AUG 13 1985

Docket Nos. 50-317
50-318

Baltimore Gas and Electric Company
ATTN: J. A. Tiernan, Manager
Nuclear Power
P.O. Box 1475
Baltimore, Maryland 21203

Gentlemen:

Enclosed is our agenda for the Enforcement Conference scheduled for 1:00 p.m., August 14, 1985 at the NRC Region I office. If you have any questions relative to these discussion items, please refer them to Dr. R. Bellamy (215) 337-5200.

Sincerely,

Original Signed By:
Ronald R. Bellamy for
Thomas T. Martin, Director
Division of Radiation Safety
and Safeguards

Enclosure: As Stated

cc w/encl:
A. E. Lundvall, Jr., Vice President, Supply
R. M. Douglass, Manager, Quality Assurance
L. B. Russell, Plant Superintendent
Thomas Magette, Administrator, Nuclear Evaluations
R. C. L. Olson, Principal Engineer
R. E. Denton, General Supervisor, Training and Technical Services
Public Document Room (PDR)
Local Public Document Room (LPDR)
Nuclear Safety Information Center (NSIC)
NRC Resident Inspector
State of Maryland (2)

bcc w/encl:
Region I Docket Room (with concurrences)
~~Senior Operations Officer (w/o encl)~~
DRP Section Chief

RI:DRSS	RI:DRSS	RI:DRSS	
White	Shanbaky	Bellamy	SLISSER
8/13/85	8/13/85	8/13/85	8/13/85

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CALVERT CLIFFS

ENFORCEMENT CONFERENCE AGENDA

It is the express purpose of the conference to:

1. Ascertain the validity of certain findings of NRC Inspection 50-317/84-16; 50-318/85-14, performed June 24-28, 1985. The particular findings to be verified in this conference are listed in the attached Discussion Items.

2. Ascertain the licensee's corrective measures relative to these findings, particularly,

   What is the current post-accident sampling capability?
   What is the operational status?
   What are the long term corrective measures to provide assurance that the capability will be maintained?

   What changes in the management control system will be made to assure that NRC required engineering or plant modifications, that may not directly effect plant operations, will be properly prioritized and effectively completed in a timely manner?

   What changes in the pre-operational testing of such modifications will be made in order to verify and validate that the effected design or system is operational and able to perform as intended?

   What Quality Assurance and Quality Control enhancements are planned?

3. Determine the licensee's perception of the import of the findings, the causal factors that resulted in the conditions noted, and corrective measures applied to prevent recurrence.

CALVERT CLIFFS ENFORCEMENT CONFERENCE

DISCUSSION ITEMS

1. Status as of June 26, 1985 of the CE-PASS In-Line capability.

1.1 The NRC's "Order Confirming Licensee Commitments on Post-TMI Related Issues" (March 16, 1983) was in reference to submittals made regarding the establishment and implementation of post-accident sampling via in-line analyses with the CE-PASS; and back-up to the in-line equipment via dilated grab sample from the CE-PASS. Such capability was declared operable on June 1, 1983.

1.1.1 Licensee records do not indicate that the system was verified to be completely operational and able to perform as indicated in a submittal to the NRC dated November 30, 1982.

1.1.2 Licensee commitments and submittals per NUREG-0737 requirements were only in regard to CE-PASS and did not infer or reference any intended use of the NSSS sink/PASA method as a back-up sampling technique upon establishment of the CE-PASS on June 1, 1983.

1.1.3 Since installation, there have been continual problems with the CE-PASS including leaking valves, inoperable valves, inoperable system components, and erroneous in-line analytical instrument indications.

1.1.4 A fully integrated and complete test of the system demonstrating the CE-PASS capability to acquire samples from all sample points and analyze such samples within the accuracies stated for each parameter has not been performed.

1.1.5 The system's ability to provide a diluted samples for back-up analyses was never proven due to unreliable dilution capability.

1.1.6 There was no test ever performed that demonstrated that the in-line radioisotopic analyzer was able to provide a factor of 2 accuracy.

1.1.7 On June 26, 1985, the applicable procedure (ERPIP 4.4.7.6) for operation of the CE-PASS was not commensurate with the current system configuration. Consequently a surveillance procedure had to be used to operate the system.

1.1.8 On June 26, 1985, a sample was not able to be acquired from the Unit-2 hot leg because the sample acquisition valve was inoperable (2-CV-5105).

1.1.9 On June 26, 1985, valves 1-SV-6529 and 2-SV-6529 would not function and thereby prevented sample flow through the CE-PASS.

1.2 On February 22, 1985, Technical Specification 3/4.7.13, "Post-Accident Sampling" was issued.

1.2.1 Subsequently, the licensee declared the CE-PASS inoperable on March 5, 1985; reported the same to the NRC on March 29, June 6, and July 22, 1985.

1.2.2 The March 29 and June 6, 1985 submittals indicated that the "preplanned alternate method of processing samples" was in effect. Such method was considered by the licensee to be the NSSS sink/PASA technique.

1.2.3 Since Technical Specification 3/4.7.13 has been issued, the CE-PASS has always been declared inoperable.

2. Status of NSSS sink/PASA Method.

2.1 The NSSS sink/PASA method was a post-accident sampling technique established originally to satisfy the interim requirements for post-accident sampling capability specified in NUREG-0578. Except as mentioned in the Order as the system to be employed until the establishment of the CE-PASS on June 1, 1983, the NSSS sink/PASA method is not referenced in any submittals relative to NUREG-0737 (II.B.3) pertaining to post-accident sampling. The method was never suggested as a "preplanned alternate method of processing specified samples". Since the CE-PASS was declared inoperable on March 5, 1985, (and earlier in view of the operating performance of CE-PASS), the NSSS sink/PASA method has been considered as the post-accident sampling capability.

2.1.1 As of June 26, 1985, no approved procedure existed for the operation of the NSSS sink/PASA system in the current configuration.

2.1.2 No personnel had been formally trained on the method and system configuration.

2.1.3 During a demonstration on June 26, 1985, the primary coolant sample was forced out the top of the burette due to a design and operator error. In later demonstrations:

2.1.3.1 On July 17, 1985, the PASA leaked all of the primary coolant through a hose clamp that was used to repair the previous deficiency;

2.1.3.2 On July 18, 1985, the controlled delivery of primary coolant sample to the burette could not be accomplished, and resulted in primary coolant being leaked from the PASA until the technician stopped the leak by putting his finger over the spigot.

2.1.4 As of June 28, 1985, there was never a time and motion study performed to verify that the NSSS sink/PASA method could be accomplished within GDC-19 dose limits.

2.1.5 The analyses procedure (ERPIP 4.4.7.4) did not contain provisions for analyses of hydrogen (or total gas) or pH.

2.1.6 No remote tools or equipment are used for sample acquisition via the NSSS sink/PASA method; and lead-lined gloves and aprons specified as necessary in the analysis procedure (ERPIP 4.4.7.4) were not available for use on June 26, 1985.

2.1.7 The PASA assembly is not a structurally sound device and contains fragile glassware components that are subject to breakage.

3. Status of Post-Accident Particulate and Radioiodine Capability.

3.1 T.S. 3/4.3.3.8 issued February 1985 specified an operability surveillance requirement for the main vent iodine and particulate sampler. Such samplers are required to be demonstrated operable by comparison with samples independently drawn from the main vent at least once per month.

3.1.1 T.S. 4.3.3.8 was never implemented. The surveillance requirement was never performed.

3.1.2 No evaluation had ever been performed to demonstrate that the samples collected by this system were representative of the effluent stream.

3.1.3 As of June 26, 1985, personnel were not trained in the procedure for collecting grab samples from this system.

3.1.4 As of June 26, 1985, the licensee was unable to demonstrate the workability of procedures for filter removal from the sampling cask in the Wide Range Gas Monitor; and subsequent analysis of such filter.

4. Status of Containment High Range Radiation Monitor (CHRRM) System.

4.1 The CHRRM system is required by NUREG-0737 and subsequent clarifications contained in RG 1.97, to be qualified to function in an accident environment as a Category I instrument system.

4.1.1 RAYCHEM sleeving of electrical connectors, including internal containment penetration-to-cable connectors is required to assure the environmental qualification of the system.

4.1.2 On June 27, 1985, none of the four internal penetration-to-cable connectors in Unit-1 were provided with protective (RAYCHEM) sleeving necessary to assure environmental qualification of the system.

5. Status of Inplant Radioiodine Monitoring Program.

5.1 T.S. 6.15 specifies that a program be implemented to assure the capability of accurately measuring airborne iodine concentrations in-plant during accident conditions. Such program included the training of personnel. To this end, the licensee established Training Instruction No. 5 which required that personnel responsible for accident monitoring, including radioiodine measurements, be trained yearly.

5.1.1 As of June 28, 1985, no personnel have been trained in this function since February 1984.