U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Report No.: 50-443/89-05

Docket No.: 50-443 License Nos.: NPF-56; NPF-67

Licensee: Public Service Company of New Hampshire
1000 Elm Street
Manchester, New Hampshire 03105

Facility: Seabrook Station, Unit No. 1

Location: Seabrook, New Hampshire

Dates: April 24 - May 26, 1989

Inspectors: N. F. Dudley, Senior Resident Inspector
D. A. Dempsey, Reactor Engineer
P. D. Drysdale, Reactor Engineer

Approved By: Donald R. Haverkamp 6/14/89
Donald R. Haverkamp, Chief Date
Reactor Projects Section No. 3C
Division of Reactor Projects

Inspection Summary:

a. Areas Inspected:

Routine inspection conducted by the Senior Resident Inspector and regional reactor engineers. Areas of inspection included operational safety, licensee reportable events, station information reports, maintenance, surveillance, and licensee followup to NRC Information Notices, previous items and other issues.

b. Results:

Operations: A non-cited violation was issued for the storage of the service water cooling tower pump in a non-seismically qualified building during Mode 4 operations (paragraph 3). The licensee's cleanup efforts in the primary auxiliary building (PAB), following discussions with NRC inspectors, improved housekeeping (paragraph 4). Two events caused by operator oversight on April 29 and May 12, 1989 were reviewed and found to have no direct safety impact on the facility operations (paragraph 6.1 and 6.2).

Security: The licensee developed contingency plans to deal with an expected large demonstration on June 4, 1989 (paragraph 5). Two unrelated security related events occurred on May 17 and May 20, 1989 which resulted in Seabrook police arresting individuals who had illegally entered the owner controlled area (paragraph 6.3 and 6.4).

Maintenance and Surveillance: The inspector performed an extensive review of the programmatic aspects of the maintenance and surveillance programs and witnessed several activities to evaluate the effectiveness of program implementation. The review and inspection found the program to be adequate for supporting low power testing. Several observations made by the inspector were presented to the licensee staff for further review (paragraph 7.1).

Radiation Control: The licensee adequately implemented the radiation controls area procedures on May 18, 1989 in preparation for low power testing.

Safety Assessment: The licensee management initiated several programs to identify the root causes of and to reduce the number of inadvertent personnel errors (paragraph 9.2). The Quality Control (QC) organization identified an improper Raychem splice installation in the power operated relief valve control and indication system. The inspector discussed with the licensee the timeliness of reporting the improper splice and the adequacy of the present QC program for inspecting Raychem splices in the containment (paragraph 7.2).

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*The NRC Inspection Manual Inspection Procedure (IP) that was used as inspection guidance is listed for each applicable report section.

DETAILS

1. Persons Contacted

Interviews and discussions were conducted with members of the licensee staff and management during the report period to obtain information pertinent to the areas inspected. Inspection findings were discussed periodically with the management and supervisory personnel listed below.

W. A. DiProfio, Assistant Station Manager
*T. C. Feigenbaum, Vice President, Engineering, Licensing and Quality Programs
*D. E. Moody, Station Manager
*J. E. Peschel, Operational Programs Manager
*N. A. Pillsbury, Independent Review Team Manager
*G. S. Thomas, Vice President, Nuclear Production
J. M. Vargas, Manager of Engineering
*J. J. Warnock, Nuclear Quality Manager

* Attended exit meeting conducted June 1, 1989

2. Summary of Facility and NRC Activities

2.1 Resident Inspector Activities

One full time senior resident inspector was assigned to the site during the entire inspection period. The inspection included 32 hours during backshift periods and fourteen hours during deep backshift periods. Deep backshift inspection was conducted from 10:00 p.m. to 12:00 a.m. on April 26, 1989; from 10:00 p.m. to 12:00 a.m. on April 28, 1989; and from 7:00 a.m. to 5:00 p.m. on May 7, 1989.

2.2 Visiting Inspector and Management Activities

The Director of Project Directorate 1-3 and the Seabrook Station Project Manager from the Office of Nuclear Reactor Regulation toured the facility with the NRC reactor projects section chief and senior resident inspector on April 26 and 27, 1989, to assess the licensee's readiness for issuance of a low power license.

The NRC reactor projects section chief visited the site again on May 9 and 27, 1989. He held discussions with senior managers and conducted an entrance interview for the Readiness Assessment Team inspection which began May 27, 1989.

During the weeks of April 24 and May 8, 1989 a reactor engineer from NRC Region I conducted an inspection of operational safety. During the week of May 22, 1989, a second reactor engineer from NRC Region I

conducted an inspection of the maintenance and surveillance program to determine the facility's readiness for conducting operational Mode 4 activities (paragraph 7.0).

2.3 Plant Status

The plant remained in operational Mode 5, cold shutdown with primary temperature between 120 to 150° F and primary pressure between 150 to 300 psig with a bubble in the pressurizer and one train of the residual heat removal system in operation. Operational Mode 4 surveillance tests were conducted in preparation for the expected heatup and low power testing. On May 26, 1989 a low power license, NPF-67, was issued.

3. Status of Previous Inspection Findings

(Closed) Unresolved Item 89-01-01: Seismic Storage of Service Water Cooling Tower Pump. This open item concerned inappropriate storage of the service water cooling tower pump and the lack of adequate operational characteristics in the technical specification surveillance requirements. To resolve this item, the licensee has stored the service water cooling tower pump and 30 rolls of five inch diameter hose in the Unit 2 cooling tower electrical switchgear room which is a seismically qualified building. Technical Specifications for license NPF-67 issued on May 26, 1989, incorporated an additional surveillance requirement to Technical Specification 4.7.5, to verify flow from the cooling tower pump greater than 200 gpm by a recirculation test flow. Both concerns raised by this open item have been resolved and unresolved item 89-01-01 is closed.

During the previous entries into Mode 4 the cooling tower pump was not stored in a seismic qualified building as required by Technical Specification 4.7.5. The improper storage was first noted by the inspector, and is considered a violation. There was minimal safety significance to this noncompliance due to the station not achieving criticality and the absence of decay heat which would have required the availability of the cooling tower following a safe shutdown earthquake. The violation is not being issued because the criteria for timely and effective corrective action, safety significance and other items specified in Section V.A of the Enforcement Policy (October 1988) were satisfied (50-443/89-05-01).

4. Operational Safety

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

Control Room
Containment
Primary Auxiliary Building
Diesel Generator Rooms
Residual Heat Removal Vaults
Waste Handling Building
Service Water Cooling Towers
Security Perimeter Fence
Intake Structure
Turbine Building

Control room instruments were observed for correlation between channels, proper functioning, and conformance with technical specifications. Alarm conditions in effect and 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. No deficiencies were noted.

While touring the facility on April 26, 1989 the Director of Project Directorate 1-3 of the Office of Nuclear Reactor Regulation noted that a lower level of cleanliness existed in certain areas of the primary auxiliary building (PAB) than in the containment. Also several floors on the -31 foot elevation and the floor in the primary sample room appeared to need repainting. As a result of these observations, the licensee initiated actions which improved the cleanliness in the PAB. The licensee also provided the inspector a copy of a painting plan that prioritized and scheduled repainting of the PAB floors. The inspector will continue to monitor the housekeeping and cleanliness in the PAB and the painting plan will be reviewed during the Readiness Assessment Team inspection to determine its adequacy and timeliness in regards to ALARA concerns.

5. Security

The inspector conducted discussions with site security managers concerning contingency plans for dealing with expected large demonstrations. The licensee's contingency plans include increasing security staffing levels, increasing readiness levels, coordinating with town and state police departments and establishing methods for alternate access to the site. The planning for demonstrations, which may include civil disobedience, appears to be well formulated.

During the reporting period new explosive detectors, new metal detectors and new X-ray machines were installed in the Security Building. The new equipment has reduced maintenance and has improved access control to the protected area.

6. Plant Operations

6.1 April 29, 1989 - Two Centrifugal Charging Pumps Running in Mode 5

At about 1:38 a.m. on Saturday April 29, 1989, a Control Room Operator (CRO) inadvertently started a second centrifugal charging pump while in Mode 5. While following operations procedure OS 1002.02 "Operation of Letdown, Charging and Seal Injection", the CRO inadvertently skipped the step which required securing charging pump A prior to starting charging pump B. Both pumps operated for eight seconds before the CRO was directed by the Unit Shift Superintendent to secure charging pump A.

Technical Specification (TS) 3.1.2.3 and its associated bases requires that a maximum of one charging pump be operable in Mode 5 and allows more than one pump to be energized provided the discharge valve is closed with the power removed from the valve operator. On May 17, 1989, memorandum SSP #890726 was written by the licensee to file concerning the reportability of the event. The memorandum concluded that the event was not reportable based on the discharge valves of the charging pumps being closed and the adequate relief capacities of the power operated relief valves and residual heat removal suction relief valve. The implementation of the requirements of TS 3.1.2.3 and the associated surveillance requirements, the reportability of the event and the accuracy of the information contained in the TS bases are considered an unresolved item pending further NRC and licensee review (50-443/89-05-02).

6.2 May 12, 1989 - Failure to Recognize Entry into Technical Specification Action Statement During Surveillance Testing

At about 8:15 p.m. on May 12, 1989, the emergency diesel generator (EDG) B output breaker was racked out to the test position as required by surveillance OX 1456.43, "ESFAS Slave Relay Testing" for approximately one hour. As a result, the operating centrifugal charging pump B was not capable of being powered from an operable emergency power source as required by Technical Specification (TS) 3.1.2.3 during the duration of the surveillance. The entry into the technical specification was not recognized by licensee personnel until shift turnover which occurred at approximately 10:40 p.m. A verification was made that the action statement for TS 3.1.2.3 had been met during the time the EDG-B output breaker had been racked to the test position and that the breaker had been properly racked in.

The inspector discussed the event with the on-shift crew and found that all members of the crew were aware of the technical specification requirement and had properly shifted charging pumps during previous performances of the surveillance test. The licensee initiated a station information report (SIR) to review the event and identify appropriate corrective action. The inspector concluded that the oversite was due to personnel error. The licensee SIR will be reviewed during a subsequent resident inspection.

6.3 May 17, 1989 - Arrest of Individual in Owner Controlled Area

At about 1:26 a.m. on May 17, 1989 two individuals were observed by the licensee security force personnel breaking into the owner controlled area in the vicinity of the laydown yard where construction material is stored. The Seabrook police were called and they arrested one individual inside the owner controlled area. The second individual escaped into the woods. The apparent motive for the forced entry was theft of construction material. No attempt was made by the intruders to approach the protected area boundary.

6.4 May 20, 1989 Demonstration at Main Gate

At about 11:36 a.m. on May 20, 1989, two individuals ignored the requests of the guard at the north access gate to leave the owner controlled area, approached and climbed the nearest high line power poles, and raised a banner that read "Stop Seabrook, No Low Power, Rally June 2, 3, and 4". After six hours of waiting for press coverage, the individuals descended the poles and were arrested by the Seabrook Police Department. There was no direct media involvement and the banner was removed by the licensee. The individuals were supported by between five and nine demonstrators who remained outside the owner controlled area. No attempt was made by the demonstrators to approach the protected area.

7.0 Maintenance/Surveillance

7.1 Maintenance and Surveillance Program and Procedure Review

An extensive review was performed of procedures applicable to plant administration; operation of plant systems; startup, operation, and shutdown of safety-related systems; abnormal plant conditions (alarms); emergency plant conditions; plant maintenance; and technical specification surveillance requirements. In general, plant procedures were observed to be well written, with clear requirements, specifications, and instructions explicitly provided in a manner which ensures that plant administrative and technical requirements are effectively implemented.

Where applicable, procedures were reviewed for technical content to ensure, as a minimum, that technical specification requirements were consistent with and fully implemented by the procedure instructions. The level of technical detail and content of station operating procedures were judged to be more than adequate to provide the necessary instructions for control of safety-related systems. Particular attention was paid to plant procedures which will be utilized upon and during the transition to operational Mode 4 (Hot Shutdown) and Mode 3 (Hot Standby). The licensee's tracking programs used to ensure that technical specification surveillances are current and satisfy program requirements prior to a mode change were also reviewed in depth.

In-service inspection (ISI) and in-service test (IST) program requirements and tracking devices were observed to be extensively developed and were controlled well by site technical support groups. The computerized tracking and control methods reviewed provide assurance to department managers that these inspection and testing requirements are completely satisfied when certifications are made prior to an operational mode change.

All plant procedures reviewed in the site document control centers and in field locations such as control room and administrative offices were observed to be current and in agreement with the Master Procedure Index. No outdated or obsolete procedures were found in any plant files. Various procedures which contain checklists were reviewed, and in all cases procedure steps matched checklist steps by number and instruction or sign-off requirements. It was noted that prerequisites, initial conditions, personnel requirements, acceptance criteria, and system restoration instructions were also clearly provided in all procedures reviewed by the inspector.

The inspector noted some particular concerns regarding site procedures as follows:

-- The administrative procedure which contains instructions for processing work requests (MA 3.1) specifies certain responsibilities to be accomplished by the "Work Request Coordinator". The inspector was not able to identify from personal interviews or from review of the site organizational chart any single individual whose title or duties fully match the description of Work Request Coordinator as described by procedure MA 3.1.

-- There does not exist a formalized procedure validation requirement or program in any site organization at Seabrook Station. It was noted that validation activity is occurring in some instances during procedure development. The inspector considered that various procedure group managers and supervisors should develop administrative requirements which can assure that new and revised procedures are verified to be consistent with technical requirements, and accurately specify both job requirements and field conditions under which they are to be worked.

-- The Maintenance Work Request procedure MA 3.1 contains a note for Work Group Supervisors to "consider holding pre-job and/or post-job briefings under certain conditions where unique or extensive jobs are encountered." The inspector opined that Work Group Supervisors should be mindful under all circumstances to consider a need for pre-job and post-job briefings, and further considered that certain work situations or plant conditions should always require that pre-job and post-job briefings be conducted by the work team.

The inspector's comments were discussed with responsible licensee managers for their consideration and the inspector had no further questions concerning this matter.

7.2 Maintenance/Surveillance Program Implementation and Work Observation

The inspector witnessed the performance of test procedure OX 1401.09, "Reactor Vent Paths Cold Shutdown and 18-Month Surveillance Test". This procedure was performed as a post-modification test on the pressurizer power operated relief valves (PORVs), RC-PCV-456A & B, which have recently been upgraded to full EQ qualification. The PORVs had also received some control circuit rewiring work in which "Raychem" splicing kits were installed. This test was also accomplished to satisfy IST requirements for the PORVs.

During the conduct of this test, the inspector noted that the procedure and the work permits contained the necessary administrative approvals prior to the commencement of work and that system tagouts had been properly established. The test equipment used during the valve stroke timing was correctly installed and calibration records were current. Personnel conducting the test were interviewed throughout the test and after data results were obtained on each PORV. All personnel demonstrated good familiarity with procedure requirements and were fully capable of judging test results against acceptance criteria specified in the test procedure. The inspector noted that no QC inspector was present or required by QC holdpoints during the performance of this surveillance, however, a pre-job briefing was conducted in the control room and adequate supervisory oversight was maintained in the control room throughout the test. Results of the stroke times for the PORVs obtained from this test were well within specified requirements. However, it was noted by test personnel that stroking the 456B valve caused the 456A valve "closed" indication (green) light on the control panel to flicker. Since these valves are connected through a common downstream header, it appeared that the reed switch for the 456A valve was receiving vibrations induced by stroking of the 456B valve. This condition invalidated the test results on both valves and additional work instructions were written to investigate and repair the 456A valve reed switch as necessary.

Near the end of the PORV testing activities, the operations/test personnel were made aware by the QC organization of an outstanding concern within the site QC organization regarding the acceptability of the new Raychem splices on both PORVs control circuits as installed under the original modification work packages. The concern involved the overlap between the Raychem sleeve and the lead insulation, which was less than the manufacturer's recommendation. The inspector reviewed the work package and noted that no QC inspection activity or hold points were required by the procedure during the installation of the Raychem splices. Subsequent investigation revealed that the QC concern had been identified two days prior to the operability test by a licensee QC inspector performing an unrelated inspection on the

PORVs. The NRC inspector discussed this situation with the QC inspection supervisor and noted the apparent lack of timely notification to the operations department of a possibly unsatisfactory plant material condition.

In light of the numerous historical problems with Raychem splice installations at the Seabrook Station, the NRC inspector questioned the current QC department policy of providing QC inspection coverage of 80% of the current Raychem installation work in the plant (reduced from 100% in February, 1989). The QC supervisor committed to provide the NRC inspector with justification for reducing QC inspection coverage for this type of work based upon the results of QA surveillance audits performed when 100% coverage was provided. Approximately 10 audit reports were written over approximately one year prior to February, 1989, and only one reported a questionable Raychem installation that required rework. The NRC inspector noted that this situation appeared to make good justification for reducing the QC coverage to 80%. However, given the untimely notification of the PORV Raychem concern and the fact that the PORVs could have been declared operable, and again inoperable to rework the Raychem splices, the NRC inspector noted that 100% QC inspection coverage of any further Raychem work inside containment may still be justified. This concern will be followed under the current unresolved item (89-04-02) for resolution of related Raychem installation and inspection practices in the plant.

The NRC inspector noted that a change to the Raychem procedure (MS 0514.09) was initiated the following day to reflect the proper method for installing and accepting the particular Raychem kit type used on the PORV control circuits. It was also noted that the QC supervisor agreed to ensure that maintenance technicians and QC inspectors would receive training on practicing the proper installation methods and obtaining the correct final configuration of the Raychem parts as specified by the manufacturer. Additional work was performed on the PORVs to completely replace the unacceptable Raychem splice and to adjust and stabilize the 456A valve reed switch. The valves were subsequently retested satisfactorily and declared operable. Test results were reviewed by the lead IST engineer and found to be acceptable.

The inspector witnessed the performance of special test procedure STP-125 which obtained emergency diesel slow start data to investigate the cause for past diesel trips following extended outages. During the conduct of this test the licensee identified incorrect valve numbers on tags attached to the drain valves on the air receivers for the air start system. The licensee also identified an error in the procedure concerning the number of emergency start buttons which should be depressed to start the diesel. Both errors were corrected prior to proceeding with the test. The conduct of the test

was well managed and coordinated by the system engineer who conducted an effective pre-job briefing. Quality control staff provided appropriate oversight during the conduct of the test.

8. Radiological Controls

The radiological controls area (RCA) procedures were implemented on May 18, 1989 in preparation for low power testing. Prior to that time signing on radiological work permits (RWP) and frisking out of the RCA were performed for training purposes only. The inspector reviewed the sign on sheets for RWPs, the posted survey maps, the issuance of dosimetry and the response of health physics personnel to an alarm condition at a whole body frisker. As a result of the alarm, a potentially contaminated hard hat was quarantined overnight to verify that the activation of the alarm was caused by naturally occurring radon gas. No deficiencies were noted.

9. Licensee Event Reporting (LER)

9.1 LER 89-005: Diesel Generator Inoperability Due to Service Water Valve Failing to Open. On March 25, 1989, service water valve SW-V-18, which provides cooling water to emergency diesel generator (EDG) B water jacket cooler heat exchanger failed to open when the EDG was started for testing. Investigation revealed the woodruff key between the butterfly valve shaft and the drive bushing had sheared, preventing SW-V-18 from opening. The set screw which holds the drive bushing on the valve shaft had become loose allowing the bushing to slide down on the shaft disengaging approximately 2/3 of the woodruff key from the drive bushing. The woodruff key sheared due to the reduced engagement. Inspection of service water valve SW-V-16 for EDG-A revealed a similar failure of the set screw to hold the bushing in place, however, the woodruff key had not yet sheared. The valve stem bushing for SW-V-16 was realigned, a new key installed and the set screw was reinstalled with loctite to preclude a recurrence of the event. Service water valve SW-V-16 for EDG-A was modified to preclude a similar failure. The inspector had no further questions.

9.2 LER 89-006: Misposition of Unborated Water Source Locked Valves. In two separate events on April 7 and April 17, the licensee identified violations of the license condition of the Seabrook "low power" license which requires boron dilution flowpath valves to be closed and locked. The details of the events and the violation issued for the events are documented in NRC Inspection Report No. 50-443/89-03 issued on May 26, 1989.

In the cover letter for LER 89-006 dated April 28, 1989, the licensee stated that actions would be taken to reduce the number of personnel errors. Further discussions with the licensee identified the following actions.

(1) The need to change the culture of plant personnel was discussed at several staff meetings between April 27 and May 2, 1989 and department heads held similar discussions with their departments.

(2) An Ad-Hoc Task Team on Operating Events and Human Performance was formed to study steps needed to minimize human errors and to provide timely and accurate assessments of operating events.

(3) A Human Performance Evaluation System is being implemented to evaluate events and to monitor the effectiveness of corrective actions.

(4) During the startup and low power testing program, the station staff has been directed to delay performance of administrative tasks such as personnel and accounting in order to concentrate on management of the testing program.

(5) The self-assessment team was reformed and is assigned the responsibility for evaluation of significant operational events during low power operations.

(6) A detailed evaluation was conducted by the IRT of nine recent Station Information Reports including the two LER events, which involved personnel errors. By trending all SIRs from July 1987 to present and all maintenance and operations SIRs since July 1988, the IRT found that the occurrence of reportable events is decreasing. Also, no common thread was found between the most recent nine events.

The licensee's efforts in attempting to identify the root causes of personnel error and in attempting to minimize future errors has been well directed and focused. The inspector will continue to evaluate the effectiveness of these ongoing programs. The specific corrective actions contained in LER 89-05 and in response to the associated violation issued in NRC Inspection Report No. 50-443/89-03 will be reviewed during a subsequent inspection.

9.3 Station Information Report 89-018: B Steam Generator Low Level RCS Trip Signal. NRC Inspection Report No. 50-443/89-03 described the generation of a reactor trip signal due to level in steam generator (SG) B decreasing below the "LO-LO" setpoint of 14%. The event occurred on April 3, 1989 and the completed Station Information Report (SIR) 89-018 was issued on May 19, 1989.

The existing guidance provided the operators at the time of the event required control of the SG level at a level above 14%. Levels in all SG had decreased close to the 14% level due to lack of operational foresight. During a surveillance test, the first SG B level channel to be tripped could not be reset due to SG B level being below the

level required to reset the channel. When recirculation flow was secured to SG B in order to refill the generator and allow resetting of the channel in test, the level in SG B decreased tripping a single channel. This second SG B low level signal in conjunction with the simulated trip signal initiated the reactor trip signal. The reactor trip breakers were open and no equipment was actuated since the solid state protection system was bypassed.

The required minimum steam generator level while in wet layup has been raised to 20% and both the wet layup procedure and the technical data curve book have been modified to reflect the new change.

10. Review of Licensee Response to NRC Initiatives

NRC Information Notice 88-89: Degradation of Kapton Electrical Insulation.

During observation of the licensee's replacement of a Raychem splice on signal cabling for the Gammametric neutron detectors, the inspector noted that Kapton insulated leads were enclosed in a junction box. The leads were enclosed in a protective plastic sleeve when they entered the conduits leading to and from the junction box. NRC Information Notice No. 88-89 "Degradation of Kapton Electrical Insulation" issued on November 21, 1988 cautions that Kapton insulation is susceptible to physical damage and to chemical attack by certain volatile chemicals such as sodium hydroxide. When questioned by the inspector, the maintenance and quality control personnel were unaware of the Kapton leads susceptibility to physical damage. The inspector also questioned the use of Kapton leads inside a box not sealed for loss of coolant accident scenarios due to the use of sodium hydroxide during containment building spray actuation.

The inspector reviewed Electrical Equipment Qualification File No. 118-03-01 which provides the bases for environmental qualification (EQ) of the Conax Corporation's Electrical Conductor Seal Assembly (ESCA). Specifically, the results of the chemical spray portion of the Environmental Design Basis Event Test were reviewed. During the test, the Kapton leads from the ECSA were encased in either a flexible or rigid metal conduit. The failure of one test specimen which occurred soon after chemical spray was initiated and was attributed to a gap in the conduit which allowed spray to impinge directly on the Kapton leads. The other specimen met all acceptance criteria established for qualification. The licensee stated that the junction boxes in the containment provide the same level of protection for the Kapton leads as did the metal conduit used in the qualification test and that the junction boxes would prevent direct spray of sodium hydroxide on the leads.

Maintenance and quality control personnel read and were provided training on the information contained in Information Notice 88-89. In an internal memorandum dated May 26, 1989, Engineering was tasked with identifying

applications where Kapton insulation is used, Technical Support and Production Services were tasked with reviewing applicable maintenance and installation procedures to ensure appropriated precautions are noted pertaining to handling of Kapton insulated wire and the Training Department was requested to provide appropriate training to field personnel. The inspector had no further questions at this time, but the licensee's actions in response to Information Notice 88-89 are subject to followup during routine resident inspection.

11. Review of Periodic and Special Reports

The inspector reviewed the April Monthly Operating Report submitted by letter NYN-89056 dated May 3, 1989.

The inspector reviewed Security Event Report (SER) No. 89-501 submitted by letter NYN-89055 dated May 3, 1989. The event is discussed in NRC Inspection Report No. 50-443/89-03.

No deficiencies or concerns were identified during the inspector's review of these reports.

12. Management Meetings

At periodic intervals during this inspection, meetings were held with senior plant management to discuss the findings. A summary of findings for the report period was also discussed at the conclusion of the inspection and prior to report issuance.