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

Region I

Report No. 50-317/80-06
50-318/80-06

Docket No. 50-317
50-318

License No. DPR-53
DPR-69

Priority -- Category C
C

Licensee: Baltimore Gas and Electric Company

P.O. Box 1475

Baltimore, Maryland 21203

Facility Name: Calvert Cliffs Nuclear Power Plant, Units 1 and 2

Inspection at: Lusby, Maryland

Inspection conducted: May 1-31, 1980

Inspectors: E. C. McCabe, Jr., for
R. Architzel, Resident Reactor Inspector — 7/21/80 date signed

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Approved by: E. C. McCabe, Jr. — 7/21/80 date signed
E. C. McCabe, Jr., Chief, Reactor Projects
Section No. 2, RO&NS Branch

Inspection Summary:
Inspection on May 1-31, 1980 (Report Nos. 50-317/80-06 and 50-318/80-06)
Areas Inspected: Routine, onsite regular and backshift inspection by the resident inspector (35 hours, Unit 1; 30 hours, Unit 2). Areas inspected included the control room and the accessible portions of the auxiliary, turbine, service, and intake buildings; radiation protection; physical security; fire protection; plant operating records; administrative controls relating to defeat of Safety Actuation signals, and a meeting with a representative of the Federal Bureau of Investigation.
Noncompliances: Unit 1, none in 2 areas, 5 in the other 2 areas. Unit 2, none in 3 areas, 2 in the other area. (Infraction - Inoperability of the AFWS, Unit 1 only, Paragraph 5.b; Infraction - Failure to report AFWS Inoperability as required by 10 CFR 50.72, Unit 1 only, Paragraph 5.b; Deficiency - Failure to log AFWS inoperability, alarms, Paragraph 3.c;Infraction - Failure to prevent smoking behind Control Room control panels, paragraph 3a; Deficiency - Acetylene gas bottle not secured, paragraph 3.a).

Region I Form 12
(Rev. April 77)

DETAILS

1. Persons Contacted

The following technical and supervisory level personnel were contacted:

E. Bauer, Assistant General Foreman-Maintenance
D. Buffington, Fire Protection Inspector
S. Davis, Performance Engineer
R. Denton, Nuclear Plant Engineer-Operations
C. Dunkerly, Shift Supervisor
R. Eherts, Performance Engineer
J. Gilbert, Shift Supervisor
J. Hill, Shift Supervisor
J. Lawson, Technical Specialist
J. Lohr, Shift Supervisor
A. Lundvall, Jr., Vice President-Supply
R. Mathews, Jr., General Supervisor-Security
R. Noel, Special Agent (FBI)
J. Rivera, Shift Supervisor
L. Russell, Chief Engineer-Nuclear Plant
J. Shugart, Supervisor-Security
D. Zyrick, Shift Supervisor

Other licensee employees were also interviewed.

2. Licensee Action on Previous Inspection Findings

(Closed) Unresolved Item (317/80-03-01; 318/80-03-01): Review Status of Fire Protection Equipment Checks. Inspector examination of Fire Protection Equipment during this reporting period revealed the sampled equipment checks were current. A Fire Inspector has been added to the Fire Marshall's staff to assist in performance of inspections, tests and surveillance.

3. Review of Plant Operations

a. Plant Tour

At various times during the inspection the inspector made tours of the facility. These included the Control Room, Auxiliary Building (all levels, no High Radiation Areas), Turbine Building, Outside Peripheral Area, Security Buildings, Health Physics Control Points, Diesel Generator Rooms, Service Building and Intake Structure.

The following observations and determinations were made:

-- Radiation controls established by the licensee, including posting of radiation areas, conditions of step-off pads and disposal of protective clothing were observed.

-- Control Room manning was observed on several occasions during the inspection, including observation of shift turnover and panel walkdowns.

-- Systems and equipment in all areas toured were observed for the existence of fluid leaks and abnormal piping vibrations.

-- Seismic restraints and hydraulic snubbers were examined on a sampling basis to verify adequate installation and fluid levels.

-- Plant housekeeping conditions, including general cleanliness conditions and storage of materials and components to preclude safety and fire hazards, were observed.

-- Control room and local monitoring instrumentation for various components and parameters were observed, including reactor power level, CEA positions and safety related valve position indication.

-- Whether proper access controls were established.

Three items of noncompliance and one unresolved item were identified with respect to access control as described in Paragraph C below.

The inspector questioned the licensee concerning the status of local switchgear indicating lights. On May 16, 1980, during a tour of the Unit 2, 45' elevation Switchgear Room, 33 indicating lights appeared to be working and 87 not working. The licensee stated that these indications (breakers open, closed, equipment status lights, potential indicators) were checked only during breaker preventive maintenance. The licensee stated that remote indication is available and used (principally in the Control Room) and that local position could be determined for the breakers by opening the front panels. The inspector acknowledged the licensee's comments and stated that the large percentage of inoperable indicators does not appear to be proper. The licensee stated that this area would be examined for possible corrective action. This item (50-318/80-06-01) is unresolved.

On May 14, 1980, during daily Control Room surveillance, the inspector noted evidence of smoking (16 cigarette butts) in the Control Room Panel Backs, an enclosed, posted No Smoking area which contains the cabling which serves the Control Panels. In addition, the inspector noted that general housekeeping for dust and dirt was necessary in this area. These concerns were brought to the attention of licensee management. The licensee stated that this problem had been previously identified by the Fire Protection Inspector and was being corrected. The inspector reviewed the Fire Protection Inspection Report dated

May 8, 1980 noting evidence of smoking and excessive trash. On May 28, 1980, the inspector again toured the Control Room Panel Backs and noticed evidence of additional smoking (26 cigarette butts) and that the panels had not been cleaned. The Shift Supervisor took action to have the Panel Backs cleaned and remove the evidence of smoking. On May 29, 1980, an individual expressed concern to the inspector that the licensee was ignoring work safety practice requirements. He specifically alleged that a full bottle of compressed gas (stated to be Butane) was improperly stored outside the Intake Structure entrance IS-1 at the Service Building 12' level, that the gas bottle had been stored in this fashion since February, 1980, and that requests to have the bottle removed had been ignored on several occasions. In addition, he stated that corrosive acid was stored in the Service Building passageway north of the IS-1 door. The inspector toured the Service Building to determine the validity of the complaints. A pallet of 10 Kg. boxes (18 total) of Oxalic Acid was stored in the Service Building passageway. The acid was in crystalline form in plastic bags inside cardboard boxes. Oxalic acid is not strongly ionizing and the crystalline form requires contact with water to become reactive. The inspector concluded that storage of the Oxalic Acid in this fashion was not a significant safety concern.

A bottle of flammable (acetylene) gas, labeled No. 218, was standing freely about 6' outside the IS-1 Intake Structure entrance. The inspector questioned the Fire Protection Inspector concerning this item. The Fire Protection Inspector stated he was cognizant of the gas bottle and thought that a Report had been issued to have it removed. No such Report was located. The inspector expressed concern to the Chief Engineer that a bottle of flammable gas had been standing freely in this area for a protracted period of time and that a worker's safety concerns were not acted upon promptly. The Chief Engineer stated that the individual had apparently not contacted the proper level of management and that BG&E did respond to safety concerns. The bottle was immediately removed from the Intake Structure entrance area.

Smoking in a posted no smoking area is a noncompliance with required Fire Protection Administrative Controls. (50-317/80-06-01; 50-318/80-06-02) Improper acetylene gas bottle storage is a noncompliance with required Fire Protection Administrative Controls. (50-317/80-06-10; 50-318/80-06-05). Because the circumstances surrounding these items were corrected, the inspector stated that the response to this report need only address actions to prevent recurrence.

b. Review of Operating Logs and Records

A review of logs and records was made to identify significant changes and trends, to assure required entries were being made, to verify Operating Orders conform to the Technical Specifications, to verify proper identification of abnormal conditions, and to verify conformance to reporting requirements and Limiting Conditions for Operation. The following records were reviewed for the report period:

- Shift Supervisor's Log
- Unit 1 Control Room Operators Log
- Unit 2 Control Room Operators Log
- Nuclear Plant Engineer - Operations Notes and Instructions
- Unit 1 and 2's Control Room Daily Operating Logs (ampling Review)
- Service Building Operators Log (May 13-20, 1980)
- Operations - Rad Chem Daily Sample and Status Update Reports (April 29-May 4, 1980)
- Operating Log - Cove Point Telephone System (January 4-May 7, 1980)
- Plant Transients and Operating Cycles, Unit 1 and Unit 2, 1980 entries
- Radiation Control Smooth Log (May 9-14, 1980)

As described in Paragraph 5.b, two items of noncompliance were identified during this inspection relating to the logging and reporting of the inoperability of the Unit 1 AFW systems on May 20, 1980.

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4. Review of Events Requiring One Hour Notification of the NRC

The circumstances surrounding the following events requiring prompt (one hour) notification of the NRC via the dedicated telephone (ENS Network) were reviewed.

-- Industrial Accident. About 10:45 a.m. on May 14, 1980, because a bolt broke during scaffolding assembly in the Auxiliary Building, a cross beam fell, striking a contractor employee across the neck and back. At 11:07 a.m. he was taken by ambulance to Calvert Memorial Hospital where the injuries were assessed as not serious. No radioactive materials were involved. The NRC was notified at 11:20 a.m. by the dedicated (ENS) phone.

-- Loss of the Service Water System (SRW), Unit 1. At approximately 5:35 p.m. on May 20, 1980 while the Unit was at 100% power, No. 12 Service Water Subsystem was returned to service following a routine cleaning of the Heat Exchanger (salt water side) tubes. At 5:50 p.m. low pressure alarms were received on both SRW subsystems. Valve lineups were verified to be correct and an investigation revealed both SRW subsystems were air bound. The reactor was manually tripped at 6:03 p.m. due to rising main turbine bearing temperatures. System venting was commenced and further investigation revealed that the cause of the air ingress was a failed tube in No. 11 Instrument Air Compressor after cooler. Apparently, an air bubble had developed in the idle No. 12 SRW heat exchanger during cleaning and when the system was returned to service both subsystems became airbound due to a common portion of piping in the Turbine Building. The affected cooler was isolated and normal flow was restored to No. 11 SRW at 8:30 p.m., and to No. 12 SRW at 9:45 p.m. after system venting.

ENS notifications to the NRC were made at 7:00 p.m. with an update at 9:39 p.m.

The inspector stated that this item would be unresolved (317/80-06-04) pending receipt and evaluation by the NRC of the 14 day followup LER. The specific concerns of the inspector related to possible noncompliance with the single failure criteria for the SRW subsystems and the specific steps the licensee planned to take to correct this apparent lack of subsystem independence.

5. Review of Licensee Event Reports (LER's)

a. LER's Reviewed

The inspector reviewed LER's submitted to the NRC:RI office to verify that the 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 indicated, and whether the event warranted onsite followup. The following LER's were reviewed:

LER (Unit No.)	Dated	Subject
80-018/03L (1)	4/30/80	No. 11 Control Room Air Conditioning Removed From Service For Maintenance
80-020/03L (1)	4/14/80	Fire Barrier Penetration (Unit 1 Cable Spreading Room to Turbine Building) not Properly Sealed
80-023/03L (1)	5/19/80	Channel B High Startup Rate Trip Inoperable
*80-022/01T (1)	4/25/80	Boron Dilution Incident Analysis Does Not Analyze the Case of a Partial Hot Leg Drain
80-022/01L (2)	4/30/80	No. 23 CHV Pump Suction Relief Line Weld Leak
**80-024/03L (2)	5/13/80	22A RCP Middle Seal Line Flexible Hose Developed a Small Leak
80-025/03L (2)	5/16/80	Channel A RPS Trip Units Bypassed to Troubleshoot Erratic Channel A Computer Flow Alarms
*80-026/03L (2)	5/16/80	Pressurizer Level Control Channels X and Y Bypassed for Corrective Maintenance

* denotes reports selected for onsite followup.
** followup LER to be submitted; this LER remains open.

-- LER 80-022/01T (1) concerned the discovery by the licensee of the fact that the FSAR Safety Analysis Section 14.3, Boron Dilution Incident, had not addressed the case when the RCS may be in a partial drain configuration. The licensee was informed of this item by the NRC Licensing Project Manager.

The inspector reviewed the licensee's corrective actions which included Revision of OP-5, Reactor Shutdown (CCOM Change Report 80-35, dated April 21, 1980) to require an increased shutdown margin of 2% prior to draining the Reactor Coolant System or administratively limiting RCS Makeup to 2 charging pumps. In addition, the inspector reviewed FCR 80-1016 which was initiated to change T.S. 3.1.1.2 to require at least a 2% shutdown margin or $\leq$ 2 charging pumps when the RCS volume is less than 9600 ft^3.

No unacceptable conditions were identified.

-- LER 80-026/03L (2) concerned corrective maintenance to find the cause of a level mismatch for the X and Y hot calibrated pressurizer level channels. The Y channel transmitter was found to have the drain valves cracked open resulting in the level mismatch. Corrective action includes placement of warning tags on these valves when the containment is accessible. This LER will remain open pending NRC examination of the placement of the identification tags.

b. Inoperability of the Unit 1 Auxiliary Feedwater System (AFWS)

At approximately 12:00 noon on May 21, 1980, the licensee informed the Resident Inspector (LER 80-026/01T) that an apparent violation of T.S. Limiting Condition for Operation (LCO) 3.7.1.2, for the AFWS had occurred between approximately 10:00 p.m. on May 20, 1980 to 1:00 a.m. on May 21, 1980.

Investigation by the inspector revealed the following sequence of events.

-- The Reactor was manually tripped from full power at approximately 6:03 p.m. following the loss of both Service Water (SRW) subsystems. (See Paragraph 4)

-- Because SRW provides cooling to the Main Feedwater Pumps, these were secured and the AFWS was used to provide water to the Steam Generators.

-- At approximately 8:30 p.m. the Senior Control Room Operator (SCRO) directed that the AFWS common suction be shifted from No. 12 to No. 11 Condensate Storage Tank (CST). This action was taken to avoid entering the T.S. action statement (minimum water level 150,000 gallons per Unit) for LCO 3.7.1.3, Condensate Storage Tank.

-- Upon being directed to realign the AFWS, the Reactor Operator (RO), utilizing OI-32, Revision 11, dated June 25, 1979 directed the Outside Operator (OSO) to open 1-AFW-131 (11 CST to AFW pump suction) and 1-AFW-167 (11 CST to AFW pump suction) and close 1-AFW-161 (12 CST to Unit 1 AFW pump suction). The RO then entered these valve position changes in the Locked Valve Deviation Log as follows:

Valve	Nomenclature	Position
1-AFW-161	11 CST Supp to U-1 AFW	Locked Open
1-AFW-131	11 CST Outlet	Locked Open
1-AFW-167	12 CST TK Supp.	Locked Shut

The RO had transposed the nomenclature and valve numbers for 1-AFW-161 and 1-AFW-167, although the lineup was correct by nomenclature. The only valve which required any locking devices was 1-AFW-161, the 12 CST Supply to Unit 1 AFW pump common suction. Valves 1-AFW-167 and 2-AFW-167, supplies to Units 1 and 2 AFW pumps suctions from 11 and 21 CST's, respectively, are locked closed as a matter of practice at Calvert Cliffs, although not required by procedures. 1-AFW-131 does not have a locking device installed.

-- At approximately 10:00 p.m., following restoration of the Service Water Systems and regaining the Main Feedwater Pumps, the SCRO directed the Unit 1 Control Room Operator (CRO) to return the AFWS to normal. The CRO directed the oncoming OSO (previous OSO had been relieved) to close 1-AFW-161 and 1-AFW-131 and open 1-AFW-167. The CRO had determined these valve numbers by using the Locked Valve Deviation Log nomenclatures and returning the system to "normal" status by nomenclature. The OSO performed the directed lineup, which resulted in no suction for the Unit 1 AFWS. When the OSO went to the valves he noted that 1-AFW-161 was already closed and 1-AFW-167 was already open. The OSO did not inform the CRO that the valves were already in the position directed.

-- At approximately 1:00 a.m. the Unit 1 Turbine Building Operator noted zero (0) suction pressure to the Unit 1 AFWS and informed the SCRO (new shift). The Unit 1 SCRO reviewed the Locked Valve Deviation Log and directed the OSO to lock open 1-AFW-161, which restored a suction path to the Unit 1 AFWS from No. 12 CST. The Shift Supervisor turned over this item to the oncoming shift supervisor at approximately 08:00 a.m. on May 21, 1980 to investigate exactly what had happened. The Resident Inspector reviewed the Control Room Operators and Shift Supervisors Logs between 7:00 a.m. and 8:00 a.m. and noted the loss of the Service Water System and Unit 1 trip. Neither log contained any entries referring to the inoperability of the AFWS. Subsequent discussions with the Shift Supervisor indicated that the exact status of the AFWS was not clear to him and thus he had turned it over as an investigation item for the oncoming shift. He stated that part of the confusion had resulted from the pressure to get the Unit back online. When questioned regarding why a prompt report had not been made via the Emergency Notification System, the Shift Supervisor stated that he had overlooked or forgotten this reporting requirement. When the inspector questioned the Unit 1 CRO concerning why no log entry had been made regarding the AFWS operability he stated that all he knew at the time was that there had been a problem, that the lineup had been restored, and that he didn't want to get involved.

The inspector determined the following items of noncompliance and unresolved items regarding this occurrence.

-- Violation of Technical Specification L.C.O. 3.7.1.2, inoperability of the AFWS is an item of noncompliance (50-317/80-06-05).

-- Failure to Report the Inoperability of the AFWS within one hour of discovery as required by 10 CFR 50.72(a)(6) is an item of noncompliance (50-317/80-06-06).

-- Failure to log this event in the Shift Supervisor's and Unit 1 Control Room Operator's Logs as required by Administrative Procedures and T.S. 6.8.1 is an item of noncompliance (50-317/80-06-07).

Locking of valves 1 and 2-AFW-167, suctions from respective Unit's AFWS's to Nos. 11 and 21 CST's, respectively when not required by any procedure contributed to the confusion in this incident. In addition, the inspector could not determine any reason for locking these valves closed, nor could the licensee provide any reason. This item is unresolved (50-317/80-06-08).

In addition, the inspector expressed concern that the licensee would shift the AFWS suction away from its preferred source during the course of the incident (a loss of main feedwater, requiring AFWS for decay heat removal) for which the specified quantity of water has been analyzed. The licensee stated that these actions were taken to avoid entry into T.S. action statement, especially for the other unit running at full power. In addition, because electrical power was available in this case, the condensate pumps were left running and they could only return water to the respective units CST (No. 11), and while No. 12 CST was being drawn down, No. 11 CST was close to overflowing.

Further discussions with the licensee concerning this situation revealed that, although both CST's supply piping was built to Seismic Category I, the Number 12 CST had been provided specifically for tornado protection. The Technical Specifications require the AFWS to take a suction from the tornado protected tank. The inspector requested that the licensee evaluate this situation in order to examine the possibility of allowing a Unit's AFWS suction to be aligned to its normal tank during normal operation, with administrative controls to shift suction in the event of tornado warnings. This action would require a Technical Specification Change Request and will be followed by the inspector (50-317/80-06-09).

6. Administrative Controls Relating to Defeat of Safety Actuation Signals

References:

1. NRC ltr dated November 29, 1978 from R. W. Reid to A. E. Lundvall, Jr., "Containment Purging During Normal Plant Operations."

2. BG&E ltr dated January 12, 1979 from A. E. Lundvall, Jr., to R. W. Reid, "Containment Purging During Normal Plant Operations."

3. BG&E ltr dated April 10, 1979 from A. E. Lundvall, Jr., to R. W. Reid, "Manual Bypasses of ESFAS Signals."

4. BG&E ltr dated June 21, 1979 from A. E. Lundvall, Jr., to R. W. Reid, "Manual Bypasses of ESFAS."

5. NRC ltr dated September 27, 1979 from D. G. Eisenhut to ALL Light Water Reactors "Containment Purging and Venting During Normal Operation."

6. NRC ltr dated October 23, 1979 from R. W. Reid to A. E. Lundvall, Jr., "Containment Purging and Venting During Normal Operation."

7. BG&E ltr dated November 15, 1979 from A. E. Lundvall, Jr., to R. W. Reid, "Containment Purging and Venting."

8. BG&E ltr dated December 14, 1979 from A. E. Lundvall, Jr., to R. W. Reid, "Containment Purging and Venting."

The inspector reviewed the listed references to determine the status of implementation of procedural controls/system modifications to ensure that manual overrides of Engineered Safety Features Actuation Systems (ESFAS) are annunciated at the system level and that override of one signal does not also cause the bypass of any other safety actuation signals. The licensee responded in reference (2) with a summary of their systems review and a listing of those equipments requiring further evaluation of the override features.

The specific components involved were:

a. Switchgear Room air-conditioning compressor.

b. Control Room air-conditioning compressor.

c. Boric Acid Pumps.

d. Diesel Generator Feeder Breakers

e. Nos. 12 and 22 Service Water Heat Exchangers Salt Water Inlet Valves.

f. Nos. 12 and 22 Component Cooling Water Heat Exchangers Salt Water Inlet Valves.

Reference 3 reported the licensees completion of evaluation of these items and planned course of action.

-- With respect to Items a and b above, local handswitches were to be removed.

Reference 4 corrected the location of controls for the Switchgear Room air conditioning compressor and deleted the removal of these handswitches because of local system operation. Item C was listed in error. Item d concerned utilizing the "pull to lock" feature for the breaker. The inspector observed that the Green open indication light does go out in the pull to lock position and that the hand switch orientation in the pull to lock position is obvious. The handswitches for the Diesel Breakers did have Administrative Controls (caution tags affixed) to caution against utilizing the pull to lock feature. The licensee plans no further action with respect to the Diesel Feeder Breakers. Items E and F above were similar, in that the heat exchanger isolated annunciation would only alarm if both the inlet and outlet valves were closed (component cooling water) or the inlet valves were closed (Service Water Heat Exchangers). These annunciators were to be modified to alarm if either the respective inlet or outlet salt water cooling valves were closed.

Reference 4 also noted the requirement for a SIAS signal to be present to receive a heat exchanger isolated alarm and stated that this portion of the logic would be removed.

The inspector reviewed FCR (Facility Change Request) 79-1009, Unit 1 Supplement 1 and Unit 2 Supplement 0, approved for implementation March 27, 1980. The inspector noted, by review of the electrical diagrams incorporated in the FCR, that the system modifications delineated above are planned in the FCR.

This item will remain open (317/80-06-10; 318/80-06-05) pending completion of the Facility Changes.

With respect to the operation of the Containment Purge Valves, the licensee committed to purge less than 90 hours/year/unit during power operation. The inspector reviewed the Units 1 and 2 Containment Purge logs and noted that, since they were started in October, 1979, Unit 1 was purged for less than 27 hours, and Unit 2 has not been purged (Modes 1-4). Subsequent

correspondence from the NRC (References 5 and 6) has questioned the ability of the containment purge and vent valves to close against LOCA conditions and the qualifications of solenoids used in the control circuitry. The licensee has committed (Reference 7) to implement a containment purge and vent valve qualification program. The licensee committed to the interim NRC position for purge and vent valve operation (Reference 8) and has determined, in consultation with the valve manufacturer (Henry Pratt Company) that the outboard valves may be opened to a disk opening of 20^{o} through 40^{o} and the inboard valves to a disk opening of 25^{o} through 45^{o}. In addition to these actions, the licensee committed to add SIAS (Safety Injection Actuation Signal) closure to the existing CIS (Containment Isolation Signal) and CRS (Containment Radiation Signal) for the purge and vent valves. Until the qualifications of the solenoids are established the Nuclear Plant Engineer-Operations has written Standing Order 79-6, issued November 27, 1979 to require not opening the Containment Purge Valves during Modes 1-4 and utilization of the Containment Normal sump drain to ECCS pump room sump flow path to vent containment. The inspector also noted (Lifted wire log entry on May 30, 1980, No. 1-80-16) that the leads are lifted to the purge and vent valve controlling solenoids. The status of the Containment Purge Valves is continuing to be examined by the NRC, Division of Operating Reactors.

No unacceptable conditions were identified during this inspection.

7. Radiation Protection/Emergency Planning Evaluation

The inspector participated in various portions of the Radiation Protection/Emergency Planning Evaluation performed between May 12-23, 1980. That participation included tours of the various plant areas, discussions with technicians and workers, and participation in meetings with licensee management. Findings relating to this team inspection are detailed in Inspection Report 50-317/80-09, 50-318/80-07.

8. Training

The inspector attended General Orientation Retraining Lectures Parts I and II and the Respiratory Protection Retraining on May 20, 1980. In addition, the inspector reviewed a new film for Fire Protection Orientation which is to be incorporated in the General Orientation Training Program. The inspector verified that the lesson plan objectives were met and the approved program schedule.

No unacceptable conditions were identified.

9. Meeting With Federal Bureau of Investigation Official

The inspector held a meeting with a representative of the Federal Bureau of Investigation (Baltimore Division) and the licensee's Security Supervisor onsite on May 29, 1980. Various aspects of the Security Plan were addressed and a discussion was held detailing the responsibilities of the FBI and the NRC with respect to threats, theft and sabotage. This meeting specifically utilized the FBI and NRC Memorandum of Understanding for Cooperation Regarding Threat, Theft or Sabotage in U. S. Nuclear Industry, dated December 13, 1979. The meeting and site visit were beneficial in acquainting participants in the capabilities and responsibilities of the Agencies.

10. Review of Periodic and Special Reports

Upon receipt, periodic and special reports submitted by the licensee pursuant to Technical Specification 6.9.1 and 6.9.2 were reviewed by the inspector. This review included the following considerations: the report includes the information required to be reported by NRC requirements; test results and/or supporting information are consistent with design predictions and performance specifications; planned corrective action is adequate for resolution of identified problems; determination whether any information in the report should be classified as an abnormal occurrence; and the validity of reported information. Within the scope of the above, the following periodic reports were reviewed by the inspector.

-- April, 1980, Operations Status Reports for Calvert Cliffs No. 1 Unit and Calvert Cliffs No. 2 Unit, dated May 15, 1980.

No unacceptable conditions were identified.

11. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable, items of noncompliance or deviations. Unresolved items addressed during this inspection are discussed in Paragraphs 3 and 5 of this report.

12. Exit Interview

Meetings were held with senior facility management periodically during the course of this inspection to discuss the inspection scope and findings. A summary of inspection findings was also provided to the licensee at the conclusion of the report period.

In addition, the Vice President-Supply met with the inspector on May 22, 1980 to discuss his review of the Inoperability of the Auxiliary Feedwater System, the actions which had been taken as of that date, and to express his concern regarding this event.