### U.S. NUCLEAR REGULATORY COMMISSION OFFICE OF INSPECTION AND ENFORCEMENT

Region I

Report No.	50-317/79-05 50-318/79-05			
Docket No.	50-318 DPR-53			с
License No.	DPR-69	Priority	Category	c
Licensee:	Baltimore Ga	s and Electric Company		
	P. O. Box 14	75		
	Baltimore, M	aryland 21203		
Facility Nam	me: <u>Calvert</u>	Cliffs Nuclear Power P	lant, Units 1 and 2	
Inspection	at: Lusby, I	Maryland		
Inspection	conducted: Mai	rch_21-23 and April 16-2	20, 1979	1
Inspectors:	D. F. Johns	on, Reactor Inspector	- 7/2 date	- 79 signed
	D. V. Kehoe	, Reactor Inspector		signed
		2	- date	e signed
Approved by	R. R. Kein	g, Chief, Reactor Proje	ēcts 7-2	- 79 e signed
/	Section	, indis branch		

Inspection Summary:

Inspection on March 21-23 and April 16-20, 1979 (Combined Report Nos. 50-317/ 79-05 and 50-318/79-05)

Areas Inspected: Routine, unannounced inspection by regional based inspectors of plant operations, licensee followup actions regarding previous inspection findings, licensee event reports, Inspection and Enforcement Bulletins and Circulars, and tours of the facility. The inspection involved 64 hours on site by two regional based inspectors.

<u>Results</u>: One item of noncompliance was identified (failure to follow procedures regarding system valve lineups - paragraph 3).

Region I Form 12 (Rev. April 77)

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## DETAILS

#### 1. Persons Contacted

- D. Buffington, Fire Marshall
- J. Carroll, Performance Engineer Operations
- \*R. Denton, Nuclear Plant Engineer Operations
- J. Gilbert, Senior Control Room Operator
- J. Hill, Shift Supervisor
- W. Jefferies, Senior Control Room Operator
- \*A. Kaupa, Radiation Safety and Chemistry Engineer
- \*J. Lemons, Nuclear Plant Engineer Maintenance
- E. Riemer, Plant Health Physicist
- J. Rivera, Shift Supervisor
- P. Rizzo, Assistant General Foreman for Electrical and Instrumentation and Control
- \*L. Russell, Chief Engineer
- J. Speciale, Foreman, Radiation Safety
- L. White, Shift Supervisor

The inspectors also interviewed other licensee employees, including members of the technical and operations staff.

- \* denotes those present at the exit interview.
- 2. Licensee Action on Previous Inspection Findings

(Closed) Infraction (317/78-38-09): The inspector verified that the Nuclear Plant Engineer-Operations (NPE-0) met with all supervisors and work leaders of the operations unit, including all Shift Supervisors and Senior Control Room Operators in a series of meetings held on January 5, 1979, January 24, 1979, January 31, 1979 and March 14, 1979. The purpose of the meetings was to convey NRC's concerns in the area of apparent inattentiveness to Technical Specification requirements and to impress upon these supervisors the necessity for absolute adherence to the Technical Specifications. A memorandum was issued on January 30, 1979 that reiterated their duties and responsibilities towards license requirements.

The licensee took the following specific actions to strengthen adherence to Technical Specification requirements:

a. The NPE-O attended retraining sessions with control room operators to personally emphasize the importance of adherence to Technical Specifications and obtain any suggestions first-hand for any improvements that would strengthen the existing administrative controls in this area.



- b. Log readings taken twice per shift have been moved ahead one hour to allow the Senior Control Room Operator extra time to do a more thorough review of logs containing Technical Specification requirements.
- c. A weekly preventative maintenance routine has been established to list and evaluate all alarms which are hanging during power operation.
- d. An NPE-O standing instruction has been issued which requires the logging of all periodic actions which are taken as a result of being in a Technical Specification "action statement."
- e. A daily information sheet is being transmitted to the Radiation Safety and Chemistry Foreman which lists all Technical Specification "action statements" for his approval.
- f. A checklist has been added to the "Reactor Trip Recovery" procedure, AOP-14, which requires the listing of all current "action statements" and their subsequent resolution prior to a change in operational modes.

(Closed) Deficiency (317/78-38-01, 318/78-34-01): Calvert Cliffs Instruction CCI-200B, "Maintenance Requests," has been revised to assign final determination of post-maintenance test requirements to the Senior Control Room Operator (SCRO). The revised CCI-200B also clarified the responsibility of the SCRO to document the method of performing post-maintenance testing and returning equipment to normal operating status.

(Closed) Infraction (317/78-13-01, 318/78-08-01).

- a. Procedure RCP 1-206 "Liquid Waste Releases Specifications and Surveillance" has been revised incorporate all sample points which will yield a representat imple of the liquid waste tank to attain flexibility in the result specific sampling point is not available.
- b. The licensee has updated the records on the Twelve Month Release Rates Calculation sheets, and future information will be transmitted to the Radiation Safety and Chemistry Engineer (RSCE) on a more timely basis.
- c. The licensee has checked and updated all instrumentation as necessary and has revised procedural requirements to preclude similar occurrences of this nature.

(Closed) Infraction (50-317/79-02-01, 50-318/79-02-01): The licensee revised procedure RCPI-207 "Gaseous Waste Releases - Specifications and Surveillance" to require calculations to be completed and the results recorded within one month following the completion of any twelve consecutive months. In addition, the Radiation Safety and Chemistry Engineer (RSCE) established a monthly report on all release rate calculations to ensure compliance with the specification in RCPI-207.

(Closed) Infraction (50-317/78-24-01, 50-318/78-18-01): Modifications were made to the sample volumes and analytical techniques to reach the action level of 5X10<sup>-8</sup> uCi/cc of radioiodine alone. Procedure SEP 1P-A (Revision 6, January 12, 1979) was revised to reflect increased sample flow rate and utilizing improved instrumentation including calibration procedures and training.

(Closed) Infraction (50-317/78-24-03, 50-318/78-28-03): The additional purchased counting equipment (SPA-3 iodide crystal-scintillation counter and MS-2 mini scaler) were calibrated with a known source (traceable to the National Bureau of Standards) on September 7, 1978. Procedure RCP2-410, "Calibration and Maintenance of the Eberline MS-2 Scaler" (Revision 3, December 21, 1978) has been established for the calibration of the above equipment.

(Closed) Infraction (50-317/78-24-04, 50-318/78-18-04): Supplies which have exceeded their posted expiration date have been removed from the Auxiliary Building First Aid Room and discarded. The Site Emergency Plan (SEP) has been revised to eliminate the use of the Service Building Emergency First Aid Room and replaced by the centralized Auxiliary Building First Aid Room only. Procedure SEP 1P-B "Controlled Area Medical Treatment Room Radiation Protection and Decontamination Supplies" (Revision 6, January 12, 1979) has established an inventory list for emergency medical supplies. In addition, the SEP was revised to include a medical inventory checklist for periodic checking of medical supplies in the Auxiliary Building First Aid Room.

(Closed) Infraction (50- /78-24-09, 50-318/78-18-09): The SEP implementing procedure A, section D was revised to include requirements in the event of a site evacuation that a member of plant security be dispatched to the farm and direct all personnel to report to the Farm Demonstration Building. The security guard will report completion of the search and notification to the site Emergency Director.

(Closed) Infraction (50-317/78-24-10, 50-318/78-18-10): The SEP, section VIII B(2) and IX and the Appendix I to the SEP has been updated and clarified to provide non-Baltimore Gas and Electric outside agencies who have a need for copies of the SEP.

(Closed) Infraction (50-317/78-24-05, 50-318/78-18-05): All personnel assigned specific SEP responsibilities have received initial or refresher training as appropriate. An accountability system has been established to verify each individual's training status. In addition CCI-405A, "Site Emergency Plan Implementing Procedure Administration" has been revised to require the Training Coordinator to maintain an up-to-date listing of all emergency team members in the Shift Supervisor's office.

(Closed) Infraction (50-317/78-24-06, 50-318/78-18-06): The SEP training conducted in 1977 was reviewed and a report was submitted to the Chief Engineer on November 17, 1978. The Training Coordinator was instructed regarding the importance of documenting this data to insure that individuals assigned SEP responsibilities are properly trained.

(Closed) Deficiency (50-317/78-24-07, 50-318/78-18-07): A report detailing the actions taken as a result of comments and recommendations made following the 1977 medical and site emergency drills was submitted to the Chief Engineer on November 17, 1978. The Training Coordinator has implemented an accountability system which will record drill participation.

(Closed) Deficiency (50-317/78-24-08, 50-318/78-18-08): A record of those participating in the 1977 medical and site emergency drill has been generated. The Training Coordinator has established applicable accountability records for further drills.

(Closed) Unresolved Item (50-317/78-38-02): The inspector verified that the missing control room logs for the dates May 11, 1978 through November 6, 1978 identified in NRC Inspection Report 50-317/78-38 have been located.

#### 3. Review of Valves Requiring Positive Control

CCI-300B, Calvert Cliffs Operating Manual, change 7, states that any valve requiring positive control, on the locked valve list, shall be entered on the Locked Valve Deviation List whenever it is in a position other than its designated locked position.

During a tour of the facility the inspector identified two valves (CVC-176 and CVC-178) which were on the Locked Valve List and were tagged shut. The subject valves are designated as locked open on the Locked Valve List but were not annotated on the Locked Valve Deviation List as required by CCI-300B.

When questioned the Control Room personnel stated that they int d CCI-300B, such that a locked valve only appeared on the Locked Val Deviation List if it was not being controlled by another procedure (Tagout,



Surveillance Test, etc). Valves CVC-176 and CVC-178 were under tagout control. According to the Chief Engineer the intent and the words of CCI-300B are to place all locked valves which are out of normal position on the Locked Valve Deviation List. Standing Order 79-02 was issued and implemented which clearly interpreted CCI-300B for all station personnel. The above is considered an item of noncompliance at the Deficiency Level. (50-317/79-05-03, 50-318/79-05-04)

4. IE Circular Followup

The inspector reviewed the licensee's followup actions regarding the IE circulars listed below:

- -- IEC 78-15 "Tilting Disk Check Valves Fail to Close With Gravity in Vertical Position";
- -- IEC 79-02 "Failure of 120 Volt Vital AC Power Supplies"
- -- IEC 79-03 "Inadequate Guard Training/Qualification and Falsified Training Records"

The review included discussions with licensee personnel, review of selected facility records, and observation of selected facility equipment and components.

With respect to the above Circulars, the inspector verified that the Circulars were received by appropriate licensee management, a review for applicability was performed, and that action taken or planned was appropriate.

The inspector had no further questions on these items.

5. In-Office Review of Periodic Reports

The inspector reviewed the Calvert Cliffs Nuclear Power Plant, Units 1 and 2 Monthly Operation Status Reports for December 1978, January 1979 and February 1979 in the Region I office.

The inspector verified that the reports included the information required to be reported by Technical Specifications, and that test results and supporting information was consistent with performance specifications. The inspector ascertained that applicable corrective actions taken or planned were adequate for resolution of identified problems and determined whether any information contained in the report should be classified as ar abnormal occurrence. The monthly status reports were closed out based upon a satisfactory review in the Region I office.



### In-Office Review of Licensee Event Reports (LER's)

The inspector reviewed LER's received in the NRC Region I office to verify that details of the event were clearly reported including the accuracy of the description of cause and adequacy of corrective action. The inspector determined whether further information was required from the licensee, whether generic implications were involved, and whether the event warranted onsite followup.

The following Unit 1 LER's were reviewed.

- -- LER 78-56/4T, dated February 6, 1979: Oyster samples collected on December 5, 1978 showed a decrease in Ag-110m activity as compared to past samples.
- -- LER 78-58/3L, dated January 4, 1979: During performance of surveillance testing on #11 diesel generator the generator room ventilation fan failed to start.
- \*-- LER 79-01/1T, dated February 23, 1979: The licensee's submittal for operation at 2700 MWt did not indicate credit for one charging pump taken in the small break LOCA analysis.
- \*-- LER 79-02/3L, dated February 22, 1979: The plant computer failed causing a loss of control element assembly pulse counting indication and incore detection system.
- \*-- LER 79-03/3L, dated March 15, 1979: During performance of surveillance testing CEA #44 dropped to the bottom of the core and momentarily could not be withdrawn.
- -- LER 79-04/3L, dated March 1, 1979: While performing a routine surveillance test #11 saltwater pump discharge check valve failed to open when the pump was started.
- -- LER 79-05/3L, dated March 1, 1979: During normal operation the azimuthal power tilt exceeded Technical Specification limits due to a dropped CEA.
- -- LER 79-07/4T, dated March 14, 1979: Due to a failure of a pipe weld approximately 5 gallons of sulfuric acid was discharged to the bay via the storm drains.

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The inspector had no further questions on these items.

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The following Unit 2 LER's were reviewed.

- \*-- LER 78-46/3L, dated January 16, 1979: While performing routine surveillance testing, it was discovered that Control Element Assembly #18 would not drive down electrically in manual individual or manual group mode.
- \*-- LER 78-47/3L, dated January 11, 1979: Refueling Water Tank (RWT) narrow range level indication was found to be out of calibration which resulted in the level being lower than the minimum required by Technical Specifications.
- \*-- LER 78-49/3L, dated January 24, 1979: During normal operation a cracked weld was discovered on the suction line of #23 charging pump. The small leak (60 drops/min) was immediately isolated and repaired within 24 hours.
- \*-- LER 78-50/3L, dated January 24, 1979: An unidentified leak was discovered in the reactor coolant system (1.46 gpm). The reactor was shutdown to facilitate a containment entry whereupon a cracked weld was found on #21 reactor coolant pump upper seal pressure sensing line.
- -- LER 78-51/3L, dated January 11, 1979: During normal operation the containment atmosphere sampling pump tripped rendering both the particulate and gaseous radioactivity monitors inoperable.
- \*-- LER 79-01/3L, dated January 24, 1979: An unidentified leakage of 1.546 gpm was discovered in the reactor coolant system. The leak was determined to be from a cracked weld on #21 reactor coolant pump middle seal pressure sensing line.
- \*-- LER 79-03/1T, dated February 1, 1979: During normal operation #22A RCP lower seal temperature alarm was received and an approximate 2 gpm increase in reactor coolant system leak rate was also evidenced. The reactor was tripped and inspection revealed a cracked weld on #22A RCP lower seal pressure sensing line.
- \*-- LER 79-04/3L, dated February 22, 1979: While performing a routine startup of #22 auxilia: feedpump, it was discovered that the throttle valve would not resea. The cause was determined to be a faulty traveling nut on the throttle linkage.

- -- LER 79-05/3L, dated February 22, 1979: During normal operation RPS channel D flow transmitter was discovered to be pegged high. The cause was attributed to the pressure transmitter isolation valve packing leaks.
- -- LER 79-06/3L, dated March 1, 1979: A bad relay in the CEA motion inhibit circuit caused a failure to actuate within 7.5 inch deviation as required by Technical Specifications.
- -- LER 79-07/3L, dated March 1, 1979: A hydraulic snubber on #21 main steam line isolation line was discovered to be inoperable due to a bent piston rod.
- -- LER 79-08/3L, dated March 1, 1979: #22B safety injection tank level dropped below Technical Specification limits. The cause was attributed to the fill valve not shutting tightly after being opened to drain #22b SIT.

\* denotes those LER's selected for onsite followup.

For the above events selected for followup the inspector conducted a record review, discussions with licensee personnel and direct observations to the extent necessary to verify the following:

- a. Corrective Action Technical
  - That corrective action was appropriate to correct the cause of the event.
  - (2) That corrective action has been taken.
  - (3) For corrective actions not yet complete, responsibility has been assigned for assuring completion thereof.
  - (4) That generic implications if identified were incorporated in corrective action.
  - (5) Whether corrective action taken or to be taken is adequate, particularly to prevent recurrence.
- b. Safety of Operations Technical
  - Whether the event involved operation of the facility in a manner which constituted an unreviewed safety question as

defined in 10 CFR 50.59(a)(2); or, for facilities or operations not covered under 10 CFR 50, in such a manner as to represent an unusual hazard to health and safety of the public or environment.

(2) Whether the event involved continued operations in violation of regulatory requirements or license conditions.

# c. Reporting Requirements - Administrative

- (1) The report accurately describes the actual event.
- (2) The safety significance stated in the report is consistent with details of the actual event determined in (1) above.
- (3) The reported cause is accurate and the LER form, if required, reflects the proper cause code.
- (4) The report satisfies the reporting requirement with respect to information provided and timeliness of submittal.

### d. Licensee Review - Administrative

- That the event was reviewed and evaluated as required by approved procedures and administrative controls.
- (2) That personnel within the licensee organization were notified of the event as required by Technical Specifications, license conditions, or approved procedures.
- (3) That review and evaluation of the event included assessment of generic implications.
- (4) That review and evaluation of the event included assessment of personnel error and procedural adequacy.
- (5) That the event was reviewed to determine whether it is a recurrence of past events.

The inspector's findings regarding licensee events were acceptable.

## 7. Review of Plant Operations (Units 1 and 2)

a. Shift Logs and Operating Records

The inspector reviewed the following Logs and Records:

- -- Shift Supervisors Log, Control Room Operators Log for the period March 30, 1979 through April 18, 1979.
- -- Nuclear Plant Engineer-Operations Notes and Instructions; all active instructions as of April 19, 1979.
- -- Lifted Wire/Temporary Jumper Logs; entries made during March 1, 1978 through April 19, 1979.
- -- Lifted Wire/Temporary Jumper Log Sheets; Unit 2 #78-28, 79-1, 79-3, 79-5, 79-6 and 79-8; Unit 1 #78-28, 78-38, 78-39, 78-50, 79-3, 79-4, and 79-6.
- Event Log; entries made during March 1, 1979 through April 19, 1979.
- -- Locked Valve Deviation Log; all active entries were reviewed.
- -- Safety Tagging Log; entries made during February 1, 1979 through April 19, 1979.
- Surveillance Test Procedures: Unit 1 0-5-1, Auxiliary Feedwater System (March 17, 1979, January 17, 1979, and February 18, 1979) and 0-8-0, Diesel Generator Weekly Test (April 11, 16, 17, 1979 and March 26, 1979); Unit 2 0-5-2, Auxiliary Feedwater System (January 29, 1979 and February 28, 1979), 0-33-2, Radiation Monitoring System Functional Test (February 15, 1979, March 15, 1979, and April 15, 1979) and 0-55-2, Containment Integrity Verification (March 25, 1979).
- Control Room Operators Surveillance Logs; entries made during March 1, 1979 through April 19, 1979.
- -- Live Equipment Requests all entries.

The logs and records were reviewed to verify the following items:

- -- Log keeping practices and log book reviews are conducted in accordance with established administrative controls.
- Log entries involving abnormal conditions are sufficiently detailed.
- -- Operating orders do not conflict with Technical Specifications.

- -- Jumper Log and Tagging Log entries do not conflict with TS's.
- -- Jumper, lifted lead, and tagging operations are conducted in conformance with established administrative controls.
- Problem identification reports confirm compliance with TS reporting and LCO requirements.
- -- Logbook reviews are being conducted by the staff.
- Surveillance test procedures are being performed, reviewed and approved in accordance with established administrative controls.

Acceptance criteria for the above review included inspector judgement, and requirements of applicable Technical Specifications and Limiting Conditions for Operations and the following Administrative Control Procedures:

- -- CCI-106, "Special Orders by the Chief Engineer"
- -- CCI-112, "Safety and Safety Tagging"
- -- CCI-114, "Plant Logs"
- -- CCI-117, "Lifted Wire and Temporary Jumper Log"
- -- CCI-118-B, "Nonroutine Technical Specification Reports Requiring Timely Reporting"
- -- CCI-104, "Surveillance Test Program"

The inspectors' findings regarding shift logs and operating records were acceptable, except as described below:

-- The inspector noted that the waver tight doors at the intake structure were left open sixteen hours a day. Technical Specification 3.7.10.g, h, and require the doors to be shut or the plant to be in cold shutdown within 24 hours. The licensee stated that the twelve air coolers in the pump room were not functioning and the water tight doors were left open during the warmer hours of the day to promote natural convection cooling of the pump motors to prevent overheating. The licensee also stated that the reason for the Technical Specification was to protect the structure from flooding during abnormal weather conditions

and that this was being accomplished by having guards stationed at these doors, when they are open, to close them during bad weather. The licensee further stated that a design change for the coolers is scheduled to be performed during the upcoming outage on Unit 1 and would be completed by June 1, 1979. The licensee also stated that with the reduced heat load in the Pump Room due to Unit 1 being shutdown, the design change would be completed on the air coolers associated with Unit 1 and Unit 2 and once the modification was complete the water tight doors would no longer have to remain open. The inspector had no further questions.

-- The inspector noted during his review of Surveillance Test Procedure (STP) 0-5-7 and 0-5-2 (March 17, 1979 and February 28, 1979 respectively) that the acceptance criteria block for the stroking time of MS-4070 and MS-4071 were left blank. The inspector further noted that the licensee was using an acceptance criteria of 1.25 times the previous value in lieu of a maximum stroke time or 1.25 times the previous value whichever is less.

The licensee acknowledged the inspector's comment and stated that a change had been issued to CCI-104, "Surveillance Test Program" that requires the surveillance test engineer to fill in all acceptance criteria in the STP prior to issuing the STP for performance. The licensee further stated that a maximum stroke time for MS-4070 and MS-4071 would be determined and made part of the acceptance criteria. This item is unresolved. (317/79-05-01, 318/79-05-01)

- The inspector noted during his review of the Lifted Wire and Temporary Jumper Log that item 75-22 had caused the wires to the Low Suction Pressure Switch to the Auxiliary Feed Pumps to be lifted. This action eliminated the Low Suction Pressure Alarm. This had been done in October of 1975 due to the fact that the switches were damaged during normal pump transients and were causing a continuous alarm.

The licensee stated that various experiments had been conducted to find an adequate pressure switch but since these could only be performed during outage conditions it had taken several years. The licensee further stated that a new set of pressure switches had been recently received and would be installed in the near future and would be tested and their adequacy determined during the upcoming outage on Unit No. 1. The licensee also stated that the adequacy of the switches would be determined by June 1, 1979. This item is unresolved pending review by NRC:RI of the above action. (317/79-05-02, 318/79-05-02)

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#### b. Plant Tour

At various times during April 17 through 19, 1979, the inspector conducted tours of the following accessible plant areas.

- -- Auxiliary Building
- -- Turbine Building
- -- Spent Fuel Pool Area
- -- Control Room
- -- Safeguards Rooms
- -- Cable Spreading Rooms
- -- Battery Rooms
- -- Outside Peripheral Areas
- -- Computer Rooms

The following observations/discussions/determinations were made:

- -- Radiation controls established by the licensee, including posting of radiation areas, the condition of step off pads, and the disposal of protective clothing were observed. Radiation Work Permits R-79-5 and R-79-6, used for entry into radiation areas, were reviewed.
- Systems and equipment in all areas toured were observed for the existence of fluid leaks and abnormal piping vibrations.
- Selected component cooling, containment spray, high pressure safety injection, low pressure safety injection, piping snubbers/ restraints were observed for proper fluid level and condition/ proper hanger settings.
- -- The indicated positions of electrical power supply breakers, control board equipment start switches, and control board remote-operated valves and the actual positions of selected manual-operated valves was observed.
- -- Selected apparatus service tags were observed for proper posting and the tagged equipment was observed for proper positioning.
- -- The Control Board was observed for annunciators that normally should not be lighted during the existing plant conditions. The reasons for the lighted annunciators were described by a Control Room Operators.
- -- The licensee's policy and practice regarding plant tours was reviewed. There were no changes in this area since the previous inspection.

- Control Room manning was observed on several occasions during the inspection.
- -- Plant housekeeping conditions, including general cleanliness conditions and storage of material and components to prevent safety and fire hazards, were observed.
- -- Observed locel and remote gauge indications and calibration stickers for High Pressure Safety Injection System, Low Pressure Safety Injection System, Core Spray and Charging Pumps.
- Observed shift turnover and verified continuity of system status was maintained.
- -- Verified that fire extinguishers are accessible and have satisfactory pressure and level, and verified that the Halon System in the cable spreading rooms and Unit 2 computer rooms were operable and that battery power supplies for lighting and fire equipment were operable.
- -- Verified th. . the battery room ventilation system was operable.

Acceptance criteria for the above items included inspector judgement and requirements of 10 CFR 50.54(k), Regulatory Guide 1.114, applicable Technical Specifications and the following procedures.

- -- CCI-107D, "Area and System Cleanliness"
- -- CCI-112A, "Safety and Safety Tagging"
- -- CCI-300B, "Calvert Cliffs Operating Manual"
- -- CCI-400A, "Radiation Safety Manual"
- -- CCI-133, "Calvert Cliffs Fire Protection Plan"

The inspector's findings regarding the plant tour were acceptable except as described below:

The inspector observed oil buildup around one of the three charging pumps in each plant, heavy boric acid crystalline buildup in the Boric Acid Room and a small accumulation of debris in the Unit 2 Safeguards Room.

The licensee acknowledged the inspector's comment and stated that the charging pump areas and Unit 2 Safeguards Room would be cleaned up immediately but that the boric acid crystallization was due to a leaking relief valve and could not be repaired until the next outage. The licensee stated this would be done by June 1, 1979. This item is unresolved. (318/79-05-03)

### 3. PG-PL Woodward Governors Installed on Auxiliary Feed Pump Turbines

A letter dated June 29, 1977 was sent by Terry Corporation to the licensee stated that the turbine may trip on overspeed if it is restarted within 30 minutes after shutdown. This results from the time required for hydraulic fluid to drain from the governor's speed setting cylinder. In their letter, Terry Corporation provided instructions for avoiding overspeed trip on restart, i.e., the speed setting knob should be turned to minimum and then returned to the proper setting.

Based on the above the licensee's actions were as follows:

- a. Labels provided by Terry Corporation containing the above instructions have been affixed to the Auxiliary Feed Pump Turbines.
- b. Procedure 01-32 "Auxiliary Feed System" was revised on April 13, 1979 (CCuM #79-65) to include instructions for manually resetting the governor. The governor controls are located in an accessible area.

The inspector had no further questions in this area.

### 9. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance or deviations. The items discussed in paragraph 7 remain unresolved.

#### 10. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection on April 20, 1979. The inspector summarized the purpose, scope and findings of the inspection.