278/84-18	S. Kucharski
July 30 (Entrance) August 2 (Exit)	Diesel Generators Cables and Electrical	277/84-26 278/84-22	F. Paulitz
July 31	Enforcement Conference (at NRC Region I)	277/84-27 278/84-23	R. Bailey
August 20 (Entrance) August 24 (Exit)	Dosimetry	277/84-25 278/84-21	F. Costello
August 20 (Entrance) August 20 (Exit)	ALARA	277/84-29	H. Bicehouse
August 31 (Exit)	License Examinations	277/84-28	J. Berry