


U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report Nos. 50-317/92-21; 50-318/92-21
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: August 2 through August 29, 1992
Inspectors: Peter R. Wilson, Senior Resident Inspector
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Approved by:


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Reactor Projects Section No. 1A
Division of Reactor Projects

9/10/92
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; radiological protection; surveillance and maintenance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

Results:

See Executive Summary.

EXECUTIVE SUMMARY

Calvert Cliffs Nuclear Power Plant, Units 1 and 2

Inspection Report Nos. 50-317/92-21 and 50-318/92-21

Plant Operations: (Operational Safety Inspection Module 71707, Prompt Onsite Response to Events at Operating Power Reactors Module 93702) Operators responded well to an automatic reactor trip on Unit 2 that resulted from an unintentional closure of a main steam isolation valve. Operators performed Unit 1 startup activities safely and professionally.

Radiological Protection: (Module 71707) Four workers knowingly entered a posted high radiation area without satisfying the requirements of the radiological control program and technical specifications. A special inspection is being conducted to allow timely develop the facts surrounding this event.

Engineering and Technical Support: (Module 71707) A previously unresolved item identifying NRC concerns with the containment air cooler degraded fan seals was evaluated and closed.

Safety Assessment/Quality Verification: (Modules 71707, 30703) BG&E's self monitoring program for validating operator rounds was evaluated. BC&E's conclusions agreed with the inspectors' independent assessment that false log keeping practices did not exist at Calvert Cliffs. The startup review board provided effective overview of startup activities. BG&E effectively implemented shutdown safety enhancements during the Unit 1 refueling outage.

DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

Unit 1 began the period in cold shutdown (mode 5) in a refueling outage. Upon completion of the outage work, BG&E conducted a plant heatup and startup. A chronology of major milestones follows:

- August 6 Entered hot shutdown (mode 4)
- August 7 Entered hot standby (mode 3)
- August 16 Began critical operations (mode 2) and low power physics testing
- August 18 Began power operations (mode 1) for main turbine testing and power escalation testing
- August 23 Shutdown from 88% power to mode 3 to repair a steam leak from a main steam line drain
- August 27 Returned to power and recommenced power escalation testing. The unit was at 88% power when the period ended.

Unit 2 began the period in mode 3 following a reactor trip at the end of the previous period. Power operation resumed on August 3. On August 17, Unit 2 tripped from full power when a malfunction closed the 22 main steam isolation valve during a partial stroke test. BG&E returned the unit to power operation on August 19, where it remained through the end of the 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
- primary auxiliary building
- radiological control point
- electrical switchgear rooms
- auxiliary feedwater pump rooms
- security access point
- protected area fence
- intake structure
- diesel generator 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 operators responded in accordance with plant operating procedures. Routine operations surveillance testing was also observed. Compliance with TS and implementation of appropriate action statements for equipment out of service was inspected. Plant radiation and releases monitoring indication systems 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 the temporary modifications log. Plant housekeeping controls were monitored, including control and storage of flammable material and other potential safety hazards. The inspector also examined the condition of various fire protection, 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 fourteen hours during backshifts and nine hours during deep backshifts. Operators were alert and displayed no signs of fatigue or inattention to duty.

The inspectors observed an acceptable level of performance during the inspection tours and observations detailed above. Housekeeping was adequate.

2.2 Followup of Events Occurring During Inspection Period

During the inspection period, the inspectors provided onsite coverage and followup of unplanned events. Plant parameters, performance of safety systems, and licensee actions were reviewed. The inspectors confirmed that the required notifications were made to the NRC. During event followup, the inspector reviewed the corresponding CCI-118 (Calvert Cliffs Instruction, "Nuclear Operations Section Initiated Reporting Requirements") documentation, including the event details, root cause analysis, and corrective actions taken to prevent recurrence. The following event was reviewed.

a. Unit 2 Automatic Trip

On August 17, Unit 2 tripped from full power due to a high steam generator (SG) differential pressure caused by the unintentional closure of No. 22 main steam isolation valve (MSIV) during testing. Operators were performing the normal bi-monthly partial stroke test on No. 22 MSIV when the valve stroked almost fully closed rather than to the desired 10% closure. The MSIV closure caused pressure in No. 22 SG to increase above the pressure in No. 21 SG, to the high differential pressure setpoint. Due to the high SG pressure, the main steam safeties lifted momentarily. Further, the No. 23 auxiliary feedwater pump started on the resulting low SG level spike from the pressure transient. Operators used the pump to maintain level after the trip. The inspectors reviewed chart recorder traces and computer records of various parameters, concluding that there were no unexplained conditions and that the plant responded as expected. Operators maintained the unit in mode 3 following the trip to conduct the required event evaluation.

The MSIVs are a "Y" type globe valve, manufactured by Edward Valve Company (formerly Rockwell), equipped with a gas-hydraulic stored energy actuator. Hydraulic oil opens and holds the valve open, while stored nitrogen gas pressure rapidly closes the valve when the oil is released to a reservoir via redundant dump valves. During a partial stroke test the oil is directed through a flow restricting orifice and one open dump valve, causing the valve to close slower than normal. When 10% closure is indicated, the operator releases the test switch, the dump valve closes, the orifice is removed from the flow path, and the valve reopens.

Inspectors reviewed operator statements and found that BG&E conducted thorough post trip review. BG&E's preliminary investigation concluded that the root cause of the MSIV closure was that the actuator hydraulic oil had degraded and thickened, over time. This conclusion was, in part, based on discussions with the valve manufacture. BG&E could not recreate the failure, but concluded that the thickened oil caused a slow closure of the dump valve when the test switch was released. This and the timing of the test circuit, allowed the orifice to be removed from the flow path before the dump valve repositioned, causing a rapid oil dump and MSIV closure.

As a preventive measure BG&E flushed and refilled the oil systems on both No. 21 and No. 22 MSIVs and tested the valves prior to restart. BG&E initiated an analysis of the removed oil to confirm the results of their preliminary investigation. They also conducted a review of the preventive maintenance requirements for the oil to ensure that it is sampled and changed at the proper frequency. The Unit 1 valves were not a concern because they had recently been overhauled.

The inspectors concluded that operator response to the trip was good. BG&E's actions to validate the root cause of the failure and prevent its recurrence were appropriate.

2.3 Unit 1 Startup Assessment

Inspectors monitored the Unit 1 startup process. Overall, operators controlled the startup well, and safety concerns were properly addressed. The Startup Review Board (SURB) assessed readiness of the unit to change modes before plant heatup and before initial criticality. The SURB was composed of the site managers and involved a formal, vigorous questioning of the entire site organization to determine unit status. The SURB process also involved surveillances of selected areas crucial to startup readiness and a rigorous schedule of manager observation tours. The inspectors noted SURB members on plant observation tours during deep backshift hours. The inspectors attended the SURB meetings and monitored selected startup testing. The SURB functioned effectively to overview the startup efforts and focus actions toward safety concerns.

Startup testing and return to power were controlled by Post Startup Test Procedure (PSTP) 2, "Initial Approach to Criticality and Low Power Physics Testing," and PSTP 3, "Unit 1 Cycle 11 Escalation to Power Test Procedure." PSTP 2 was begun on August 15 and governed testing through initial criticality up to 1% power. It included in-core thermocouple evaluation, physics test panel hookup, precritical control rod testing, initial criticality, and low power physics

testing. PSTP 2 was completed satisfactorily and PSTP 3 was begun on August 18. PSTP 3 governed testing from 1% to 95% power, where testing was complete. PSTP 3 included power indication monitoring, CECOR/BASSS verification, shape annealing factor testing, power distribution monitoring, reactivity coefficient testing, reactor flow testing, and calorimetric verification.

Procedural compliance and proper communications were observed. The operations staff was challenged during the startup due to the positive temperature coefficient of reactivity of the new core. Training was conducted on the simulator to prepare operators for this condition. Several outage modifications had a potential to impact reactor power operations. These included new feed flow nozzles and new turbine bypass valves. Operators were briefed on the modifications and the various reactor power indications available during startup and power escalation. An appropriate level of supervision was noted for startup testing and major evolutions.

A high level of professionalism and supervisory involvement was noted during startup activities. One specific instance of good control and coordination was observed on August 19, during main turbine overspeed testing at Unit 1 concurrent with the Unit 2 startup. To support these activities, management augmented control room and plant operator staffing and clearly defined responsibilities and authorities. The augmented operations crew exhibited safe control of both units.

PSTP 3 was halted at 88% power on August 23 due to a steam leak from a main steam header drain pot (1-DR-3) on the high pressure turbine inlet. Following unit shutdown to mode 3 it was determined that a two inch drain line and the eight inch condensing pot for 1-DR-3 were cracked. An investigation by plant engineering determined that the crack was caused by high cycle fatigue failure due to thermal expansion and vibration of the drain line against a nearby conduit support. The offending support was determined to be unnecessary and was removed and 1-DR-3 was repaired. BG&E conducted a walkdown of the main steam system to verify that the condition did not exist elsewhere. Unit 1 returned to power on August 27 and was in PSTP 3 at 88% power when the inspection period ended.

3.0 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 adequate. Overall, an acceptable level of performance was observed.

3.1 Improper Entry Into a High Radiation Area

On August 13, a Unit 1 containment coordinator, his assistant, and two other decontamination workers knowingly entered a posted high radiation area (i.e. an area containing dose rates greater than 100 mrem/hour) without satisfying the requirements of the radiological posting. The individuals entered the No. 12 reactor coolant pump (RCP) bay in the Unit 1 containment, which was posted as a "high radiation area, gamma dose rate meter required, radcon escort required", without gamma dose rate meters or a radcon escort. Further, these workers did not have a special work permit for entry into this area as required. To allow timely assessment of this issue a special inspection is being conducted.

4.0 MAINTENANCE AND SURVEILLANCE

4.1 Maintenance Observation

The inspector reviewed selected maintenance activities to assure that:

- the activity did not violate TS 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. The maintenance activities reviewed, with notable observation as appropriate, included:

MO 19204954	Perform Calibration Checks on Steam Generator Wide Range Level Indication LI-1114C and Level Recorder LR-1114D
MO 19205028	Replace Safety Injection Tank Narrow Range Level Indication LY-341A

- MO 19205781 Repair Steam Leak Upstream of Steam Generator Blowdown Valve 1-BD-4013
- MO 19205705 Calibrate No. 11 Steam Generator Wide Range Level Transmitter
- MO 19103309 Reinstall Concrete Shield Blocks on Containment Equipment Hatch

The inspectors noted that there was no post maintenance test associated with this work and questioned BG&E about the performance of radiation surveys. These surveys were routinely performed at power; however, as an enhancement, BG&E modified the policy for startup radiation surveys to include this shield in its initial surveys. A change to the maintenance procedure to notify the radiological controls organization whenever shielding is reinstalled was also under consideration.

- MO 19205684 Replace Steam Generator Wide Range Level Transmitter LT-1114B

One of four newly installed SG wide range level transmitters failed its post modification test, because its response was the reverse of the expected. The desired condition was a high output for a low differential pressure. This transmitter produced a low output for low differential pressure. A new transmitter was installed and satisfactorily tested. BG&E initiated a review of concerns with the defective transmitter including why the unsatisfactory response had not been determined prior to installation. Further, BG&E was reviewing this issue for potential reportability under 10 CFR Part 21. The inspectors concluded that BG&E response was appropriate.

4.2 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, TS were satisfied, testing was performed by qualified personnel, and test results satisfied acceptance criteria or were properly dispositioned.

The surveillance testing observed 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. The surveillance testing activities reviewed, with notable observation as appropriate, included:

- STP M-3-1 Unit 1 Main steam Safety Valve Setpoint Testing
- STP M-564-1 Wide Range Noble Gas Monitor Calibration Check
- PSTP-2 Initial Approach to Criticality and Low Power Physics Testing
- PSTP-3 Unit 1 Cycle 11 Escalation to Power Test Procedure

STP M-460-0 Seismic Accelerometer Functional Test

STP O-5A-2 AFW System Quarterly Test

STP M-2-1 Pressurizer Safety Valve Testing

The inspectors observed preparations for this test and observed that there were no prerequisites to verify suitable quench tank conditions. Operations verified suitable quench tank conditions and initiated a request for procedure change to include these checks in the future.

5.0 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 inspectors had no noteworthy findings in this area.

A graded site emergency preparedness exercise was conducted on August 18. The scenario involved a loss of shutdown cooling following a seismic event. The results are documented in NRC Combined Inspection Report 50-317 and 50-318/92-20.

6.0 SECURITY

During routine 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.

7.0 ENGINEERING AND TECHNICAL SUPPORT

7.1 Containment Air Cooler Degraded Fan Seals

The inspectors reviewed BG&E's evaluation of concerns resulting from the discovery in October 1991 that the gum rubber fan seals on all of the containment air coolers (CACs) had degraded in place and disintegrated. The issue was documented in NRC Inspection Report 50-317 and 50-318/91-24. The issue was unresolved (91-24-01) pending NRC evaluation of: the operability of the CACs in the past, with degraded seals and high bay water temperature; the lack of any preventive maintenance or periodic inspection requirements that would have identified the degraded seals earlier; and the generic implications or 10 CFR Part 21 requirements arising from the degraded seals.

The inspectors examined the following BG&E documents, with attachments, which formed the basis for their conclusion that the CACs remained operable with reduced air flow, resulting from the degraded seals, at bay water temperatures up to 90 degrees F:

- NEU 92-120, "Review of Bechtel Hot and Cold Leg LOCA Calculations for Degraded CAC Analysis"
- NEU 92-115, "Review of ABB/CE's MSLB Analysis"
- EQTAR 79, Environmental Qualification Technical Assessment Report.

The documents adequately supported and recorded BG&E's determination that the CACs were operable without the seals.

BG&E has completed the preliminary evaluation for upgrading the preventive maintenance (PM) on the CAC fan seals. The final evaluation and PM upgrade are being tracked to completion in the PM system. The preliminary evaluation concluded that a visual inspection of the fan seals every refueling outage would satisfactorily monitor their condition.

The Unit 1 CAC seals have been replaced with environmentally qualified EPDM material. Unit 2 currently has new gum rubber seals that were installed in the fall of 1991 that will be upgraded to EPDM during the spring 1993 refueling outage.

BG&E determined that the degraded fan seals were not reportable under 10 CFR 21 because they were not discussed in the vendor manuals, procurement documents, or equipment specifications except to mention that they existed and where they were installed. In addition, the absence of the seals did not make the CACs inoperable. The seals were unique to the CACs, gum rubber was not used in this application elsewhere in the plant. BG&E reviewed and found the other flexible ductwork joint material used in the plant acceptable for radiation resistance.

The inspectors concluded that these actions adequately address the previous NRC concerns with the degraded CAC fan seals and the inspector had no further questions.

8.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION

8.1 Plant Operations and Safety Review Committee

The inspector attended several Plant Operations and Safety Review Committee (POSRC) meetings and verified that a proper quorum was present. The meeting agendas included procedural changes, proposed changes to the TS, Facility Change Requests, and minutes from previous meetings. Items for which adequate review time was not available were postponed to allow committee members time for further review and comment. Overall, the level of review and member participation was adequate in fulfilling the POSRC responsibilities. No unacceptable conditions were identified.

8.2 Plant Operator Activities

The inspectors evaluated BG&E's self monitoring program for validating operator rounds to determine if false log keeping practices exist at Calvert Cliffs. BG&E's program was in response to NRC Information Notice 92-30, "Falsification of Plant Records," and recent industry experiences. The evaluation was performed using the guidance of NRC Temporary Instruction (TI) 2515/115, "Verification of Plant Records."

BG&E's validation was performed by the Plant Operating Experience Review Unit (POER). The fundamental element of the validation was a comparative analysis of operator logs with the security computer log to confirm required entries into monitored rooms. Over a thirty-five day watchsection rotation, sixty-seven different operators were verified conducting their required rounds. Each operator was verified over an average of four rounds, with each round having at least two checkpoints. Over 500 data points were validated; only one could not be confirmed. The unconfirmed point was subsequently resolved to the satisfaction of the Superintendent of Nuclear Operations.

POER also evaluated operations management's promulgated expectations toward watchstation logs and rounds. This evaluation resulted in some recommendations for clarifying expectations with regard to equipment out of service, timely log keeping, and the use of qualified alternate operators.

Upon completion of the review, POER concluded that false log keeping practices do not exist within the Nuclear Operations Section. The inspectors reviewed POER's evaluation and recommendations and discussed them with operations management and POER personnel. The evaluation was found to satisfy the requirements of TI 2515/115. In order to maintain a high level of confidence in the veracity of operator logs, operations management is developing a permanent self monitoring program to provide timely indication of any concerns which might develop with operator rounds. The conclusions of POER agreed with the inspectors' independent assessment, as documented in NRC Inspection Report 50-317 and 50-318/92-16, that non-licensed operators were providing accurate and complete log readings and were conducting rounds in a professional manner.

8.3 Completion of Unit 1 Refueling Outage

During this period, BG&E completed the Unit 1 refueling outage begun on March 19. In addition to refueling, some of the major tasks comprising the outage included:

- an emergency diesel generator overhaul
- steam generator eddy current testing, tube plugging, and thermal sleeve replacement, and blowdown piping replacement
- dual safety water header cleaning, inspection, repair, and replacement
- turbine bypass valves replacement
- feedwater flow elements replacement

- a reactor coolant pump replacement
- main turbine inspection and repair
- saltwater intake structure cleaning
- 4 Kv safety buses preventive maintenance
- over 50 major modifications, over 280 STPs, over 760 PMs, and over 1200 maintenance orders

The outage was originally scheduled for 97 days. BG&E extended the schedule due to additional work identified during the outage, required rework, and miscellaneous equipment problems. The extended outage duration, additional work, and higher than anticipated dose rates contributed to significantly exceeding the original outage radiation exposure goals, as further discussed in NRC Combined Inspection Report 50-317 and 50-318/92-17.

During the outage, BG&E clearly focused on shutdown safety. Several new safety measures, enhancements to existing measures, and increased shutdown safety awareness were evident. These included a focus on safety by the outage coordinator and plant staff and the integration of an outage safety summary schedule into the outage scheduling process.

Attention was placed on maximizing the availability of: safety related systems for decay heat removal (DHR), reactor coolant system inventory control, and electrical power supplies. The status of equipment was tracked by operators on a "minimum essential equipment list." Also, containment closure was maximized during the outage. During reduced inventory conditions, particular emphasis was placed on DHR capability, containment closure, and the time to boil if DHR was lost.

BG&E performed a self assessment of the shutdown safety measures near the beginning of the outage. The self assessment results will be fed into BG&E's outage critique. Also, measures to continue improvement were put in place. The inspectors concluded that BG&E effectively implemented shutdown safety enhancements during the outage.

9.0 FOLLOWUP OF PREVIOUS INSPECTION FINDINGS

Licensee actions taken in response to open items and findings from previous inspections were reviewed. If corrective actions were appropriate, thorough, and would prevent recurrence, the inspector closed previous concerns. Those items for which additional licensee action was warranted remained open. The following items were reviewed.

9.1 (Closed) Unresolved Item 50-317 and 50-318/91-24-01: Containment Air Cooler Degraded Fan Seals.

This item involved concerns from a discovery that the gum rubber fan seals on all of the containment air coolers had degraded in place and disintegrated. The concerns were resolved as documented in Section 7.1.

9.2 (Open) Escalated Enforcement Item 50-317 and 50-318/92-80-04: Load Sequencer Design.

This item involved failures of BG&E's to: take appropriate corrective action to preclude a potential common mode failure of EDGs and ECCS loads, take appropriate design control measures to prevent improper load sequencing, to notify the NRC as soon as practical of an unanalyzed condition that significantly compromised plant safety, and submit a timely Licensee Event Report of the occurrence. The item was determined to be a violation of NRC requirements as documented in a letter from Mr. T.T. Martin (NRC) to Mr. G.C. Creel (BG&E), Notice of Violation and Proposed Imposition of Civil Penalty - \$50,000 (Combined NRC Inspection Report Nos. 50-317/92-80 and 50-318/92-80), dated August 7, 1992.

10.0 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.

On August 19 and 20, a meeting was held onsite between the NRC, BG&E, and industry representatives. The purpose of the meeting was to discuss the verification and validation of industry guidance under development for the implementation of the new maintenance rule (10 CFR 50.65).

On August 28, NRC Commissioner Gail de Planque and members of her staff visited the site. They were hosted by Mr. Robert Denton, Plant General Manager. The primary purpose of the visit was a generic indoctrination to power reactor operation. The visit included tours of: the control room simulator, the plant, and the independent spent fuel storage installation. Mr. Larry Nicholson, Region 1 Reactor Projects Section Chief, accompanied the tour.

10.1 Meeting With Calvert County Officials

On August 13, the resident inspectors met with Messrs. Michael Moore, President, Calvert County Commission; Richard Holler, County Administrator; Vernon Horsman, Director of Emergency Management; and Robert Short, Director of Public Safety. The purpose of the meeting was to provide an overview of NRC functions and to discuss the role of the resident inspectors at Calvert Cliffs.

10.2 Preliminary Inspection Findings

A special inspection concerning an unauthorized entry into a posted high radiation area, was being conducted as discussed in section 3.1.

10.3 Attendance at Management Meetings Conducted by Region Based Inspectors

<u>Date</u>	<u>Subject</u>	<u>Inspection Report No.</u>	<u>Reporting Inspector</u>
8/19/1992	EP Drill	50-317/92-20 50-318/92-20	J. Lusher
8/21/1992	Security	50-317/92-22 50-318/92-22	R. Albert