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U. S. NUCLEAR REGULATORY COMMISSION

Region I

Report No. 50-317/82-26  
50-318/82-22

Docket No. 50-317, 50-318

License No. DPR-53, DPR-69 Priority -- Category C

Licensee: Baltimore Gas and Electric Company  
P. O. Box 1475  
Baltimore, Maryland 21203

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

Inspection At: Lusby, Maryland

Inspection Conducted: September 14 - October 12, 1982

Inspectors: Elc McCabe, Jr 10/12/82  
R. E. Architzel, Senior Resident date submitted  
Inspector

Elc McCabe, Jr 10/12/82  
D. C. Trimble, Resident Inspector date submitted

Approved by: Elc McCabe 10/13/82  
E. C. McCabe, Jr., Chief, Reactor date approved  
Projects Section 2B

Inspection Summary:

Inspection on 9/14-10/12/82 (Combined Report Nos. 50-317/82-26 and 50-318/82-22).

Areas Inspected: Routine, onsite regular and backshift inspection by the resident inspector (162 hours). 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; maintenance; surveillance; plant operations; radioactive waste releases, open items, and reports to the NRC.

Violations: Two: Failure to carry out fuel pin serial number verification, detail 3.d; Inoperability of Hydrogen Purge System, detail 3.b.

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DETAILS

1. Persons Contacted

The following technical and supervisory personnel were contacted:

J. T. Carroll, General Supervisor, Operations  
R. E. Denton General Supervisor, Training/Technical Services  
C. L. Dunkerly, Shift Supervisor  
W. S. Gibson, General Supervisor, Electrical & Controls  
J. E. Gilbert, Shift Supervisor  
J. R. Hill, Supervisor, Operations/Training  
S. E. Jones, Assistant General Supervisor, Training  
A. E. Lundvall, Jr., Vice President, Supply  
J. A. Mihalcik, Senior Engineer, Fuel Management  
N. L. Millis, General Supervisor, Radiation Safety  
G. S. Pavis, Engineer, Operations  
P. G. Rizzo, Engineering Analyst  
L. B. Russell, Plant Superintendent  
J. A. Tiernan, Manager, Nuclear Power Department  
R. L. Wenderlich, Engineer, Operations  
D. Zyriek, Shift Supervisor

Other licensee employees were also contacted.

2. Licensee Action on Previous Inspection Findings

(Closed) Unresolved Item (317/82-02-02) Calibration of Imbedded Thermocouples used for Bearing Temperature Measurements. The licensee has examined this area and determined that continued use of thermocouples (incapable of being calibrated in place due to design) is preferable to use of contact pyrometers. An exemption request to the requirements of ASME Code Section XI was submitted to the NRC in a letter dated August 30, 1982. Justification included that trends in temperature versus absolute temperature are an indicator of bearing degradation; the increased accuracy of the thermocouples versus pyrometers on the bearing casing; and, continued application of the vibration monitoring program.

(Closed) Inspector Follow Item (317/82-23-04) Review Plant Operations and Safety Review Committee (POSRC) Meeting Minutes. The inspector reviewed the minutes for POSRC Meeting 82-117 held on 9/8/82. The minutes accurately reflected the items approved by the committee during the meeting observed by the inspector. The latest POSRC outstanding items list, dated 8/25/82, was also reviewed. The inspector noted that activities which had been tabled, sent back for rework, or otherwise not approved by the committee were not documented. The inspector discussed this point with the POSRC Chairman, noting that such a tabulation would result in the meeting minutes more accurately reflecting activities of the POSRC. The Chairman acknowledged the inspector's comments.

(Closed) Unresolved Item (318/82-07-07) Charging Pump Room Cubicle Fire Doors. The inspector verified that the automatic

closing fire doors were repaired and appropriately labeled as fire doors.

### 3. Review of Plant Operations

#### a. Daily Inspection

The inspector toured the facility to verify proper manning and access control, and observed adherence to approved procedures and LCOs. Instrumentation and recorder traces were reviewed. Nuclear instrument panels and other reactor protective systems were examined. Control rod insertion limits were verified. Containment temperature and pressure indications were checked against Technical Specifications. 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, tagout log books, and operating orders were reviewed for operating trends and activities. During egress from the protected area, the inspector verified operability of radiological monitoring equipment and that radioactivity monitoring was done before release of equipment and materials to unrestricted use.

These checks were performed on the following dates: September 15, 16, 17, 20, 23, 24, 27, 28, 29, October 5, 6, and 8, 1982.

On 9/24/82 the inspector asked the Unit 2 Control Room Operator, who had just completed his oncoming shift turnover, for the status of a fire alarm which had annunciated on the previous shift and had not yet cleared. The alarm was for the Unit 2 Piping Penetration Room (27 and 5 foot elevations). The operator was not aware of the alarm. The operator then attempted to clear the alarm at the alarm panel. The alarm did clear. The inspector was concerned that information regarding the fire alarm was not passed on to the oncoming shift during shift turnover. CCI 307 requires the oncoming Control Room Operator to review and understand all alarms. The inspector was also concerned that the operator clearing the alarm assumed that it was caused by welding operations in the Penetration Room. (The alarm had been annunciating periodically in the recent past due to smoke resulting from welding activities associated with a facility design modification for the Auxiliary Feedwater System). The operator did not voluntarily initiate a search of the area to confirm that there was no fire. The inspector discussed this with the Shift Supervisor and the General Supervisor of Operations (GSO). The GSO stated that the operator would be counselled on maintaining an awareness of alarm status and proper actions following receipt of alarms. This item will be further reviewed (317/82-26-06).

#### b. Weekly System Alignment Inspection

Operating confirmation was made of selected piping system trains. Accessible valve positions in the flow path were

verified correct. Proper power supply and breaker alignment was verified. Visual inspections of major components were performed. Operability of instruments essential to system performance was verified. The following systems were checked:

Unit 1 Steam Dump and Bypass System on 9/16/82.

Unit 2 Main Steam Isolation Valves Hydraulic System on 9/24/82.

Unit 1 Auxiliary Feedwater System in the Auxiliary Building on 10/8/82.

Unit 2 Hydrogen Purge System on 9/30/82.

On 9/30/82 the inspector noted that the valve lineup in Operating Instruction (OI-41B) Revision B for the Hydrogen Purge System required the installation of a blind flange inside Containment on the discharge of the replacement blower. The installation of this flange would prevent the Hydrogen Purge System from operating properly in that replacement air could not reach Containment. The Hydrogen Purge System is described in Section 6.8.3.1 of the Units 1 and 2 Final Safety Analysis Report (FSAR) as a system which "shall be used as a means of hydrogen control should the recombiners fail to operate." Section 14.19.4 of the FSAR describes the use and capabilities of the system following an accident. The inspector discussed this item with a Senior Operations Engineer and was informed that OI-41B did not require installation of the blind flange until about 5/14/82 when Revision 3 was issued. Surveillance Test Procedure (STP) 0-55 valve lineup records showed that the flange was in place on Unit 1 when the STP was completed on 9/24/82. Operations personnel stated they were uncertain whether or not a flange was currently installed on Unit 2. A 2/23/82 STP 0-55 record indicated that a flange was not installed on Unit 2.

10CFR50.59(a)(1) permits a change to a facility or procedure as described in the Safety Analysis Report, without prior Commission approval, only when a change in the Technical Specifications or an unreviewed safety question is not involved. 10CFR50.59(a)(2) states that an unreviewed safety question is involved if the probability of occurrence of a malfunction of equipment important to safety previously evaluated in the Safety Analysis Report may be increased.

The procedure change and facility change adding the blind flange to the Hydrogen Purge System introduced an unreviewed safety question in that the probability of occurrence of a malfunction of this equipment was increased. Therefore, the licensee should not have installed the flanges without seeking Commission approval. This is a violation (317/82-26-05).

On 9/30/82 the inspector verified that Hydrogen Purge System components (blower and valves) were still included in the

licensee's preventive maintenance program and that this maintenance was being conducted.

c. Biweekly Inspection

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

Tagout 34180, Service Water Pump #12, verified on 9/24/82.

Tagout 34245, Unit 1 Main Steam Isolation Valve Hydraulic System High Pressure Pump, verified on 9/16/82.

Tagout 34241, Unit 1 Steam Dump and Bypass System-Turbine Bypass Valve 1TBV-3940 Repair, verified on 9/16/82.

Tagout 34342, Unit 1 #11 Charging Pump, verified on 10/7/82.

On 9/16/82 the inspector verified a tagout associated with the Steam Dump and Bypass System which can be used as a means for removal of reactor core decay heat. The inspector noted that the control air pressure gages associated with the turbine bypass valve controllers were in generally poor condition (face plate glass missing/broken and indicating needles over-ranged high) making it difficult to positively determine that the valves were capable of proper operation. The inspector pointed this item out to the acting Unit 1 Instrument Maintenance Supervisor. On 10/8/82 the inspector noted that control air pressure gages had been repaired.

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

No violations were identified.

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 the use and operational status of area radiation and air monitors were reviewed. Equipment tagouts were sampled for conformance with TS LCOs. Plant housekeeping and cleanliness were evaluated. Other TS LCOs, including RCS Chemistry and Activity, Secondary Chemistry and Activity, watertight doors, and remote instrumentation were checked.

On 9/16/82 the inspector noted that the Unit 1 fire door between the 69 foot elevation east passageway and the Spent Fuel Pool Area would not close properly. He pointed this item out to the Senior Control Room Operator for initiation of corrective action. Maintenance Request (MR) O-82-4719 was initiated for this item on 9/17/82.



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On 9/20/82 the inspector reviewed OI 46, Revision 2, Seismic Measurement Equipment, and discussed use of the Seismic Monitoring System with Control Room Operators. One licensed operator stated that he would use a template, which is kept near the monitoring recorder, overlaid on the recorder printout, to determine if further action was necessary following a seismic event. OI 46 did not mention the use of this template. The procedure listed threshold values for an Operating Basis Earthquake (OBE) and a Safe Shutdown Earthquake (SSE) which can be obtained directly from the recorder printout. The template was deficient in that it did not indicate whether its limits were for an OBE or a SSE. Proper classification of an event (OBE or SSE) is important in that plant operation may continue after an OBE, but the plant shutdown is required following a SSE. Additionally, the Emergency Plan classifies an OBE as an "Alert" condition and a SSE as a "Site Emergency" condition. These conditions require different degrees of response actions. Emergency Response Plan Implementing Procedure (ERPIP) 3.4 does discuss the use of a template to ascertain peak acceleration values, but no values were shown on the template described above. This item was discussed with the Shift Supervisor and the GSO. The GSO stated that he believed the licensee no longer intended to use the template. He stated that he would relook at OI-46 and ERPIP 3.4, delete any reference to the template (if appropriate), and ensure that the OI and ERPIP were compatible. This item is unresolved pending licensee corrective action (317/82-26-02).

On 9/15/82 the inspector observed an underwater transfer (in the Spent Fuel Pool) of two Unit 1 irradiated fuel pins from a pin storage basket to a cask shipping basket. The governing procedure for the transfer was procedure FH-35, "Irradiated Fuel Inspection / Fuel Assembly Reconstitution / Fuel Pin Transfer in the Spent Fuel Pool", Revision 2, approved on 9/8/82. The procedure stated that an underwater television camera was to be used to verify fuel rod serial numbers and shipping basket locations. A television camera was not used. The inspector pointed this out to the Nuclear Fuel Management Principal Engineer in charge of the transfer. The engineer, who had not been aware of the deviation, stated that the television serial number verification step was unnecessary since the pin numbers had been properly verified and documented previously when they were originally placed into the storage basket. He did acknowledge, though, that the individual actually performing the transfer erred by not following the procedure or by not seeking a proper change to the procedure. Technical Specification 6.8.1 requires that written procedures be established, implemented, and maintained covering refueling operations. Fuel Handling Procedure FH-35, Revision 2, was established by the licensee to govern refueling operation activities involving inspection of irradiated fuel, fuel assembly reconstitution, and fuel pin transfers in the Spent Fuel Pool. Failure to carry out a step requiring fuel pin serial number verification by underwater television camera is a violation (317/82-26-01).

The potentially severe radiological hazards associated with irradiated fuel make it imperative that adequate management controls exist during handling activities. In addition to the licensee's failure to carry out a procedural step, as described above, the inspector noted, as apparent management control weaknesses in the licensee's conduct of this spent fuel pin handling operation, that the governing procedure, FH-35, did not clearly designate who was in charge of the transfer, what that individual's responsibilities and authority included, or where he should be physically stationed during the transfer. Additionally, while the licensee has implemented a formal program for training and qualifying "New Fuel" handling supervisors, a similar program has not been implemented for personnel conducting spent fuel movements. These apparent weaknesses were discussed with licensee management personnel. The licensee committed to review and reassess the adequacy of its management controls in the spent fuel handling area.

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.

At 2:15 p.m. on 9/28/82 a contractor employee injured her back while lifting scaffolding in the Auxiliary Building. She was taken by ambulance to Calvert Memorial Hospital. Radioactive materials were not involved.

Unit 1 pressurizer level was found to be greater than -5% from program level (178" program versus 160" actual level) at 4:40 p.m. on 9/28/82. The reactor was at 50% power and the pressurizer level control system was in the "local process" versus "remote process" mode. As a result the level had gradually (over the previous hour) drifted 7" low as power oscillated. At the time of the event a small load change resulted in the additional deviation and Pressurizer Level Channel X and Y Deviation Alarms. The operator shifted to remote process and restored level to within program by 4:47 p.m.. The inspector reviewed the Alarm Procedure and verified the appropriateness of the procedure and response. The procedure for low level includes verification of all charging pumps running and minimum letdown, carrying out the appropriate LOCA Emergency Operating Procedure if necessary, or shifting level controls if the cause is the control system.

No violations were identified.

5. Radioactive Waste Releases

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

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Gaseous Waste Permit G-117-82, Release of Waste Gas Decay Tank #12 on 9/16/82.

Liquid Release Permit R-080-82, #12 Reactor Coolant Waste Monitor Tank released on 8/28/82.

Liquid Permit R-089-82, Release of Reactor Coolant Waste Monitor Tank #12 on 9/16/82.

Liquid Permit M-131-82, release of #11 Waste Neutralizing Tank on 9/13/82.

A Radiological Event was declared at 10:50 a.m. on 9/28/82 due to an alarm received on the Gaseous Unit 1 Waste Processing Ventilation monitor. The Annual Emergency response plan exercise was in progress at the time and was interrupted to allow investigation of the alarm. The inspector was in the Control Room for the duration of the event observing licensee actions. No increase was observed in site release rates. A drain valve was found to be partially open on the #12 Reactor Coolant Waste Evaporator seal water tank. The valve was closed and the Radiological Event secured at 11:25 a.m.. The Emergency Response Plan exercise recommenced at 11:30 a.m.. The inspector noted no unacceptable conditions with respect to licensee actions and analysis during the Radiological Event.

The inspector noted that the Technical Specification limit for gaseous radioactive material release rate for iodine and particulates with half lives greater than 8 days was apparently incorrectly specified in procedure RCP-1-604, Radioactive Gaseous Waste Permits, Revision 3, approved 9/15/82. The procedure correctly specifies 220 cu meters/second as the administrative limit (equal to the T.S. objective), and specifies the limit as  $2 \times 10^4$  cubic meters/second as the limit. The actual limit is 2 microcuries/second. This is unresolved pending revision of RCP 1-604 to specify the correct limit or demonstration that the limit specified is conservative (317/82-26-04).

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

Observation of the following were made:

- Identification, authorization, and badging;
- Access control searches;
- Escorting;
- Communications; and
- Compensatory measures when required.

No unacceptable conditions were identified.

7. Review of Licensee Event Reports (LERs)

a. LERs 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 LERs were reviewed.

<u>LER No.</u>	<u>Event Date</u>	<u>Report Date</u>	<u>Subject</u>
<u>Unit 1</u>			
82-51	8/27/82	9/24/82	Plant air header isolation valve inside Containment was open vice locked shut.
82-53	9/10/82	9/27/82	Hydrogen Analyzer inoperable.
82-54	8/31/82	9/30/82	#12 Auxiliary Feedwater Pump inoperable.
82-55	8/20/82	9/17/82	Reactor Coolant System Leakage increased to 2 GPM.
82-56	9/07/82	9/30/82	Containment Particulate and Gaseous RMS sample pump tripped.

Unit 2

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82-40	8/25/82	9/24/82	Pressurizer level deviated from program level by more than 5%.
82-41	8/26/82	9/24/82	Excessive leak rate past Containment Personnel Air Lock Outer Door gasket.
82-42	8/24/82	9/23/82	Inner door on normal personnel hatch to Containment would not shut completely.

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 10CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

Unit 1 LER 82-40/1T, Drift of Reactor Protective and Engineered Safeguard Features Pressure and Differential Pressure Transmitters. This report was previously addressed in inspection report 50-317/82-18. The drift which was experienced in the pressurizer pressure transmitters has been determined to be caused by changes in containment temperature. The suspected cause is the failure of the transmitters (Barton Instrument Company, Model 763) to meet their thermal effects specifications in the containment ambient temperature. An output shift in excess of the specification was observed to occur during the Unit 1 cooldown following a shutdown on 9/17/82. The shift was determined to be generic to certain Barton differential pressure and pressure transmitters, and up to 6.0% of range in magnitude for containment temperature changes of approximately 30 degrees. The transmitters were installed in the Reactor Protection and Engineered Safety Features systems as part of the Environmental Qualification upgrade initiated by IE Bulletin 79-01. Prior to restart of Unit 1, the Plant Operations and Safety Review Committee determined, on 9/25, that heatup was acceptable if indicated pressure was within minus 100, +15 psid of actual pressure. Transmitter calibration was required prior to withdrawing shutdown CEAs. The inspector reviewed a telecopy Safety Evaluation dated 9/23/82 from the vendor (Combustion Engineering) which concluded that the safety analysis actuation setpoints were sufficiently conservative to allow a 100 psi drift. The limiting accident analyzed was a 2-loop, no load, main steam line break. (169 psig margin to setpoint was used in analysis.) Pressurizer pressure, steam generator pressure, steam generator water level, and subcool margin monitor pressure input Barton transmitters were all recalibrated by the licensee prior to entering Mode 2. Calibrated test gages were installed at the NSSS sample sink monitoring pressurizer pressure and both steam generator pressures. These readings are compared and logged with the safety channel readings once

per shift to check for any further output drift. Investigation of the cause of the drift by licensee and vendor personnel is continuing. An updated report will be written when more information becomes available. This LER remains open pending receipt and evaluation by the NRC of additional information.

#### 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.

M-82-911, observed portion of lubrication of Service Water Pump #12 motor/pump coupling on 9/24/82.

PMS-1-56-1-RQ1-11 Calibration Check, Loop #12 (H&B) Cold Leg Temperature for Reactor Regulating Systems, observed on 10/5/82.

No unacceptable conditions were identified.

#### 9. Surveillance Testing

The inspector observed parts of test to verify: Performance in accordance with approved procedures, LCOs were satisfied, test results (if completed) were satisfactory, removal and restoration of equipment were properly accomplished, and that deficiencies were properly reviewed and resolved. The following tests were reviewed.

STP-0-46-2, Unit 2 Boration Flow Path Temperature Determination, observed on 9/20/82.

STP-0-54-0, Seismic Instrument Channel Check, observed on 9/20/82.

No violations were identified.

#### 10. Spent Fuel Shipment

On 9/22 and 9/23/82 the inspector observed portions of a fuel handling operation activity involving the transfer of a basket containing spent fuel pins to a shipping cask and the subsequent transfer of the cask offsite. The inspector reviewed the governing procedure, FH-33, Revision 1 approved by the POSRC on 9/15/82. He verified that a proper radiological survey was conducted of the cask and the transportation vehicle which showed acceptable radiation levels for shipment. He verified that the truck driver had received proper training, the driver was in possession of and knowledgeable of

necessary procedures, proper escort requirements were met, and necessary communications equipment was available and operating satisfactorily.

No violations were identified.

#### 11. Emergency Response Plan Exercise

The inspectors were a part of the NRC team which observed and evaluated the licensee's annual Emergency Response Plan exercise conducted on 9/28/82. Observations and findings were provided to the team leader. The results and NRC evaluation will be documented in inspection report 317/82-25; 318/82-21.

During a review of the licensee's Emergency Response Plan Implementing Procedures (ERPIP's) and Emergency Operating Procedures (EOP's) the inspector noted that those procedures do not adequately address a radioactive liquid spill such as would occur following a rupture of a Refueling Water Tank (RWT).

EOP 10, Accidental Liquid Waste Release, Revision 4, approved on 8/26/81, discusses the possibility of leakage from a ruptured RWT passing through the unmonitored storm drain system and flowing into the Chesapeake Bay. That procedure, though, does not define actions to be taken in the event of such leakage. Instead, it refers the reader to ERPIP 3.1. For a radiological event ERPIP 3.1 refers the reader to ERPIP 3.6. ERPIP 3.6 directs the reader to assess whether an Emergency Action Level (EAL) has been met. An event such as the RWT leakage to the bay does not meet any of the EAL criteria described for the logical classification category of "Radioactivity Release". ERPIP 3.6 classifies a large or uncontrolled spill of Reactor Coolant as a "Radiological Event". If the reader does not consider the RWT liquid to be reactor coolant, then he is at a loss procedurally on what future steps are necessary. If the reader classifies RWT liquid as reactor coolant, a Radiological Event Condition would exist. The remaining steps in ERPIP 3.6 are oriented toward dealing with gaseous releases. Again, the reader is at a loss procedurally on what future steps to take. The inspector pointed out this procedure deficiency to the GSO, Plant Health Physicist, and Plant Superintendent. The Plant Superintendent stated that a review of these procedures would be conducted. This item is unresolved pending licensee action to modify its emergency procedures to adequately address spills of radioactive liquid and subsequent NRC review ((317/82-26-03)).

#### 12. 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 informa-

tion 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:

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

No unacceptable conditions were identified.

13. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable. Unresolved items are discussed in paragraphs 3.b,d and 5 of this report.

14. 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.