U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Report Nos.	92-26
Docket Nos.	50-334 50-412
License Nos.	DPR-66 NPF-73
Licensee:	Duquesne Light Company One Oxford Center 301 Grant Street Pittsburgh, PA 15279
Facility:	Beaver Valley Power Station, Units 1 and 2
Location:	Shippingport, Pennsylvania
Inspection Period:	November 19 - December 21, 1992
Inspectors:	Lawrence W. Rossbach, Senior Resident Inspector Peter P. Sena, Resident Inspector
Approved by:	Timothy J. McGinty for John F. Rogge, Chief Reactor Projects Section No. 4B

12/31/92
Date

Inspection Summary

This inspection report documents the safety inspections conducted during day and backshift hours of station activities in the areas of: plant operations; radiological controls; surveillance and maintenance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

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EXECUTIVE SUMMARY

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Plant Operations

The licensee continued to operate the units in a safe manner. A hydraulic instability similar to the waterhammer events described in earlier inspections reoccurred in a unit 2 auxiliary feedwater line. The licensees procedures were effective in stopping this event. The licensee is preparing a submittal to NRC on their plans for preventing these events.

Licensee analysis indicated that potential foreign material within the spent fuel pool, removed during recent vacuuming activities, did not have an effect on pool water chemistry. Foreign material, which has been positively identified, was properly evaluated and dispositioned by the licensee.

Maintenance and Surveillance

The licensee identified that they failed to test an incore detector for contamination during the installation process as required by procedure. This was of minor safety significance as licensee evaluation provided a high degree of confidence that the detector was free of contamination. This was a non-cited violation. Maintenance personnel took timely and appropriate action to repair an emergency diesel generator jacket water leak.

The licensee has taken good action to ensure pump vibration data is consistently obtained from the same bearing locations. Additional attention to detail is warranted to ensure pump vibration data is properly recorded on the trending sheets. Operators demonstrated good health physics practices during charging pump testing.

Emergency Preparedness

The licensee declared an unusual event based on security computer problems. The computer problem did not meet the reporting requirements of 10 CFR 73.71 but did meet the unusual event criteria in the licensee's emergency preparedness plan. The shift supervisor took the correct action in declaring the event. The licensee is currently evaluating formal changes to the security compromise unusual event criteria.

Security

Security officers took appropriate action per their safeguards plan in response to a security computer failure.

Engineering and Technical Support

Two open items involving the ability of motor operated valves to operate were closed. Specific implementation of generic letter recommendations will be reviewed as part of a future motor operated valve inspection.

DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

Unit 1 operated at approximately 90% power throughout this inspection period without any significant operational events. The utility operates Unit 1 at 90% power to accommodate system demand.

Unit 2 operated at full power throughout this inspection period except for a reduction to approximately 46% power from November 26 to 30 to accommodate lower system demand. On November 26, a hydraulic instability occurred in the auxiliary feedwater piping similar to the waterhammer events described in previous inspection reports. This is discussed in more detail in Section 2.2 below.

On November 28 the licensee made a notification of an unusual event due to a loss of intrusion detection and access control capabilities. This is described in more detail in Sections 5.1 and 6.1 below.

2.0 PLANT OPERATIONS (71707, 93702)

2.1 Operational Safety Verification

Using applicable drawings and check-off lists, the inspectors independently verified safety system operability by performing control panel and field walkdowns of the following systems: Quench spray, auxiliary feedwater, and emergency diesel generators. These systems were properly aligned. The inspectors observed plant operation and verified that the plant was operated safely and in accordance with licensee procedures and regulatory requirements. Regular tours were conducted of the following plant areas:

- Control Room
- Auxiliary Buildings
- Switchgear Areas
- Access Control Points
- Protected Areas
- Spent Fuel Buildings
- Diesel Generator Buildings
- Safeguard Areas
- Service Buildings
- Turbine Buildings
- Intake Structures
- Yard Areas
- Containment Penetration Areas

During the course of the inspection, discussions were conducted with operators concerning knowledge of recent changes to procedures, facility configuration, and plant conditions. The inspectors verified adherence to approved procedures for ongoing activities observed. Shift turnovers were witnessed and staffing requirements confirmed. The inspectors found that control room access was properly controlled and a professional atmosphere was maintained. Inspectors' comments or questions resulting from these reviews were resolved by licensee personnel.

Control room instruments and plant computer indications were observed for correlation

between channels and for conformance with technical specification (TS) requirements. Operability of engineered safety features, other safety related systems, and onsite and offsite power sources were verified. The inspectors observed various alarm conditions and confirmed that operator response was in accordance with plant operating procedures. Compliance with TS and implementation of appropriate action statements for equipment out of service was inspected. Logs and records were reviewed to determine if entries were accurate and identified equipment status or deficiencies. These records included operating logs, turnover sheets, system safety tags, and the jumper and lifted lead book. The inspectors also examined the condition of various fire protection, meteorological, and seismic monitoring systems.

Plant housekeeping controls were monitored, including control and storage of flammable material and other potential safety hazards. The inspectors conducted detailed walkdowns of accessible areas of both Unit 1 and Unit 2. Housekeeping at both units was acceptable.

2.2 Reoccurrence of Unit 2 Auxiliary Feedwater Hydraulic Instability Following Power Reduction

On the evening of November 25, the licensee began reducing power on Unit 2 due to reduced load demand. On November 26, shortly after reaching 46% power, a noise was heard coming from the auxiliary feedwater piping to the 'B' steam generator. This indicated the reoccurrence of a hydraulic instability similar to the waterhammer events described in inspection report 92-20. Temperatures of 82°F on the 'B' line and 76°F and 79°F on the 'A' and 'C' lines at the containment penetrations did not indicate any significant backleakage of feedwater into the auxiliary feedwater system. As in the previous events, spiking was observed on the 'B' auxiliary feedwater line flow recorder 2FWE-FR100. The spiking was half the magnitude observed in the previous event. Operators started an auxiliary feedwater pump and feed the 'B' steam generator at a throttled rate of approximately 80 gpm for a few minutes in accordance with operating procedure OM 2.24.4Q. This stopped the hydraulic instability and it did not recur. No damage was identified to piping or snubbers. After this event the licensee installed test pressure gauges on all three auxiliary feedwater lines per Temporary Modification 2-92-25 to be used to study pressures between the system check valves. As requested by the NRC in inspection report 92-20, the licensee is preparing a submittal to the NRC describing their plans for resolving this issue.

2.3 Fuel Pool Foreign Material Control

During the Unit 1 spent fuel pool cleanup activities, the licensee's contractor vacuumed portions of the pool floor. Four vacuum filters were generated, which contained activated metal fines and corrosion products. These vacuum filters contained a total activity of 3.75 curies. The inspector performed a review of the Unit 1 and Unit 2 1992 fuel pool chemistry reports to determine if any potential foreign material had an effect on the pool water chemistry. The licensee performed a chemical analysis for aluminum, boron, calcium,

chloride, magnesium, fluorine, gross activity, tritium, lithium, pH, total conductivity, and turbidity. No out-of-specification conditions due to the presence of potential foreign material were identified by the inspector. The licensee also performed an additional analysis to identify the presence of copper within the borated water. The licensee's analysis indicated 82 parts per billion copper. This amount of copper is only a minor activation concern and does not affect plant material. The licensee is currently investigating the source of the copper and evaluating its impact.

The inspector also reviewed procedure 1/2CMP-75-Refueling-3M, "Fuel Pool Tool Control." This procedure requires that proper tool/material accountability be maintained while performing work around the spent fuel pool. Known foreign material that is identified within the pool is required to be reported to refueling supervision. If the material cannot be retrieved, then each item must be tracked by the refueling department "fuel pool foreign material tracking" log. Also, each item must be evaluated and dispositioned by an engineering analysis. The inspector reviewed the tracking log and noted that current foreign material includes stainless steel shear pins, white rags, and a light bulb. Each of these items was properly evaluated by the licensee and deemed not to affect the fuel pool chemistry or stored spent fuel or plant material. A visual inspection of the spent fuel pools by the inspector did not identify any additional foreign material.

3.0 RADIOLOGICAL CONTROLS (71707)

Posting and control of radiation and high radiation areas were inspected. Radiation work permit compliance and use of personnel monitoring devices were checked. Conditions of step-off pads, disposal of protective clothing, radiation control job coverage, area monitor operability and calibration (portable and permanent), and personnel frisking were observed on a sampling basis. Licensee personnel were observed to be properly implementing their radiological protection program.

4.0 MAINTENANCE AND SURVEILLANCE (62703, 61726, 71707)

4.1 Maintenance Observations

The inspectors reviewed selected maintenance activities to assure that: the activity did not violate Technical Specification Limiting Conditions for Operation and that redundant components were operable; required approvals and releases had been obtained prior to commencing work; procedures used for the task were adequate and work was within the skills of the trade; activities were accomplished by qualified personnel; radiological and fire prevention controls were adequate and implemented; QC hold points were established where required and observed; and equipment was properly tested and returned to service.

Maintenance work requests (MWRs) reviewed included:

MWR 013744 Incore Instrument Drive Detector 'B'

MWR 015109	Emergency Diesel Generator 2-1 Jacket Water Leak
MWR 015067	Disconnect and Reconnect Motor 2HDH-P22B Thermocouple
MWR 013865	Install Design Change Package DCP 1926, RWST Temperature Indicator TI-QS-100B Span Change

On November 20, 1992, instrumentation and control (I & C) technicians performed scheduled maintenance on the incore detector system. The 'B' incore detector was indicating high background voltage. MWR 013744 was generated to replace the detector and referenced corrective maintenance procedure (CMP) 3II-ND-A-B-C-D-E 1I, "Repair and Replacement of Flux Mapping System Components." Prior to installing the new detector, licensee personnel failed to test the sealed source for leakage or contamination as specified per procedure. The incore neutron flux detectors are fission chambers enriched with 90% Uranium-235.

Technical specification surveillance requirement 4.7.9.1.2.C states that fission detectors be tested within 31 days prior to being subjected to core flux. To satisfy this surveillance, the CMP states "the new incore flux detector has been tested by Rad Con and certified free of surface contamination within 31 days as required by technical specification 3/4.7.9.1." A verification signature by a radiation controls representative is specified on the CMP cover page. Radiation control personnel were not informed of this survey requirement, although I & C personnel did have the opportunity to communicate this requirement. In particular, this job was scheduled per the plan-of-the-day meeting involving all plant disciplines. Additionally, since the maintenance required a containment entry, an ALARA pre-job brief was conducted. Nuclear Group Administrative Procedure 3.3, "Reactor Containment Entries," specifies that the work party supervisor conduct the pre-entry briefing describing the tasks to be performed. However, I & C supervision did not fully read the CMP prior to the job brief and thus did not inform the technicians or radiation controls personnel of the survey requirement.

On November 23, licensee personnel discovered the survey oversight. However, the licensee was unable to test the detector since it had already been subjected to a core flux during an incore flux map on November 21. The manufacturer's shipping documentation certified the detector to be free of surface contamination. Direct readings and smears of the packing material by the licensee also indicated no contamination, and thus the licensee had a high degree of confidence that the detector did not leak. On December 18, the licensee replaced the 'B' incore detector and appropriately performed the survey requirement.

The licensee also evaluated the applicability of technical specification 3.7.9.1 to this incident. The limiting condition for operation states that "each sealed source containing radioactive material either in excess of 100 microcuries of beta and/or gamma-emitting material or 5 microcuries of alpha-emitting material shall be free of greater than .005 microcuries of removable contamination." The licensee obtained vendor documentation which indicated that

the detector contained 5.2 milligrams of uranium with a total activity of .29 microcuries. The inspector reviewed this documentation and agreed that technical specification 3.7.9.1 does not apply to the incore detector as previously thought. Therefore, the failure to test the source for contamination or leakage is not a missed technical specification surveillance.

Overall, the failure to test the incore detector for contamination or leakage is of minor safety significance. However, the inspector is concerned that licensee personnel failed to follow a procedure with clear instructions and that a less than adequate pre-job briefing was conducted. The licensee has taken appropriate action, including procedure changes, personnel counseling, and continued training, to prevent recurrence. The failure to test the incore detector for contamination or leakage as required by licensee procedures is not being cited as a violation because the criteria in Section VII.B of the Enforcement Policy for exercising enforcement discretion was satisfied.

On December 2, the licensee identified a potential jacket water leak on the Unit 2, number 1 emergency diesel generator. This was identified by a high-level alarm on the rocker arm lube-oil reservoir. The rocker arm lube-oil system is a separate system from the diesel main lube-oil system. The licensee partially drained about 0.3 liters of purple colored water from the lube-oil reservoir. Jacket water was identified due to the presence of borate-nitrate corrosion inhibitor. The licensee concluded, with vendor assistance, that the presence of water in the engine oil does not warrant the engine inoperable. The rocker arm lube-oil system is maintained in standby, thus the water would stratify and could be drained from the bottom of the reservoir. The inspector agreed with this conclusion.

Even though an operability concern did not exist, the presence of water is detrimental in that it reduces the lubricating capability of the oil. The licensee thus took appropriate action to identify the source of the water and repair the jacket water leak. Maintenance personnel removed the engine covers and identified the number four cylinder right exhaust valve as leaking coolant. The licensee replaced the O-ring for the exhaust valve. Also, the rocker lube oil was drained and replaced with new, clean oil and the oil filters were replaced. The licensee's root-cause failure analysis indicated that a longitudinal piece of the O-ring was missing and was probably cut during the manufacturer's original installation into the water passage block. Overall, the inspector concluded that the licensee took timely and appropriate action to repair the jacket water leak. Also, a good root-cause analysis was conducted by the licensee which verified that the leak was not a result of previous maintenance practices.

4.2 Surveillance Observations

The inspectors witnessed/reviewed selected surveillance tests to determine whether properly approved procedures were in use, details were adequate, test instrumentation was properly calibrated and used, Technical Specifications were satisfied, testing was performed by qualified personnel, and test results satisfied acceptance criteria or were properly dispositioned. The following operational surveillance tests (OSTs) and maintenance surveillance procedures (MSPs) and operating manual procedures (OMs) were reviewed:

OST 2.13.8 Containment Depressurization System Position Verification, Train 'A'

OST 2.15.3 Primary Component Cooling Water Pump Test

1MSP 2.04I Power Range Neutron Flux Channel N-NI42 Refueling Calibration

1OM 7.4AN Returning a Charging Pump to Service Following Mechanical Maintenance

OST 1.7.4 Centrifugal Charging Pump Test

OST 1.30.1A Auxiliary River Water Pump (WR-P-9A) Test

The inspector observed good health physics practices by the operators performing the charging pump test. The operators used hand held radiation meters (ion chamber mode RO-2) while working within the pump cubicle. The licensee only requires the use of meters for zone 5 radiation areas (>100 mR/hr). The charging pump cubicles are Zone 4 (50-100 mR/hr) radiation areas. The inspector also identified two minor procedural deficiencies associated with OM 7.4AN. Specifically, OM 7.4AN referenced the incorrect procedure for pump venting. Also, OM 7.4AN specified that pump vibration readings be taken in displacement units (mils). The licensee's inservice testing (IST) program requires that vibration readings be taken in velocity units (in/sec). The operator performing the test had already measured pump vibration in in/sec per OST 7.4. The inspector was informed that OM 7.4AN would be changed to specify the correct venting procedure and proper vibration units.

During the performance of OST 30.1A, the inspector noted that some minor confusion existed as to the placement of the vibration meter probe for vibration point 3 (bearing identification: motor outboard horizontal). The procedure indicated that the vibration meter be placed on the painted doughnut-shaped hole on the motor shroud. The measured vibrations at this point were .36 in/sec and not within the acceptable range. A metal vibration checkpoint tag was affixed to the pump motor directly below the painted hole. Vibration at this point was .09 in/sec and within the acceptable range. The licensee compared these readings to the baseline data and concluded that the metal vibration tag is the correct checkpoint. However, the inspector was concerned that pump vibration data could be invalidated by the incorrect placement of vibration meter probes. The inspector subsequently performed a review of the pump vibration data for the Unit 1 pumps for charging, riverwater, low-head safety injection, recirculation spray, and auxiliary feedwater. The inspector noted that these pumps had fixed metal location tags for vibration measurements points. Each numbered vibration point correctly corresponded with the locations described and diagrammed in each respective OST. The inspector was informed that the use of these tags is a recent change to the IST program. The inspector was also informed that the auxiliary riverwater pumps had been removed from the IST program and the "balance of plant" pumps are currently being updated with the fixed metal location tags. The inspector concluded that the use of these tags will ensure that pump vibration data is consistently

obtained from the same bearing location.

The inspector also reviewed the vibration trending data which is logged by the shift technical advisors. The vibration data is trended in tabular vice graphical form. This format is consistent with the licensee's IST program requirement. The inspector did note that the vibration data for the auxiliary feedwater pumps (1FW-P-3A and 3B) and the component cooling water pump (1CC-P-1C) was recorded out of sequence. With the information recorded in this manner, vibration trending information could produce misleading results. The inspector informed the IST personnel of this discrepancy who then reviewed the data and noted no adverse trends.

Overall, the inspector concluded that the licensee's IST vibration data is providing beneficial information. Good action has been initiated by the licensee to ensure vibration data is consistently measured from the same bearing locations. However, additional attention to detail is needed to ensure vibration data is properly trended and recorded.

5.0 SECURITY (71707)

Implementation of the physical security plan was observed in various plant areas with regard to the following: protected area and vital area barriers were well maintained and not compromised; isolation zones were clear; personnel and vehicles entering and packages being delivered to the protected area were properly searched and access control was in accordance with approved licensee procedures; persons granted access to the site were badged to indicate whether they have unescorted access or escorted authorization; security access controls to vital areas were maintained and persons in vital areas were authorized; security posts were adequately staffed and equipped, security personnel were alert and knowledgeable regarding position requirements, and that written procedures were available; and adequate illumination was maintained. Licensee personnel were observed to be properly implementing and following the Physical Security Plan.

5.1 Security Computer Failure

On November 28, 1992, at 4:33 a.m., the central alarm station experienced problems with the prime central processing unit (CPU). This resulted in a loss of intrusion detection capability. Access controls remained completely functional. The licensee's security force initiated appropriate compensatory measures as described in their NRC approved safeguards plan. The licensee also made an emergency notification system (ENS) call to the NRC per 10 CFR 73.71.

Throughout November 28, the licensee performed troubleshooting activities on the suspect CPU. At 4:35 p.m., the licensee attempted to halt the prime CPU and let the backup CPU automatically take over security monitoring and control functions. As a precaution, appropriate compensatory measures were pre-established by the licensee. The backup CPU again failed to automatically take over the functions of the prime CPU. As previously

experienced, there was a loss of intrusion detection capability. Additionally, access control functions were lost. The backup CPU took over and restored the lost functions. The licensee determined that this computer failure was not a 1 hour reportable event per 10 CFR 73.71, as the system was restored in 10 minutes. The licensee did, however, declare an unusual event due to the computer failure (see Section 6.1).

The licensee subsequently traced the computer problems to the backup CPU and completed their repair effort without incident. The inspector reviewed this event and concluded that security personnel took appropriate action in response to the computer failures per their security plan. The inspector also reviewed Regulatory Guide 5.62, "Reporting of Safeguards Events," and noted that the licensee's initial ENS call was conservatively reported.

6.0 EMERGENCY PREPAREDNESS (71707)

6.1 Notification of Unusual Event

On November 28, 1992, the licensee declared an unusual event based on problems experienced with the security computer (see Section 5.1). The security supervisor informed the control room of the problems with the prime and backup CPUs at 4:41 p.m. The licensee's Emergency Preparedness (EP) plan states that a "total loss of the alarm monitoring and card reader access control system (including backup CPU) as reported by the security administrator" is an unusual event. The control room declared the unusual event at 5:01 p.m., 20 minutes after being informed of the security computer failure. The licensee immediately terminated the event at 5:02 p.m. since the computer was already restored at 4:45 p.m. The inspector reviewed the event notification worksheet and noted that all required notifications were satisfactory completed.

The inspector discussed with the shift supervisor the delay in declaring the unusual event between 4:41 p.m. and 5:01 p.m. The inspector was informed that questions existed as to the differences between the morning and the afternoon security computer failures. The morning computer failure did not result in the declaration of an unusual event since there was no loss of card reader access control. Additionally, the shift supervisor questioned as to why the afternoon computer failure was not a reportable safeguards event per 10 CFR 73.71 but met the unusual event criteria per the licensee's EP plan. The licensee's EP plan allows the shift supervisor 15 minutes to assess the emergency condition prior to declaring the emergency event. Thus, the shift supervisor was only 5 minutes late in declaring the unusual event. The inspector concluded that this delay was of minimal safety significance as the computer system had already been restored within 10 minutes of its failure.

The inspector also discussed the content of the security compromise unusual event criteria with the licensee's emergency preparedness manager. The licensee has subsequently issued a memorandum to clarify the intent of the emergency action level criteria. The clarification states, in part, that "a security administrator's report of a 'total loss' to the control room is initiated when the security reporting requirement (*i.e.*, inability to perform function for

greater than 10 minutes) is exceeded." The inspector considered this a satisfactory short-term solution to ensure that a declaration of an unusual event is not done at a lower level threshold than the reportability criteria of 10 CFR 73.71. The inspector did conclude that the shift supervisor made the proper unusual event declaration based on the wording of the emergency action level. Formal changes to the security compromise unusual event criteria are currently under evaluation by the licensee for submission to the NRC.

7.0 ENGINEERING AND TECHNICAL SUPPORT (37700, 37828, 71707)

7.1 (Closed) Unresolved Items 50-334/89-10-01 and 50-412/89-11-01: Ability of Motor Operated Valves (MOVs) to Operate Under Design Basis Differential Pressure Conditions

These unresolved items were opened during combined NRC inspection numbers 50-334/89-10 and 50-412/89-11 to address a lack of documented justification to demonstrate the operability of certain MOVs under design basis differential pressure conditions. Subsequent to this inspection, NRC issued Generic Letter (GL) 89-10 on June 28, 1989, to address the above and other operability concerns for the MOVs on a generic basis. This GL requested the licensees to evaluate and resolve the identified operability concerns within 5 years or three refueling outages.

The NRC's MOV team inspection (50-334/92-80 and 50-412/92-80) reviewed the licensee's actions in response to GL 89-10, including the measures taken to establish technical justification for the MOVs to operate under design basis conditions. The licensee established procedure ES-G-014, "Sizing of Valve Motor Operators," Revision 1, dated March 21, 1992, for this purpose. The Unit 2 reviews were complete, and Unit 1 reviews were about 50% complete at the time of the above team inspection. The NRC team found that the licensee's actions were in conformance with the applicable Generic Letter 89-10 recommendations with a few minor exceptions. Based on the review, this item is administratively closed. Specific implementation of the GL recommendation for the valves discussed in inspection report numbers 50-334/89-10 and 50-412/89-11 will be reviewed as part of a future MOV program implementation inspection.

8.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (40500, 71707, 90712, 91700)

8.1 Review of Written Reports

The inspectors reviewed Licensee Event Reports (LERs) and other reports submitted to the NRC to verify that the details of the events were clearly reported, including accuracy of the description of cause and adequacy of corrective action. The inspectors determined whether further information was required from the licensee, whether generic implications were indicated, and whether the event warranted further onsite followup. The following LERs were reviewed:

Unit 1:

92-09 "Reactor Trip Due to Reactor Coolant Pump Trip on Ground Fault Indication"

This event was reviewed in NRC inspection reports 92-22 and 92-24. The inspectors have no additional comments on this event.

92-10 "Engineered Safety Features Actuation - Automatic Start of River Water Pump Due to Low System Pressure"

On October 19, 1992, with the unit in cold shutdown, the 'A' reactor plant river water pump (WR-P-1A) auto-started on low system pressure. At the time of the pump start, the river water system was being returned to its normal alignment following the completion of a surveillance test. Specifically, river water was being aligned from the recirculation spray heat exchangers to the component coolant water heat exchangers. The licensee determined that the system realignment resulted in a momentary drop in river water pressure. Additionally, the river water system was operating at lower than normal pressure due to increased river water flow needed for residual heat removal cooling. The inspector reviewed this event and had no safety concerns. The river water system remained operable at all times. The licensee has changed their surveillance test to prevent recurrence.

92-11 "Use of Unqualified Relay in Small Break LOCA Analysis"

This event was reviewed in NRC inspection report 92-24. The inspectors have no additional comments on this event.

The above LERs were reviewed with respect to the requirements of 10CFR50.73 and the guidance provided in NUREG 1022. Generally, the LERs were found to be of high quality with good documentation of event analyses, root cause determinations and corrective actions.

9.0 EXIT MEETING

9.1 Preliminary Inspection Findings Exit

At periodic intervals during this inspection, meetings were held with senior plant management to discuss licensee activities and inspector areas of concern. Following conclusion of the report period, the resident inspector staff conducted an exit meeting on December 21, 1992, with Beaver Valley management summarizing inspection activity and findings for this period.

9.2 Attendance at Exit Meetings Conducted by Region-Based Inspectors

During this inspection period, the inspectors attended the following exit meetings:

Dates	Subject	Inspection Report No.	Reporting Inspector
12/18/92	50.59 TERs and Minor Mod Program	50-334/92-28; 50-412/92-27	R. Paolino

9.3 NRC Staff Activities

Inspections were conducted on both normal and backshift hours: 20 hours of direct inspection were conducted on backshift; 1 hour was conducted on deep backshift. The times of backshift hours were adjusted weekly to assure randomness.

R. Janati, Nuclear Engineer, Pennsylvania Department of Environmental Resources (DER), visited the site and inspectors on December 18, 1992, and discussed inspection activities and the licensee's performance.