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U. S. NUCLEAR REGULATORY COMMISSION
Region I

Docket/Report 50-317/82-27 License: DPR-53
50-318/82-23 DPR-69

Licensee: Baltimore Gas and Electric Company

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

Inspection At: Lusby, Maryland

Dates: October 12 - November 9, 1982

Submitted:

E. E. Architzel, Sr.
R. E. Architzel, Sr. Resident Inspector November 10, 1982
date

D. C. Trimble
D. C. Trimble, Resident Inspector November 10, 1982
date

Approved:

E. C. McCabe, Jr.
E. C. McCabe, Jr., Chief, Reactor November 17, 1982
Projects Section 2B date

Summary:

10/12-11/9/82 Inspection Report 50-317/82-27, 50-318/82-23.

Areas Inspected: Routine resident inspection (83 hours) of the control room, accessible parts of plant structures, plant operations, radiation protection, physical security, fire protection, plant operating records, maintenance, surveillance, radioactive waste releases, open items, TMI Action Plan items, and reports to the NRC. One Violation was found: No audible indication of source range neutron flux (detail 3.c).

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DETAILS

1. Persons Contacted

The following technical and supervisory personnel were contacted:

G. E. Brobst, General Supervisor, Chemistry
D. E. Buffington, Fire Protection Inspector
J. T. Carroll, General Supervisor, Operations
P. T. Crinigan, Senior Engineer
R. E. Denton General Supervisor, Training/Technical Services
C. L. Dunkerly, Shift Supervisor
S. M. Davis, General Supervisor, Operations QA
W. S. Gibson, General Supervisor, Electrical & Controls
J. E. Gilbert, Shift Supervisor
S. E. Jones, Assistant General Supervisor, Training
D. W. Latham, Principal Engineer, Operational, Licensing
R. O. Mathews, Assistant General Supervisor, Nuclear Security
J. E. Kivera, Shift Supervisor
P. G. Rizzo, Engineering Analyst
L. B. Russell, Plant Superintendent
J. A. Snyder, Supervisor, Instrument Maintenance Unit 2
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) Violation (317/82-18-06) Failure to Adequately Establish Maintenance Procedures Resulting in an Inadvertent Safety Injection Actuation. The licensee responded to this violation in a letter dated 9/15/82. The inspector verified that Function Test Procedures (FTI's 104, 105, 107, and 117) used for calibration and checking of Reactor Protective and Engineered Safety Features Actuation Systems transmitters and loops have been appropriately revised (approved 9/29/82). The revision added a caution note to ensure that only one channel at a time is tested and that all alarms, trips and actuation functions are reset prior to testing another channel. The inspector also questioned the licensee concerning treatment of generic aspects of this event. The GS-Electrical and Controls stated that they intended to review Notices of Violation, LERs, NCRs, and QA Audit Findings to gather examples of errors which have occurred in 1982. After analyzing these errors, they will conduct a training session/seminar with I&C personnel to make them aware of these occurrences and aid in preventing recurrence of these and similar events. These commitments were confirmed in a memorandum dated October 12, 1982.

(Open) Unresolved Item (317/82-26-04) Revise Procedure Limit for Group II Radioactive Material or Demonstrate that the

Limit Specified is Conservative. The licensee provided the inspector with calculations demonstrating their basis for the determination of a conservative Group II (I-131 and particulates with half-lives > 8 days) release rate. The T.S. objective for Group II release rate (averaged over a yearly interval) is $\sum Q_i / (MPC)_i < 220$ cu m/sec where Q_i is the annual controlled release rate (Ci/sec) of radioisotope i and $(MPC)_i$ ($\mu\text{Ci/cc}$) is defined for radioisotope i in Column 1, Table II of Appendix B to 10CFR20.

This calculational form is consistent with the Group I release rate and objective, and yields units of cu m/sec when calculated. The Appendix B Technical Specification 2.3.B.2 instantaneous limit for Group II release rate is stated in different physical terms and specified as $< 2.0 \mu\text{Ci/sec}$.

The licensee used MPC I-131 as the most limiting of expected Group II isotopes ($1\text{E}-10 \mu\text{Ci/cu m}$) and calculated a units-translated limit ($2.0\text{E}4$ cu m/sec.).

The inspector reviewed the licensee's calculations. The inspector noted that if all activity being released was I-131 at the procedural-translated limit the T.S. limit would be satisfied. In general, the inspector noted that by creating a translated-limit where the limit was based upon the smallest $(MPC)_i$, the true limit ($\sum Q_i$) could be exceeded if the release in question had any isotope with a larger $(MPC)_i$. For example, $Q_{\text{max}}(\text{Co-58}) = (2\text{E}4 \text{ cu m/sec}) / (2\text{E}-9 \text{ Ci/cu m}) = 40 \mu\text{Ci/sec}$. A conservative approach would have used the largest $(MPC)_i$ in the calculation of the limit.

Radioactive Gaseous Waste Release Permits G-002-81 (1/1/81) through G-067-81 (12/17/81) and G-001-82 (1/3/81) through G-072-82 (7/3/82) were reviewed by the inspector. Although many isotopes were released with larger $(MPC)_i$'s than $1\text{E}-10$ Ci/cu m, none were sufficiently close to the procedural limit such that the T.S. limit ($2.0 \mu\text{Ci/sec}$) was exceeded.

The inspector further noted that the procedure (RCP-1-604) only examined integrated release rates for batch releases. Because the T.S. limits are established in terms of site release rates, releases should be calculated by adding batch release rates to the continuous Unit 1 and Unit 2 Main Vent release rates.

The licensee acknowledged the procedural deficiencies and stated that they would both be corrected.

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 limits were verified. Containment temperature and pressure indications were checked. 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 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 October 12, 13, 14, 18, 19, 20, 27, 28, 29, November 2, 4, and 5, 1982.

On 10/25/82 with Unit 2 in Mode 6 operation, the inspector noted that the audible indicator for source range nuclear flux had been removed (during panel modifications associated with an Auxiliary Feedwater System modification) and was not operable. The audible indicator had been removed before the plant was placed in Mode 6 operation on 10/21/82. Technical Specification 3.0.4 states that entry into an Operational Mode shall not be made unless the conditions of the Limiting Condition for Operation are met without reliance on provisions in the action requirements. Technical Specification 3.9.2 requires, as a Limiting Condition for Operation for Mode 6 operation, that two source range neutron flux monitors shall be operating, each with continuous visual indication in the Control Room and one with audible indication in the Containment and Control Room. Unit 2 entry into Mode 6 without an operable audible indication of source range nuclear flux is a violation (318/82-23-01).

On 10/22/82 the inspector noted that a Maintenance Request (MR 0-82-4672 dated 9/15/82) had been written for # 12 Low Pressure Safety Injection (LPSI) Pump stating that the pump Differential Pressure (D/P) was in the Action Range during performance of a surveillance test (STP 0-73-1) which implements Inservice Testing requirements. The inspector pointed out to the licensee that Section XI, Subsection IWP (Inservice Testing of Pumps in Nuclear Power Plants) of the ASME Code (Summer Addenda 1976) generally states that if deviations fall in the Required Action Range, the pump shall be declared inoperative. He questioned why #12 LPSI Pump was still considered operable. The licensee reviewed records of the most recent Inservice Test of the pump and informed the

inspector that the MR was incorrect and that the pump D/P was below the required action range. The pump therefore could still be considered operable. The inspector accepted the licensee's explanation.

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 2 Containment Purge System verified on 10/13/82.

Unit 1 Penetration Room Ventilation System on 10/18/82.

Unit 1 Containment Atmosphere Particulate and Gaseous Radiation Monitoring System on 11/5/82.

No unacceptable conditions were identified.

c. Biweekly Inspection

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

Tagout 52-1106, #11 Component Cooling Pump verified on 10/15/82.

Tagout 112, dated 10/16/82, on the Unit 2 Control Element Assembly trip breakers reviewed on 11/4/82.

The inspector noted that for Tagout 52-1106, the tags for the discharge valves for the #11 Component Cooling Water Pump were switched. Tag #3 was supposed to be on discharge valve #114 and tag #4 on discharge valve #113; they were reversed. The valves in question are adjacent to each other and provide a parallel suction path for the #11 Component Cooling Water Pump. Both valves were required to be tagged shut and were tagged shut. The inspector discussed this with the Tagging Authority who stated that the tags would be corrected and that the error would be discussed with the individuals who placed the tags. The inspector considered this example of improper tagging to be an isolated example. Proper implementation of the tagging requirements will be routinely examined by the N&C.

On 11/4/82 the inspector noted that there were no controls established, such as a rope barrier or step off pad with warning signs, to prevent personnel passage using a permanently installed ladder between the Unit 1 27 foot elevation East Penetration Room (an area free of general radiological contamination) and the 5 foot elevation East Penetration Room

(a radiologically contaminated area). The inspector pointed this out to Health Physics personnel who stated that a rope barrier was supposed to be in place at the ladder and they were surprised that the rope was missing. They informed the inspector that proper controls would be established immediately. The inspector had no further questions.

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. The use and operational status of personnel monitoring practices, and area radiation and air monitors 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.

On 10/21/82, the inspector noted an accumulation of oil and water in a sump housed inside the #21 Fuel Oil Storage Tank missile protection barrier, east side. Additionally, the inspector noted an excessive build up of oil on the sides and around the base of all three Diesel Generator engines. Both of the above problems represent an increase in fire hazards in safety-related areas, and were discussed with the Plant Superintendent, General Supervisor- Operations, and the Fire Protection Inspector. The licensee committed to initiate cleanup efforts in those areas. The Fire Protection Inspector stated that the licensee had previously noted the oil accumulations in the diesel rooms and had already made some improvements. He acknowledged, though, that additional work was necessary.

On 11/4/82 the inspector noted a buildup of hydraulic oil from an apparent hydraulic oil leak on the floor of the Unit 1 Main Steam Piping Penetration Room, making the floor slippery. Additionally, unused coils of welding leads and extension cords were laying on the floor. The oil and cords in combination with assembled scaffolding made passage through the room difficult and perhaps dangerous. The inspector informed the Shift Supervisor and General Supervisor of Operations (GSO) of the condition of the room. Neither individual was aware of the hydraulic oil problem. The GSO had previously noted the problem with the cords and scaffolding and had requested corrective action. The GSO stated he would investigate the hydraulic oil problem. Cleanup of the #21 Fuel Oil Storage Tank sump, the Diesel Generator Rooms, and the Unit 1 Main Steam Piping Penetration Room will be reviewed during a future inspection (317/82-27-01).

In light of some of the mentioned housekeeping problems, the inspector questioned the Plant Superintendent concerning how often plant supervisors made tours of the facility to take

note of general housekeeping and maintain awareness of facility status. The Plant Superintendent stated that several recent changes had been made in this area to improve surveillance by supervisors. The previous week, the General Supervisor-Operations had independently initiated daily one-hour tours of different portions of the facility.

In a memorandum dated 10/28/82, the Plant Superintendent (one of 7 zone monitors) had revised the requirements of Special Order 81-02 to assign supervisors as zone monitors and require them to inspect assigned zones with the applicable zone inspector on at least a monthly basis. He also stated that the administrative and other burdens on his principal staff made it difficult for them to get out in the plant, however, this was an important activity and that they would try to improve participation and frequency. The Plant Superintendent stated that his action would at least provide detailed inspection of all zones by senior supervisors monthly.

4. Surveillance: Testing

The inspector observed parts of tests 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 deficiencies were properly reviewed and resolved. The following tests were reviewed.

STP-M-571 Local Leak Rate Test, 2ZWC9 observed on 10/14/82.

STP-M-211-1 Secondary CEA Position Display Out of Sequence Alarm Check on 11/5/82.

No unacceptable conditions were identified.

5. Radioactive Waste Release

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-137-82, pre-release calculation for combined release of Unit 2 Containment Purge and Unit 1 Containment Vent, reviewed on 11/4/82.

Liquid Permit R-111-82, 10/31/82 release of #12 Reactor Coolant Waste Monitor Tank, reviewed on 11/4/82.

Observed part of release of #12 Reactor Coolant Waste Monitor Tank, Liquid Waste Tank Permit R-112-82 on 11/2/82.

A Radiological Event was declared at 3:44 a.m. on 10/15/82 due to an increased Unit 1 Main Vent (MV) Particulate Monitor reading. Actual releases were found to be below minimum detectable. The cause of the increase was a gasket leak on #22 CVCS ion exchanger, coupled with a bypass flow in the particulate monitor allowing room air to contaminate the sample flow. The event was terminated at 5:22 a.m. following discovery of an open cover on the MV particulate monitor and isolation of the ion exchanger. Once the cover was closed on the monitor, the readings returned quickly to normal background. The inspector reviewed the licensee's actions, examined instrumentation recordings, and examined the event's reportability. Air sample results taken in the MV Fan Room showed 8.6×10^{-9} $\mu\text{Ci/cc}$ (0.05 MPC) confirming that the source of MV particulates was fan room air. A MV particulate continuous monitor sample was pulled and analyzed and showed no activity (10^{-14} $\mu\text{Ci/cc}$ minimum detectable). Airborne levels in the Auxiliary Building 45' hallway near the leak showed 1×10^{-8} $\mu\text{Ci/cc}$, confirming the source of the activity.

The inspector discussed this event's reportability with the General Supervisor - Operations because of the inoperability of the MV particulate monitor while the cover was not secured. An internal event report form (CCI-118 form) had been completed, however because the requirement to have an operable MV particulate monitor is contained in the Appendix B, Environmental Technical Specifications, and not as a Limiting Condition for Operation, no report was required. (10CFR20 and 10CFR50.72 reporting requirements would still apply but were not exceeded in this instance of equipment inoperability.) The inspector observed that the covers on both monitors had been immediately locked by the licensee.

The POSRC had also directed that I&C personnel provide a report to the committee addressing the probable cause and corrective action for this event. The inspector stated that this report would be reviewed by the NRC, and that aspects surrounding the reportability of inoperable equipment required by Appendix B Technical Specifications would also be reviewed (317/82-27-02).

6. Observation of Physical Security

The resident inspector checked, during regular and offshift hours, 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

Observations of the following were made:

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

About 3:15 a.m. on 10/21/82 licensee security personnel discovered a small quantity of marijuana in a shaving kit belonging to the driver of a truck undergoing a routine security search prior to entry into the protected area. The driver and truck were denied entrance into the protected area. The State Police were notified and the driver taken into custody by the police. The truck was carrying non-radiologically controlled ventilation ducting.

No violations were identified.

7. Review of Licensee Event Reports (LERs)

a. LERs submitted to NEC: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>			
82-52	9/13/82	10/13/82	#11 Diesel Generator inoperable.
82-60	8/27/82	10/21/82	Oyster samples collected per ETS showed Ag-110m to be 496 +/- 9 pCi/kg.

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82-61	9/26/82	10/25/82	Pressurizer level deviated from program level by more than 5%.
82/62	9/27/82	10/25/82	Pressurizer level deviated from program level by more than 5%.
<u>Unit 2</u>			
82-43	9/29/82	10/28/82	#21 Emergency Diesel Generator inoperable.
82-44	9/15/82	10/15/82	#21 Emergency Diesel Generator inoperable.
82-45	10/01/82	10/29/82	RPS low flow trip unit, Channel A failed.
82-46	9/20/82	10/20/82	RPS Channel C trip unit for high pressurizer pressure tripped.
82-47	10/04/82	11/03/82	#23 HPSI Pump breaker inoperable.
82-48	10/16/82	10/28/82	#21 Steam Generator Safety Valve found set to lift at 929 psig vs 1035 psig +/-1%.
82-49	10/22/82	10/23/82	Unplanned reactivity insertion of more than 0.5% Δ k/k.

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.

1/81-78 An update report, dated 4/23/82, provided additional information on the breakage of eight air blower discharge flange bolts discovered on Diesel Generator 12. After reviewing the update report, the inspector was uncertain whether the root cause had been identified and whether the other Diesel Generators had been adequately checked for similar problems. A licensee representative stated that the root cause was determined to be incomplete engagement of the bolts in threaded inserts housed in the base metal. The bottom two or three threads of the inserts were scored preventing the bolts from tightening properly and, in effect, bottoming out. The bolt heads were therefore not flush with the flange, allowing movement in the joint which led to

fatigue failure of the bolts. All bolts and inserts were replaced and proper engagement checked. Similar bolts in the other diesels thread into the base metal instead of into inserts. The bolts on the other diesels were torque checked and inspected to verify that the bolt heads were flush with the flange. After repair of Diesel Generator 12, vibration readings were taken on all three diesels' air blower discharge flanges and headers. There was no excessive vibration. A preventative maintenance procedure has been initiated to check blower bolts on a bi-weekly basis for detection of possible bolt failure. The inspector had no further questions.

Between 8:30 a.m. on 10/21/82 and 6:10 a.m. on 10/22/82 with Unit 2 shutdown in Mode 6 operation, Reactor Coolant System (RCS) boron concentration decreased from 2593 ppm to 2463 ppm. Then, without operator action boron concentration began increasing and by 2:50 p.m. on 10/22/82 reached 2591 ppm. The licensee could not identify the cause for the approximate 130 ppm dilution nor the subsequent concentration increase, but believed it may have been related to the injection of unborated water into the RCS during a steam generator hydroblasting operation. An investigation was initiated. Such a dilution would have resulted in a reactivity addition of 0.5% $\Delta k/k$. Based upon the initial RCS boron concentration, shutdown margin throughout the dilution would have remained above 22% $\Delta k/k$. It is significant to note that, throughout the event, there was no audible indication of source range nuclear flux available to the operator. The absence of the audible flux indication is a violation described in paragraph 3.a.. This event was reported as a prompt report (2/82-49). Additional licensee actions will be reviewed upon receipt of the followup report.

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 G-82-5154 Spontaneous trips on Channel A Reactor Protective System TM/LP observed on 10/14/82.

M-82-6587, observed portion of Installation of New 4A/4B Containment Electrical Penetration Assemblies into Existing Spare Sleeve Z7ED2 on Unit 2 on 10/20/82.

PM-2-41-E-A-2, Perform Breaker and Disconnect Switch Inspection, observed performance on disconnect #89-2404 for #23 Charging Pump on 10/14/82.

The inspector also observed portions of the disassembly and electropolishing of the old spent fuel racks. The licensee is performing this change to allow scrapping of the stainless steel contained in the fuel racks.

The inspector and accompanying Section Chief observed a training session being conducted on a full scale Steam Generator mock-up on 10/19/82. The workers were preparing for installation of Steam Generator Nozzle dams in the hot and cold leg primary nozzles of the steam generators. An automatic welding machine had been fabricated for the welding of weld material inserts into holes which were to be drilled into the nozzle walls.

No unacceptable conditions were identified.

9. Materials Handling

On October 19, 1982, radiation protection was discussed with the Nuclear Power Department Manager and, by telephone, with the Vice President, Supply. The history of materials handling events was discussed and identified as not being unusual in severity or frequency. No above limit exposures were involved. Control over handling of highly radioactive materials was identified as an area which might benefit from comprehensive review, and the licensee confirmed that such a review had been initiated and was planned for completion within 60 days. That review will be evaluated after completion (317/82-27-03; 318/82-23-02).

10. Licensee Action on NUREG 0660, NRC Action Plan Developed as a result of the TMI-2 Accident

The NRC's Region I Office has inspection responsibility for selected action plan items. These items have been broken down into numbered descriptions (enclosure 1 to NUREG 0737, Clarification of TMI Action Plan Items). Licensee letters containing commitments to the NRC were used as the basis for acceptability, along with NRC clarification letters and inspector judgment. The following items were reviewed.

II.E.1.1(2) Auxiliary Feedwater System - Long Term System Modifications and II.E.1.2(l.b.2) Auxiliary Feedwater System Automatic Initiation implementation. The inspector reviewed FCR 79-1062, Revision 2, dated July 7, 1982, Auxiliary Feedwater Modifications and verified that these modifications adequately address the requirements of NUREG 0737 item II.E.1.2 and, upon completion, will satisfy the requirements of II.E.1.1(2) and II.E.1.2.(l.b.2). The inspector performed a physical walkdown of the entire Auxiliary Feedwater System on Unit 2, including the five separate modifications contained in FCR 79-1062 to verify current status.

Based on direct observation and review of FCR 79-1062 and P&ID, Auxiliary Feedwater System Unit 2, Revision OG, dated October 19, 1982, the system is approximately 85 to 90% complete. The licensee's schedule is to complete the Unit 2 modifications by the end of the November 1982 outage. Unit 1 modifications are scheduled to be performed and completed during the November 1983 outage. These items remain open pending completion of the modifications and will be examined during subsequent inspections.

11. 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 reports were reviewed:

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

The inspector reviewed the licensee's summary report of "Startup Testing for Sixth Cycle" for Unit 1 and noted that the cover letter incorrectly stated that the report was for Unit 2. He pointed this out to the Nuclear Fuel Management Principal Engineer who was already aware of the problem. A revised cover letter was submitted on November 1, 1982. No additional problems were identified.

No unacceptable conditions were identified.

12. 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, 5, and 9 of this report.

13. 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.