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U. S. NUCLEAR REGULATORY COMMISSION
Region I

Docket/Report 50-317/82-29 License: DPR-53
50-318/82-25 DPR-69

Licensee: Baltimore Gas and Electric Company

Facility : Calvert Cliffs Nuclear Power Plant, Units 1 & 2

Inspection At: Lusby, Maryland

Dates: November 10 - December 14, 1982

Submitted:

Elbe McCabe, Jr 12/27/82
R. E. Architzel, Sr. Resident Inspector date

Elbe McCabe, Jr 12/27/82
D. C. Trimble, Resident Inspector date

Approved:

Elbe McCabe 12/30/82
E. C. McCabe, Jr., Chief, Reactor Projects Section 2B date

Summary:

11/10-12/14/82. Inspection Report 50-317/82-29, 50-318/82-25.

Routine resident inspection (123 hours) of the control room, accessible parts of plant structures, plant operations, radiation protection, physical security, fire protection, plant operating records, maintenance, surveillance, radio-active waste releases, open items, TMI Action Plan items, Plant Operations and Safety Review Committee activities, and reports to the NRC. No violations were identified.

DETAILS

1. Persons Contacted

The following technical and supervisory personnel were contacted:

- D. E. Buffington, Fire Protection Inspector
- J. T. Carroll, General Supervisor, Operations
- R. Cantrell, Senior Materials Engineer
- R. E. Denton General Supervisor, Training/Technical Services
- C. L. Dunkerly, Shift Supervisor
- W. S. Gibson, General Supervisor, Electrical & Controls
- D. W. Latham, Principal Engineer, OL&S Unit
- J. F. Lohr, Shift Supervisor
- G. S. Pavis, Engineer, Operations
- J. E. Rivera, Shift Supervisor
- L. B. Russell, Plant Superintendent
- J. A. Tiernan, Manager, Nuclear Power Department
- D. Zyriek, Shift Supervisor

Other licensee employees were also contacted.

2. Licensee Action on Previous Inspection Findings

(Closed) Unresolved Item (317/82-26-04) Procedure Limit for Group II Release Rate. RCP-1-604 has been revised (change 82-027, approved 10/29/82) to require that a Gaseous Multiple Release Permit (procedure attachment 6) be completed whenever radioactive gaseous waste is being discharged from any 2 or more continuous or batch release sources. The procedure and attachment were also revised to specify the correct Group II release rate as 2.0 uCi/sec.

(Open) Unresolved Item (317/82-23-03) Design Adequacy of the Chemical and Volume Control Isolation System (CVCIS). This item was reexamined by the NRC during this inspection (Detail 7.b).

(Closed) Violation (318/82-07-06) and (318/82-16-02), Failure to Clear Tagout on a Service Water Pump following Maintenance and Failure to Clear Tag on Post Accident Sampling System Valve following Installation Testing. The licensee responded to these violations in letters dated 6/22 and 10/15/82. The inspector verified implementation of the licensee's corrective action. Actions taken included revising CCI-112, Safety and Safety Tagging by specifically requiring that all additions to tagouts be performed in a similar manner as the original tagouts and that the procedure was revised (Revision D, dated 10/10/82) to require the Watch Engineer's stubs to be maintained at the Control Room Operator's desk to keep the Control Room personnel aware of tagout status. Proper implementation of tagout requirements will be routinely examined in future NRC inspections.

(Closed) Unresolved Item (317/82-07-04, 318/82-07-04) Develop and Implement Method for Independent Verification of High and Low Voltage Permits. CCI-112D, revised 10/10/82, now requires a second check (independent verification) upon removal from and restoration to service for Low Voltage and Outage Tagout Requests. This change is in accordance with the guidance of TMI Action Plan Item I.C.6, Verify Correct Performance of Operating Activities.

3. Review of Plant Operations

a. Daily Inspection

The inspector toured the facility to check manning, access control, and adherence to approved procedures and LCO's. Instrumentation and recorder traces were reviewed. Nuclear instrument panels and other reactor protective systems were examined. Control rod insertion was checked against limits. Containment temperature and pressure were reviewed. Nuclear instrument panels and other reactor protective systems were examined. Status of control room annunciators was reviewed. Stack monitor recorder traces were reviewed for indications of releases. Panel indications for onsite/offsite emergency power sources were examined for automatic operability. Control room, shift supervisor, and tagout log books, and operating orders were reviewed for operating trends and activities. During egress from the protected area, the inspector checked operability of radiological monitoring equipment and radioactivity monitoring done before release of equipment and materials to unrestricted use.

These checks were performed on the following dates: 11/9, 11/10, 11/12, 11/17, 11/19, 11/23, 11/24, 12/8, 12/9, 12/10, 12/13, 12/15, and 12/16/82.

On 11/12/82 the inspector noted that the Unit 2 Main Vent Particulate Radiation Monitor was alarming on low flow. The inspector informed the Control Room Operator who was not aware of the alarm. The operator initiated a Maintenance Request for monitor repair.

b. Weekly System Alignment Inspection

Operating confirmation was made of selected piping system trains. Accessible valve positions in the flow path were examined. Power supply and breaker alignment was checked. Visual inspections of major components were performed. Operability of instruments essential to system performance was assessed. The following systems were checked:

- 22 Low Pressure Safety Injection Pump shutdown cooling/recirculation flow path on 11/19/82.

- Lineup of Unit 1 Salt Water System in the Intake Structure on 11/12/82.
- Lineup checks of the Unit 1 Service Water and Salt Water Systems in the Unit 1 Service Water Pump Room was verified on 11/12/82.

c. Biweekly Inspection

Verification of the following tagouts indicated the action was properly conducted.

- Tagout 34388, Salt Water System (Header #21), verified on 11/12/82
- Tagout 481, Diesel Generator #12, verified on 11/12/82.

Boric acid tank samples were compared to the Technical Specifications. Tank levels were also confirmed.

d. Other Checks

During plant tours, the inspector observed shift turnovers, security practices at vital area barriers, completion and use of radiation work permits, protective clothing and respirators. Personnel monitoring practices, and area radiation and air monitor use and operational status were reviewed. Equipment tagouts were sampled for conformance with LCO's. Plant housekeeping and cleanliness were evaluated. Other LCO's, including RCS Chemistry and Activity, Secondary Chemistry and Activity, watertight doors, and remote instrumentation were checked.

About 10:40 p.m., 11/19/82, on the 10 foot elevation of the Unit 1 Containment, smoke was seen coming from a trash can holding Hydrazine soaked cheesecloth rags which had been used to clean the Hydrazine Addition Tank. The fire was immediately extinguished by means of a CO2 fire extinguisher and the rags were removed from Containment. The licensee's Fire Protection Inspector believed the fire was caused by spontaneous ignition from a chemical reaction associated with the Hydrazine. The licensee plans to conduct further investigation to determine better methods of handling and disposing of Hydrazine. Final licensee resolution of this problem will be reviewed during a future inspection (318/82-25-01).

At 4:16 a.m. on November 19, 1982, a small fire was discovered in the Outage Planning Room on the second floor of the South Service Building. The building is in the protected area but not adjacent to safety-related structures nor does it house safety-related equipment. A BG&E employee walking past the room discovered the fire, reported it to the Control Room and extinguished it with water. The fire was contained on a desk top in the room and appeared to be caused by a flammable liquid which had been poured in the base

of a plastic tape dispenser. A burnt match and the partially melted tape dispenser were on the table top. No other damage occurred. A State of Maryland Fire Marshall and licensee investigators looked into the incident. The inspector talked with the investigators and examined the area in question. The fire was too small to actuate the sprinklers in the overhead of the Outage Planning Room. Region I received 24 hour notification of this incident from the Security Supervisor at 8:42 a.m. on 11/19/82 and subsequently notified the FBI. An FBI agent from the Baltimore, Maryland office came to the site during the afternoon of 11/19/82 to followup on the licensee's investigation. No violations were identified. The perpetrator has not been identified. No similar incidents have been identified.

During the week beginning 11/8/82, the inspector received a worker complaint that electrical cable containing asbestos was being improperly disposed of by a licensee subcontractor. The inspector notified the Industrial Safety Inspector of the complaint. The licensee inspector immediately investigated, verified that the complaint was valid, and initiated corrective action.

At 8:55 a.m. on 12/9/82 the licensee declared a Radiological Event upon receiving a Unit 1 Main Vent Gaseous RMS Alarm (reading 760 counts per minute, just at the alarm setpoint). The alarm cleared within one minute and was apparently caused by letdown from the Reactor Coolant System (RCS) to the Liquid Waste Processing System. Unit 1 was in the process of returning to full power and frequent dilution of the RCS necessitated diversions to the Waste Processing System. Diverted liquid passes through a degasifier and subsequently into the Reactor Coolant Waste Receiver tanks. The vent on the #12 Reactor Coolant Waste Receiver Tank was recently connected directly to the Auxiliary Building Exhaust System, which exhausts to the Main Vent. Airborne radioactive materials samples taken in various levels of the Auxiliary Building during this event indicated no above normal levels. Repetition of the diversion resulted in increased Main Vent Gaseous Monitor response confirming the source of the activity. The inspector observed the licensee's response to this event, which had been declared to evaluate the indications of airborne activity and was terminated shortly after 9:00 a.m. No unacceptable conditions were identified with respect to the licensee's actions or evaluation of this event which is considered to be a normal operational increase in Main Vent release rate.

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

The circumstances surrounding the following events requiring prompt NRC (one hour) notification per 10CFR50.72 via the dedicated telephone (ENS-line) were reviewed.

The Unit 1 Reactor tripped at 9:55 a.m. on 11/9/82 on Low Steam Generator (S/G) level in #11 S/G following a loss of 120 V a.c. power to the Main Feedwater Regulating Valves. Immediately prior to the trip, operator

attempts to control S/G level by local manual operation were unsuccessful. The 120 V a.c. power was lost when a breaker supplying d.c. power to #11 inverter opened. It was believed that the breaker was bumped open accidentally by personnel pulling cable in the Cable Spreading Room. Following the plant trip, the inspector observed operator response to the event in the Control Room and inspected the Cable Spreading Room in the vicinity of the tripped breaker. Operator response was appropriate. During the event the breaker supplying normal a.c. power to the #11 4160 volt bus tripped. The licensee initiated an Event Report investigation. On 11/22/82 the inspector learned that the probable cause of trip of the 4160 volt breaker was an Engineered Safety Features Actuation System (ESFAS) bus Under Voltage (U.V.) trip. When d.c. power to the inverter was lost, a transient occurred in inverted power output causing spurious ESFAS Channel 'A' U.V. actuation. No actual injection occurred.

While Unit 2 was in Mode 6, ESFAS (Safety Injection, Channel A) actuations occurred at 3:08 p.m. on 11/10 and again at 8:27 a.m. on 11/11/82. Both actuations were caused by technician error while performing Surveillance Test Procedure M-520-2, Refueling Engineered Safety Features Actuation System Calibration. The 11/10/82 trip occurred when a technician attempted to terminate a test, prior to its completion, after seeing what he believed to be an off-normal indication (later investigation showed that the indication was proper). A system low pressure block was not correctly reinserted. The 11/11 trip occurred when a technician again did not correctly insert a system low pressure block. The procedural step directing block insertion was obscured beneath the clip of the clipboard carrying the surveillance procedure. The licensee plans to reprint the surveillance procedure and ensure that procedural steps appear low enough on each page such that they will not be obscured during clipboard use. A general licensee problem of ESFAS trips due to technician error was addressed in the current SALP Report for this facility dated 12/8/82 and discussed in the SALP Management meeting on 12/14/82. Safety system actuations caused by technician errors will be closely followed by the NRC (318/82-25-02).

About 12:50 p.m. on 12/1/82 the licensee notified the NRC of an act which threatened the safety of site personnel. A contractor employee, apparently disgruntled by the loss of his lunch from a common use refrigerator within the protected area three days in a row, reportedly put a sandwich laced with poison and animal feces in his lunch on 12/1/82. That day, upon discovery that his lunch was missing again, the employee notified the licensee about 12:30 p.m. of his actions and the potential danger to the individual involved. The licensee announced the event on the plant page system several times, requesting the lunch taker to report to the Site Medical Representative for treatment. No one came forth. No illness attributable to this incident has been identified. The contractor employee involved worked in the Sewage Treatment Plant and did not have access to vital plant areas; the licensee denied this individual further access to plant property.

A loss of load Turbine Trip/Reactor Trip occurred at 2:26 p.m. on 12/8/82, when the Control Room Operator selected the Manual Sequential Mode for operation of the Control Rod Drive System. All five regulating group rods (which were at 132") began moving outward when an out motion command was given, creating an under-voltage condition on the rod trip bus, causing the trips. The simultaneous motion of all regulating group rods occurred because they were inserted below the upper computer stop (133.5") to minimize guide tube wear problems. In order to minimize wear of the CEA guide tubes, the positions of the CEAs is varied between 132" and 135" each month. (Technical Specifications consider the rods fully out above 129".) As discovered on 12/8, when the CEAs are below the upper computer stop of 133.5", all CEAs will move out in the manual sequential mode of operation. The licensee stated that Operating Procedures would be revised to preclude recurrence. The inspector observed the licensee's post trip recovery actions from the Control Room. Safety systems functioned as designed and the event was reported as required. The NRC will review (317/82-29-01) the revised operating procedures and the mechanism by which this rod insertion practice was implemented and reviewed for operational impact.

At 7:46 a.m. on 12/15/82 #11 Containment Air Cooler tripped and was declared inoperable. The licensee then determined that two of the remaining three coolers (#13 and #14) were inoperable because their backup emergency power source (#12 Diesel Generator) was out of service. The licensee entered a one hour Technical Specification Action Statement per T. S. 3.0.3. At 8:30 a.m. emergency backup power was restored by aligning #21 Diesel Generator to #14 bus. The licensee then continued operation in T. S. Action Statement 3.6.2.2 (for an inoperable cooler).

5. Radioactive Waste Releases

Records and sample results of the following radioactive waste releases were reviewed to verify conformance with regulatory requirements prior to release.

- Gaseous Waste Permit G-139-82, release of #13 Waste Gas Decay Tank on 11/10/82.
- Liquid Waste Tank Release Permit M-180-92, release of #11 Miscellaneous Waste Monitor Tank on 11/14/82.

No unacceptable conditions were identified.

6. Observation of Physical Security

The resident inspector checked, during regular and offshift hours, on whether selected aspects of security met regulatory requirements, physical security plans, and approved procedures.

a. Security Staffing

- Observations and personnel interviews indicated that a full time member of the security organization with authority to direct physical security actions was present, as required.
- Manning of all three shifts on various days was observed to be as required.

b. Physical Barriers

Selected barriers in the protected area and the vital areas were observed. Random monitoring of isolation zones was performed. Observations of truck and car searches were made.

c. Access Control

Checks were made of identification, authorization, and badging, access control searches, escorting, communications, and compensatory measures when required. No violations were identified.

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

- a. LER's submitted to NRC:RI were reviewed to verify that the details were clearly reported, including 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.

<u>LER No.</u>	<u>Event Date</u>	<u>Report Date</u>	<u>Subject</u>
<u>Unit 1</u>			
82-57	9/27/82	10/26/82	Channel A Th reading 11 degrees low
82-58	10/19/82	11/05/82	ESFAS Sensor Channel ZE for #11 S/G pressure failed
82-59	10/07/82	11/05/82	RPS Channel D trip units for high power thermal margin/low pressure & axial shape index bypassed
82-63	10/04/82	11/12/82	Spent Fuel Pool Ventilation System inoperable
82-64	10/14/82	11/12/82	RWT inadvertently drained (to Spent Fuel Pool) to a level of 455 inches

82-70	11/18/82	12/02/82	Location of pressure transmitters caused CVCIS to be inoperable
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Unit 2

82-50	10/17/82	11/12/82	MSIV stroked shut in 12.72 seconds, exceeding TS limits
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82-51	10/15/82	11/12/82	Turbine Building Service Water Isolation Valve inoperable
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82-52	10/25/82	11/09/82	Audible Source Range Indication inoperable.
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- b. For the LER's selected for onsite review, the inspector verified that appropriate corrective action was taken or responsibility assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

1/82-70, Design Adequacy of the Chemical and Volume Control Isolation System (CVCIS). As a precautionary measure while performing an engineering review of the design adequacy of the CVCIS system, the licensee placed one Unit 1 sensor channel in a tripped condition, changing the actuation logic from two out of four sensor trips to one out of three.

During the week of November 29, 1982 the licensee discovered that an air passage (described in the FSAR) in the wall between the West Piping Penetration Room and the Letdown Heat Exchanger Room had been blocked off by a metal plate. This plate prevented communication of pressure changes between the two rooms. After learning of the presence of the plate (on 12/6/82) the inspector contacted licensee management personnel and questioned the ability of the sensors in the Letdown Heat Exchanger Room to sense an adverse pressure in the West Piping Penetration Room. He requested the licensee to review Technical Specification 3.3.2.1 to see if additional action was necessary now that sensor operability in the Letdown Heat Exchanger Room could not be assured. On 12/7/82 the licensee concluded that Technical Specifications required that Unit 1 should be placed in a 48 hour TS Action Statement. Unit 2 was in a refueling outage. During the 48 hour period, the licensee initiated action under Facility Change Request 82-1057, initiated on 12/7/82, and the associated Safety Evaluation. The change was to restore the design of the CVCIS sensors by restricting air passage from the Letdown Heat Exchanger Room to the 27 foot elevation passageway and by providing a means for the communication of pressure changes between the West Piping Penetration and the Letdown Heat Exchanger Rooms.

The modification basically installed a 1/8" steel plate on the existing Letdown Heat Exchanger Room wire cage door, sealed other openings around this door, and opened a piping knockout (approximately 4x2') between the two rooms. (The wall between the rooms was not a fire barrier.) The inspector also examined the completed modifications and post maintenance testing (verification of proper direction air flow into the Piping Penetration Room with the exhaust fans running) on 12/9/82. No unacceptable conditions were identified.

8. Plant Maintenance

The inspector observed and reviewed maintenance and problem investigation activities to verify compliance with regulations, administrative and maintenance procedures, codes and standards, proper QA/QC involvement, safety tag use, equipment alignment, jumper use, personnel qualifications, radiological controls for worker protection, fire protection, retest requirements, and reportability per Technical Specifications. The following activities were included.

- MR-M-82-6632, observed portion of new cubicle installation for the Unit 2 Auxiliary Feedwater System Upgrade (FCR 79-1062, Work Package 79-1062-E-36-II, on 11/19/82.
- MR-M-82-2343, observed portion of repair of 2 CV 5170, Salt Water Supply Valve to #21 ECCS Pump Room Cooler on 11/14/82.
- MR-M-82-2693, observed portion of overhaul of Unit 2 Personnel Air Lock Door operating mechanism (FCR 82-24) on 12/9/82.
- MR-M-82-6587, installation of spare type 4-A/4-B Unit 2 Containment Electrical Penetration (FCR-80-1060), observed on 11/23/82.

During the observation of work on spare type 4-A/4-B electrical penetrations, the inspector noted that Containment Liner Welds were being ground flush, however, no directions to perform such grinding were included in the maintenance package. The inspector noted that the Weld Authorization Traveller for the welding (Serial No. MEN-82-8064) only specified magnetic particle testing. The workers involved stated they were grinding the cap off the weld in preparation for ultrasonic examination. The Quality Control Inspector following the job had already identified the failure to specify the ultrasonic testing on the Weld Authorization Traveller as a finding on his QC inspection report. The code classification of the welds was listed as not applicable for Section XI, however, Section III, Subsection m.e., 1977 edition was specified as the appropriate code for the welds. The inspector discussed the nondestructive testing (NDT) being performed on the Containment Penetration Welds with the licensee's responsible engineer and an NRC Region I specialist. An ultrasonic examination of the welds was being

performed in accordance with Southwest Research Institute NDT Procedure 600-41, Revision 4, dated March, 1982. The inspector reviewed the procedure and selected Unit 1 NDT examinations summary records (similar welds and NDT's were performed on Unit 1 during the spring of 1982).

The NRC specialist stated that it was standard practice to grind welds flush prior to performing an ultrasonic examination as a part of the examination itself, and that specific authorization was not necessary. The specialist noted that the code required radiographic examination of Containment penetration liner welds, however, in case of interference or other inability to perform radiography, an exemption request allowing the use of ultrasonic examination would be appropriate. Discussions with the responsible engineer indicated that, due to physical constraints, radiography was not feasible for the subject welds, and that ultrasonic testing using both straight and angle beam examinations from both sides of the welds were made in lieu of radiography. The licensee further stated that they did not believe an exemption request was required for the NDT performed, in that the original welds were not made to ASME Section III requirements. The inspector had no further questions regarding the Containment penetration welds, however a copy of the Southwest Research examination procedure and selected examination results were forwarded to NRC Region I for review. This item will remain open (318/82-25-03) pending further NRC review.

9. Surveillance Testing

The inspector observed parts of tests to assess performance in accordance with approved procedures and LCO's, test results (if completed), removal and restoration of equipment, and deficiency review and resolution. The following tests were reviewed.

- STP M-522-2, Undervoltage Relay Calibration and Response Time Test, observed on 12/7/82.
- T-82-00049, Post Modification Testing of Flow between the Letdown Heat Exchanger Room and the Unit 1 West Piping Penetration Room, observed on 12/9/82.
- Observed sampling of the Unit 1 Travelling Screens for impingement per Environmental Operating Procedure-15, Impingement Studies on 11/22/82.

No unacceptable conditions were identified.

10. Review of Welding Program

Review of the licensee's qualified welding procedure P4-LH, "Hard Surfacing and Repair of Hard Surfacing on P4 Base Metals Using the Shielded Metal Arc Welding" showed that the procedure specified a range of welding machine current (90-125 amps) to be used. Subsequent

discussions with QA, Maintenance, and Materials personnel showed that welding machines are not included in the licensee's routine calibration program. Additionally, although calibrated clamp-on ammeters are available on site and could be used in the field to check for proper current prior to welding, they are not routinely used for that purpose.

On 12/13/82 the inspector expressed concern to the licensee's Senior Materials Engineer that sufficient controls may not exist to ensure welding operations are being conducted using proper weld current. The engineer stated that he would review the controls in this area and indicated that control upgrades may be appropriate. This item is unresolved pending licensee review of its controls on welding machine current (317/82-29-02).

11. Observation of Refueling

On 12/18/82 the inspector witnessed the loading of two fuel assemblies into the core (each conducted by a different operations shift) from the Refueling Machine. Proper licensee compliance with Technical Specifications regarding staffing and Containment integrity were verified. On 11/19/82 the inspector conducted a records review to assess whether Technical Specification surveillance for the fuel handling was being conducted. No unacceptable conditions were identified.

12. Emergency Planning

On 12/9/82 the inspector attended a meeting held by the licensee in preparation for a medical drill scheduled for December 16, 1982. The drill had been requested by the NRC because of inadequate licensee response to a simulated medical emergency during the 9/28/82 full-scale Emergency Preparedness Exercise. The inadequacy concerned a lengthy response time by the first aid team due to radiation exposure taking unwarranted precedence over injury treatment. During the 12/9/82 meeting the licensee discussed methods of improving its response to medical emergencies. No unacceptable conditions were identified.

13. Plant Operations and Safety Review Committee (POSRC)

The inspector attended POSRC meeting 82-163 held on 12/15/82 as an observer. The meeting was conducted in accordance with the requirements of Technical Specifications 6.5.1.6 and 6.5.1.7, including the provisions for quorum, membership, and review of items for which the committee had responsibility. Items reviewed included proposed modifications to the plant facility, security procedure changes, surveillance test procedure changes, lifted wire/jumper lead entries, Licensee Event Reports, and an operating procedure change. Typically, each agenda item was briefly introduced to the Committee by a presenting individual with knowledge of the item. The item was then discussed and approved or tabled pending receipt of additional information or resolution of discrepancies. No unacceptable conditions were identified. Following the meeting the

inspector asked the POSRC Chairman (the Plant Superintendent) how he ensured that all items requiring POSRC review are placed on the agenda. He stated that most of the items requiring Committee review are directed to the Committee through procedural requirements. Other items are placed onto the Committee's Outstanding Item List (OIL) when the Chairman becomes aware of them and determines Committee review is necessary. The Committee secretary uses the OIL in making up meeting agendas. The inspector later reviewed the meeting minutes and found no discrepancies.

14. Review of Periodic and Special Reports

Upon receipt, periodic and special reports submitted pursuant to Technical Specification 6.9.1 and 6.9.2 were reviewed. That review included the following: Inclusion of information required by the NRC, test results and/or supporting information consistency with design predictions and performance specifications, planned corrective action adequacy for resolution of problems, determination whether any information should be classified as an abnormal occurrence, and validity of reported information. The following periodic report was reviewed:

October, 1982 Operations Status Reports for Calvert Cliffs No.1 Unit and Calvert Cliffs No. 2 Unit, dated November 15, 1982.

No unacceptable conditions were identified.

15. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable. Unresolved items are discussed in paragraphs 4 and 10 of this report.

16. 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 findings was also provided to the licensee at the conclusion of the report period.