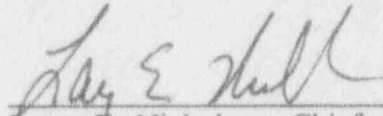


U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report Nos. 50-317/94-09; 50-318/94-09
License Nos. DPR-53/DPR-69
Licensee: Baltimore Gas and Electric Company
Post Office Box 1475
Baltimore, Maryland 21203
Facility: Calvert Cliffs Nuclear Power Plant, Units 1 and 2
Location: Lusby, Maryland
Inspection conducted: February 6, 1994, through March 12, 1994
Inspectors: Peter R. Wilson, Senior Resident Inspector
Carl F. Lyon, Resident Inspector
Henry K. Lathrop, Resident Inspector
Roy L. Fuhrmeister, Project Engineer, DRP
Thomas J. Kenny, Senior Reactor Engineer, DRS

Approved by:


Larry E. Nicholson, Chief
Reactor Projects Section No. 1A
Division of Reactor Projects

3/20/94
Date

Inspection Summary:

This inspection report documents resident inspector core, regional initiative, and reactive inspections performed during day and backshift hours of station activities including: plant operations; maintenance; engineering; and plant support.

Results:

See Executive Summary.

EXECUTIVE SUMMARY

Calvert Cliffs Nuclear Power Plant, Units 1 and 2

Inspection Report Nos. 50-317/94-09 and 50-318/94-09

Plant Operations: (Operational Safety Inspection Module 71707, Prompt Onsite Response to Events at Operating Power Reactors Module 93702) There were no significant operational events during the period.

Maintenance: (Maintenance Observations Module 62703, Surveillance Observations Module 61726) Maintenance orders and surveillance testing were generally characterized by excellent pre-evolution briefs, control, and coordination, as exemplified by pressurizer safety valve testing and AFW flow testing. A non-cited violation was identified during ESF logic testing, however, when a logic module was inadvertently actuated due to lack of self-verification. BG&E had good controls in place for troubleshooting.

Engineering: (Module 71707) BG&E's followup of the reactor vessel seal instrument line leak demonstrated thoroughness and good engineering judgment. The as-found boric acid attack of the Unit 1 in-core instrument studs/nuts was much worse than predicted in an engineering evaluation performed in June 1993. BG&E's root cause analysis of why two dry storage canisters were not vacuum dried to required specifications revealed a procedural noncompliance due to lack of a questioning attitude that was a non-cited violation.

Plant Support: (Module 71707) BG&E declared an Unusual Event and responded appropriately to a loss of onsite meteorological instrumentation during a winter storm.

The fuel assemblies offloaded from Unit 1 had no leaks. BG&E noted that good chemistry control was a significant contributing factor to this success.

The weekly plant housekeeping report was a good initiative begun to focus supervisory attention on problem areas during the outage.

Safety Assessment/Quality Verification: (71707, Evaluation of Licensee Self-Assessment Capability Module 40500) The engineering evaluation of the reactor vessel seal instrument line leak was updated as new information became available from inspection and metallurgical examination, demonstrating good follow-up and thoroughness. BG&E was investigating why the June 1993 operability evaluation of the in-core instrument flange leaks was not validated by as-found conditions.

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DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

Unit 1 began the period at full power. BG&E shut down the unit on February 8 to begin a refueling outage. The unit entered Mode 5 (cold shutdown) on February 10 and Mode 6 (refueling) on February 18. Core offload was begun on February 26, 1994 and completed on March 2, 1994.

Unit 2 operated at power without significant incident for the entire period.

2.0 PLANT OPERATIONS

2.1 Operational Safety Verification

The inspectors observed plant operation and verified that the facility was operated safely and in accordance with licensee procedures and regulatory requirements. Regular tours were conducted of the following plant areas:

- | | |
|-----------------------------------|---------------------------|
| -- control room | -- security access point |
| -- primary auxiliary building | -- protected area fence |
| -- radiological control point | -- intake structure |
| -- electrical switchgear rooms | -- diesel generator rooms |
| -- auxiliary feedwater pump rooms | -- turbine building |

Control room instruments and plant computer indications were observed for correlation between channels and for conformance with technical specification (TS) requirements. Operability of engineered safety features, other safety related systems and onsite and offsite power sources was verified. The inspectors observed various alarm conditions and confirmed that operator response was in accordance with plant operating procedures. Compliance with TS and implementation of appropriate action statements for equipment out of service was inspected. Plant radiation monitoring system indications and plant stack traces were reviewed for unexpected changes. Logs and records were reviewed to determine if entries were accurate and identified equipment status or deficiencies. These records included operating logs, turnover sheets, system safety tags and temporary modifications log. The inspectors also examined the condition of meteorological and seismic monitoring systems. Control room and shift manning were compared to regulatory requirements and portions of shift turnovers were observed. The inspectors found that control room access was properly controlled and that a professional atmosphere was maintained.

In addition to normal utility working hours, the review of plant operations was routinely conducted during backshifts (evening shifts) and deep backshifts (weekend and midnight shifts). Extended coverage was provided for 12 hours during backshifts and 5 hours during deep backshifts. Operators were alert and displayed no signs of inattention to duty or fatigue.

The inspectors observed an acceptable level of performance during the inspection tours detailed above.

2.2 Followup of Events Occurring During Inspection Period

There were no significant operational events during the period.

2.3 Plant Operations and Safety Review Committee

The inspectors attended several Plant Operations and Safety Review Committee (POSRC) meetings. TS 6.5.1 requirements for required member attendance were verified. The meeting agendas included safety significant issue reports, proposed tests that affected nuclear safety, 10 CFR 50.59 evaluations, reportable events, and proposed changes to plant equipment that affected nuclear safety. Overall, the level of review and member participation was satisfactory in fulfilling the POSRC responsibilities.

3.0 MAINTENANCE

3.1 Maintenance Observation

The inspector reviewed selected maintenance activities to assure that:

- the activity did not violate technical specification limiting conditions for operation and that redundant components were operable;
- required approvals and releases had been obtained prior to commencing work;
- procedures used for the task were adequate and work was within the skills of the trade;
- activities were accomplished by qualified personnel;
- where necessary, radiological and fire preventive controls were adequate and implemented;
- quality verification hold points were established where required and observed; and
- equipment was properly tested and returned to service.

The work observed was performed safely and in accordance with proper procedures. Inspectors noted that an appropriate level of supervisory attention was given to the work

depending on its priority and difficulty. Notable observations are included below for selected activities. Maintenance activities reviewed included:

MO 19301575 Setpoint test of 1-RV-200 and 201

The pre-evolution brief included good discussion of potential problems and desired responses. Responsibilities for test control were properly distributed and the test was well-executed.

MO 29401224 Replace broken stud on Unit 2 ECCS exhaust filter housing sample tray

The MO resulted from discovery of the broken stud and a test equipment failure following a routine change of the charcoal filters. Good coordination between the engineering, maintenance, procurement, and test units was required to resolve the problem before the expiration of the technical specification action statement.

MO 19305914 Install freeze seal on Unit 1 pressurizer surge line

Pre-evolution briefs to the operating crews included contingency plans and initial conditions. Operators were attentive and suggested several enhancements that were incorporated into the setup. BG&E was unable to establish the freeze seal plug, however, due to existing thermal conditions in the pressurizer, the pipe, and the refueling pool. Further NRC inspection of the freeze seal was documented in NRC Inspection Report 50-317 and 318/94-11.

MO 19305927 Weld SW pump discharge piping supports

Inspectors noted good supervision and attention to detail.

MO 19303478 Convert 11 EDG from present 300 HP/cylinder turbo blower parallel arrangement to 350 HP/cylinder turbo blower series arrangement

MO 19301105 Overhaul 12 AFW pump

3.2 Surveillance Observation

The inspectors witnessed/reviewed selected surveillance tests to determine whether properly approved procedures were in use, details were adequate, test instrumentation was properly calibrated and used, technical specifications were satisfied, testing was performed by qualified personnel, and test results satisfied acceptance criteria or were properly dispositioned.

The surveillance testing was performed safely and in accordance with proper procedures. Inspectors noted that an appropriate level of supervisory attention was given to the testing

depending on its sensitivity and difficulty. Notable observations are included below for selected activities. The following surveillance testing activities were reviewed:

STP M-2-1 Pressurizer Safety Valve Testing

STP O-73H-1 AFW Large Flow Testing

Inspectors noted excellent pre-evolution briefs and test control for both STPs. There was good discussion of contingencies for potential problems and a good safety perspective. Alarm conditions as a result of the testing were anticipated by the operators and response was appropriate.

STP O-11-2 ECCS pump room ventilation test

STP O-7A-2 A Train ESF Logic Monthly Testing

Logic module A-8 was inadvertently actuated by the logic cabinet operator. The intention of the test step was to actuate the A-7 module. The operator apparently became distracted by an abnormality on the sensor cabinet and failed to verify his finger was on the right button. There was no actual safety consequence to the module actuation. The A-8 module was reset and affected equipment was returned to normal. The inadvertent actuation was reported to the NRC as required by 10 CFR 50.72. BG&E immediately began a root cause analysis of the event. The analysis was still in progress at the end of the period.

Notwithstanding the lack of safety consequence and BG&E's corrective actions, the failure to properly implement the STP was a violation of NRC requirements. TS 6.8.1 requires that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. These included procedures for surveillance testing. The violation was not cited because the criteria for discretion specified in the NRC Enforcement Policy, Section VII.B., was satisfied.

3.3 Review of Troubleshooting Activities

The inspectors performed a review of licensee troubleshooting activities in accordance with guidance provided in NRC Region I Temporary Instruction (TI) 94-01. The objective of this inspection was to assess the effectiveness of BG&E's control of the troubleshooting process, including procedures and past performance. The inspectors concluded that BG&E had good controls in place for troubleshooting performed on both safety and non-safety related equipment/systems.

BG&E had implemented a site-wide procedure which was used by all personnel performing troubleshooting outside the structures of a maintenance order. The procedure, Calvert Cliffs Instruction (CCI) 117, "Temporary Modification Control," clearly delineated responsibilities,

established risk determinations and approvals, and provided guidance on troubleshooting performance and minor repairs. Additionally, CCI-117 established the requirements for data collection to facilitate root cause analysis. CCI-117 contained a troubleshooting control form (TCF) which plant personnel used to plan the troubleshooting activity, obtain the required management approval, and provide step-by-step instructions and verifications. Depending on the potential safety risk (i.e., plant trip, safety system actuation or radiation release), successively higher levels of BG&E's management review were required for approval. In all cases, operations shift supervision approval was also required.

The inspectors discussed the performance of troubleshooting with a number of BG&E supervisory personnel, who indicated that the TCF was used whenever procedure support for a given evaluation was not available. They also stated that corrective maintenance for problems identified during troubleshooting was controlled via the maintenance order process, except for minor repairs such as fuse replacement or minor control system adjustments. The TCF then became a part of the maintenance order package.

The inspectors reviewed a number of completed TCFs from operations and maintenance troubleshooting activities. The level of detail appeared adequate for the work involved, test equipment used was properly documented, an appropriate risk level had been assigned, and the performance steps on the TCF were completed and verified where required.

A review of documentation related to troubleshooting activities in the past three years indicated that no significant plant events had been caused by the troubleshooting itself. One event occurred coincident with the troubleshooting of radio frequency interference problems in the Unit 2 containment, but was due to factors not related to the troubleshooting (see LER 50-318/91-003). As a result of the review, inspectors concluded that BG&E had implemented a well-controlled and effective troubleshooting program and that additional inspection effort in the area was not required.

4.0 ENGINEERING

4.1 Reactor Vessel Seal Instrument Line Repair

BG&E completed the metallurgical examination of the Unit 2 reactor vessel O-ring seal leak detector instrument line. Leakage from the line was noted during a routine post-trip containment inspection, as documented in Section 4.2 of NRC Inspection Report 50-317/93-32 and 50-318/93-32. The examination confirmed that the failure mechanism was transgranular stress corrosion cracking (TGSCC); however, the corrosion was found to have initiated from inside the pipe rather than outside, as was previously believed.

Following evaluation by Materials Testing and Evaluation Unit (MTEU) personnel, BG&E concluded that the most likely initiator of the TGSCC was a contaminant left from original construction on the inside of the pipe. The line was a dead leg with no circulation or cleansing, so any chloride source initially present in the pipe would tend to remain there.

Liquid could enter the pipe when the refueling pool was flooded, and it would remain stagnant in the line. Coupled with residual stress in the pipe from fabrication or thermal stress during operational transients, the conditions for TGSCC could have been present.

Even though the flawed portion of line on Unit 2 was replaced during the January shutdown, BG&E intends to re-route and replace the line during the next refueling outage. BG&E also conducted nondestructive evaluation of the Unit 1 instrument line and discovered flaw indications. As a result, the entire line was re-routed to an alternate flange tap and replaced. To prevent recurrence of TGSCC in the leakage monitor lines, BG&E intends to flush the piping with de-ionized water and dry it with compressed air after each refueling to remove moisture which creates an environment conducive to TGSCC.

The metallurgical examination of the Unit 1 line was not complete at the end of the period. BG&E was still evaluating the generic effects of the issue for any other susceptible piping. Inspectors discussed the issue with engineering personnel and reviewed the updated operability evaluation for Unit 2. BG&E's follow-up of the issue demonstrated thoroughness and good engineering judgment.

4.2 ICI Flange Leakage

Following shutdown for the outage, BG&E inspected the Unit 1 in-core instrumentation (ICI) flanges and found that four of the eight had been leaking, rather than seven of eight as previously believed. The leakage was initially noted following discovery of boric acid buildup on the containment air coolers in June 1993, as documented in section 7.2 of NRC Inspection Report 50-317 and 318/93-16. BG&E's operability evaluation at that time concluded that the corrosion rate of the ICI flange studs, nuts, and the reactor head was not high enough to be a concern. The corrosion was thought to be minimal because the boric acid was dry. During the post-shutdown inspection, however, BG&E unexpectedly found that one of the top nuts of the ICI flange stud/nut combination was completely dissolved by the boric acid that leaked from the flange. The stud had dropped out of the flange. The adjacent stud/nut was about half dissolved. Each flange is held by eight, 1-3/4" studs. These conditions did not validate the operability evaluation performed in June 1993. BG&E's analysis of the issue and its generic implications was in progress at the end of the period.

The NRC is concerned that the unexpected flange fastener degradation constituted a serious precursor to an unisolable leak on the reactor vessel head. A specialist inspector was dispatched to develop a comprehensive understanding of the circumstances surrounding this event. This issue is unresolved (UNR 50-317 and 318/94-09-01) pending the results of further inspection.

4.3 Corrective Actions

Inspectors reviewed BG&E's corrective actions to date for a Notice of Violation (50-317 and 50-318/93-31-01) associated with a failure to promptly resolve the concern that the service water system may have been unable to perform its safety function under certain accident conditions. The issue was documented in NRC Inspection Report 50-317 and 318/93-31.

Prior to the NRC identifying weak issue resolution regarding the service water system concern, BG&E had performed an internal audit of the corrective action process (Corrective Actions Audit 93-12). BG&E concluded that the program was ineffective in preventing significant conditions adverse to quality (SCAQs) from recurring and that SCAQs were not being resolved in a timely manner. The audit proposed a number of corrective actions, the most prevalent being the personal involvement of management and supervisors with improved accountability and timely intervention. Some of the actions have been implemented.

With regard to the violation, BG&E has taken corrective actions to address the particular issue and prevent recurrence. However, the item remains open until BG&E has implemented the corrective actions of their own audit and a sufficient time has passed to assess the effectiveness of those actions.

4.4 Spent Fuel Handling Crane Testing

Inspectors reviewed BG&E's response and corrective actions for a Notice of Violation (50-317 and 50-318/93-02-02) resulting from several instances of procedural noncompliance associated with testing of the new spent fuel handling crane in January 1993. The testing was documented in NRC Inspection Report 50-317 and 318/93-02.

The inspectors reviewed documentation of training records, attendance lists, and training outlines that reemphasized working in conformance to procedures. The inspectors also reviewed documentation of a complete retesting of the crane. The training was adequate, retesting of the crane was satisfactorily completed, the event was reviewed by all responsible parties, and the crane was not used until it was properly certified. Further NRC review of the issue is not required.

4.5 Dry Storage Canister Vacuum

BG&E completed the root cause analysis performed to determine why two dry storage canisters (DSCs) were not dried to the vacuum required by technical specifications prior to being loaded in the dry storage facility. The issue was documented in NRC Inspection Reports 50-317 and 50-318/93-33 and 93-32 as unresolved item 93-33-03. During the vacuum drying evolution, a range switch on a pressure indicator was set incorrectly. As a result, actual pressure within the DSCs was ten times higher than indicated pressure.

Inspectors reviewed the root cause analysis report, discussed it with BG&E investigators, and attended POSRC discussion of the findings. The report was thorough and included a discussion of the event, the causal factors, and recommended corrective actions. Inspectors concluded that the primary causes for the event were the pressure indicator range switch out of position, inadequate procedure compliance, and less-than-adequate questioning attitude. Some additional causal factors were attributed to training and supervision.

While the reason that the range switch was mispositioned could not be determined, the investigation indicated that it was changed sometime after completion of the dry runs at the end of September and before the first DSC load in early November. The switch is inside a panel, not normally visible or accessible. Nevertheless, adherence to the procedure and a better questioning attitude were other barriers that might have prevented the event. The procedure called for a stepped pressure reduction to prevent ice formation in the DSC or the vacuum drying system. Since the range switch was on the wrong scale, the first indicated pressure was already below the pressure plateaus required by the procedure. Operators believed they had already passed through the plateaus required by the procedure, rationalized that they had met the intent of the procedure, and signed off the steps without processing a procedure change.

BG&E's corrective actions included a site-wide safety break to stress the importance of procedural compliance, re-emphasis on self-checking and good questioning attitude, clarifying project ownership and supervisory responsibility, and appropriate personnel actions. While the POSRC recommended adding a switch position verification to the procedure, BG&E intends to re-configure the equipment to eliminate the switch.

Notwithstanding BG&E's corrective actions and the lack of actual safety consequences, the failure to comply with the procedure was a violation of NRC requirements. TS 6.8.1 requires that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. These included procedures for refueling. The violation was not cited because the criteria for discretion specified in the NRC Enforcement Policy, Section VII.B., was satisfied. Unresolved item 50-317 and 318/93-33-03 is considered closed.

5.0 PLANT SUPPORT

5.1 Radiological Controls

During tours of the accessible plant areas, the inspectors observed the implementation of selected portions of the licensee's Radiological Controls Program. The utilization and compliance with special work permits (SWPs) were reviewed to ensure detailed descriptions of radiological conditions were provided and that personnel adhered to SWP requirements. The inspectors observed that controls of access to various radiologically controlled areas and use of personnel monitors and frisking methods upon exit from these areas were adequate. Posting and control of radiation areas, contaminated areas and hot spots, and labelling and

control of containers holding radioactive materials were verified to be in accordance with licensee procedures.

Health Physics technician control and monitoring of these activities were determined to be good. Overall, a good level of performance was observed.

5.2 Emergency Preparedness

The inspectors toured the onsite emergency response facilities to verify that these facilities were in an adequate state of readiness for event response. The inspectors discussed program implementation with the applicable personnel. The resident inspectors had no noteworthy findings in this area.

BG&E declared an Unusual Event at 8:43 p.m. on February 11 due to loss of the onsite meteorological instrumentation. The wind speed and direction instruments froze during a winter storm. Operators entered the appropriate TS action statements and declared the Unusual Event in accordance with approved emergency action level (EAL) criteria. The Unusual Event was ended when the instruments were returned to service at 5:40 a.m. on February 14, 1994.

5.3 Security

During routine inspection tours, the inspectors observed implementation of portions of the security plan. Areas observed included access point search equipment operation, condition of physical barriers, site access control, security force staffing, and response to system alarms and degraded conditions. These areas of program implementation were determined to be adequate. No unacceptable conditions were identified.

5.4 Plant Chemistry

The inspectors verified that primary and selected secondary water chemistry were maintained with technical specification and procedural limits. In addition, they reviewed secondary water activity analysis and radiation monitor alarm status to confirm steam generator tube integrity. The inspectors also examined analysis trending data to determine if appropriate action was being implemented to restore plant chemistry to normal values. There were no unacceptable conditions identified.

Inspectors noted that no leaks were found in the fuel assemblies removed from Unit 1. BG&E attributed the success to improved foreign material control and good chemistry control. As a result, the expected increase in gaseous activity released due to the Unit 1 containment purge for the refueling shutdown did not occur. While BG&E expected a release of around 200 curies, the actual release was about 20 curies. Good maintenance attention and fuel integrity appear to be major contributors to this low release.

5.5 Fire Protection

During plant tours, the inspectors assessed plant areas for fire hazards including ignition sources and flammable materials. They also examined fire alarms, extinguishing equipment, emergency lighting, actuating controls, fire fighting equipment, and fire barriers for operability. In addition, the inspectors verified that required compensatory measures, such as fire patrols, were properly implemented.

5.6 Housekeeping

The inspectors assessed the control of plant housekeeping in safety related areas. They also examined these areas for potential missile hazards such as gas cylinders that could damage safety significant equipment. General plant housekeeping during the period was good, despite a tremendous influx of equipment and material associated with the refueling outage. As a result of BG&E's concern to keep control of housekeeping during the outage, a weekly plant housekeeping report was initiated to ensure supervisory focus and additional effort were put on potential problem areas. Inspectors accompanied some supervisory tours and found the report to be a good initiative.

6.0 REVIEW OF WRITTEN REPORTS

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

Units 1 and 2:

LER 94-001 Reactor Trip Due to Opening of 13.8 kV Feeder Breaker

Unit 2:

LER 93-005 Failure to Continuously Monitor Main Vent Effluent Iodine and Particulates

Unit 1:

LER 94-001 Unit 1 reactor Trip and ESFAS Actuation Due to 12 120 VAC Inverter

The above LERs were reviewed with respect to the requirements of 10 CFR 50.73 and the guidance provided in NUREG 1022. Generally, the LERs were found to be of high quality with good documentation of event analyses, root cause determinations, and corrective actions.

7.0 FOLLOWUP OF PREVIOUS INSPECTION FINDINGS

Licensee actions taken in response to open items and findings from previous inspections were reviewed. The inspectors determined if corrective actions were appropriate and thorough and previous concerns were resolved. Items were closed where the inspectors determined that corrective actions would prevent recurrence. Those items for which additional licensee action was warranted remained open. The following items were reviewed.

7.1 (Closed) Violation 50-317 and 318/93-02-02

The item concerned several instances of procedural noncompliance associated with testing of the new spent fuel handling crane in January 1993. NRC review of the issue is discussed in section 4.4.

7.2 (Updated) Violation 50-317 and 318/93-31-01

The item involved failure to promptly resolve a concern with operability of the service water system under certain accident conditions. The issue is discussed in section 4.3 and remains open pending additional evaluation of BG&E's corrective actions.

7.3 (Closed) Unresolved Item 50-317 and 318/93-33-03

The item concerned BG&E's continuing investigation and evaluation of the causes and effects of loading two dry storage canisters into the dry storage facility without vacuum drying them to the required specifications. The issue is closed, as discussed in section 4.5.

7.4 (Open) Unresolved Item 50-317 and 318/94-09-01

This item involves the discovery of significant degradation of the fasteners on a Unit 1 in-core instrument flange, as discussed in section 4.2.

8.0 MANAGEMENT MEETING

During this inspection, periodic meetings were held with station management to discuss inspection observations and findings. At the close of the inspection period, an exit meeting was held to summarize the conclusions of the inspection. No written material was given to the licensee and no proprietary information related to this inspection was identified.

8.1 Preliminary Inspection Findings

Non-cited violations were identified regarding procedural compliance during a surveillance test and during dry storage canister vacuum drying, as discussed in sections 3.2 and 4.5, respectively.

8.2 Attendance at Management Meetings Conducted by Region Based Inspectors

<u>Date</u>	<u>Subject</u>	<u>Inspection Report No.</u>	<u>Reporting Inspector</u>
2/25/1994	Pressurizer Repairs	50-317/94-11 50-318/94-11	R. Fernandez
2/18/1994	Outage Radcon	50-317/94-08 50-318/94-08	J. Furia
2/18/1994	Digital Mods	50-317/94-02 50-318/94-02	J. Calvert
3/3/1994	Security	50-317/94-12 50-318/94-12	R. Albert
3/11/1994	ISI	50-317/93-34 50-317/93-34	P. Patniak