



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-4005

April 18, 2003

Mr. Robert E. Link, Site Manager  
Framatome ANP, Inc.  
2101 Horn Rapids Road  
Richland, Washington 99352

SUBJECT: NRC INSPECTION REPORT 70-1257/03-02

Dear Mr. Link:

On March 24-28, 2003, the NRC conducted a routine inspection at the Framatome ANP facility in Richland, Washington. The purpose of the inspection was to determine whether activities authorized by your license were conducted safely and in accordance with NRC requirements. The areas examined during the inspection were radiation protection, training and low level radioactive waste storage. Within those areas, the inspection consisted of a selective examination of procedures, representative records, equipment, facilities and interviews with personnel. An exit briefing was conducted on March 28, 2003, with members of your staff.

Activities conducted at the facility were generally characterized by implementation of effective programs in the areas reviewed.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available **electronically** for public inspection in the NRC Public Document Room **or** from the *Publicly Available Records (PARS) component of NRC's document system (ADAMS)*. ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, please contact Dr. D. Blair Spitzberg at (817) 860-8191 or Wayne Britz at (817) 860-8194.

Sincerely,

/RA/

D. Blair Spitzberg, Ph.D., Chief  
Fuel Cycle & Decommissioning Branch

Docket No.: 70-1257  
License No.: SNM-1227

Enclosure:  
NRC Inspection Report  
70-1257/03-02

Framatome ANP, Inc.

-2-

cc w/enclosure:

Doug Adkisson, Richland Operations Manager  
Framatome ANP, Inc.  
2101 Horn Rapids Road  
Richland, Washington 99352

Donald W. Parker, Manager  
Environmental, Health, Safety & Licensing  
Framatome ANP, Inc.  
2101 Horn Rapids Road  
Richland, Washington 99352

Loren J. Maas, Manager  
Licensing and Compliance  
Framatome ANP, Inc.  
2101 Horn Rapids Road  
Richland, Washington 99352

Calvin D. Manning, Manager  
Nuclear Criticality Safety  
Framatome ANP, Inc.  
2101 Horn Rapids Road  
Richland, Washington 99352

Washington Radiation Control Program Director

bcc: (via ADAMS e-mail distribution):

- TPGwynn
- EECollins
- JEWhitten
- DBSpitzberg
- WLBritz
- DAAyers, RII
- PLHiland, RIII
- GFSanborn, RIV
- RWise, RIV
- SMFrant, FCFB/NMSS
- PSLee, FCFB/NMSS
- JWLubinski, SPIB/NMSS
- LARoche, FCFB/NMSS
- MIS System
- FCDB
- RIV Materials Docket File

ADAMS: Yes    No    Initials: \_\_\_\_\_

Publicly Available    Non-Publicly Available    Sensitive    Non-Sensitive

DOCUMENT NAME: draft: s:\dnms\fcdb\wlb\30125702.wpd    final r:\\_dnms

RIV:DNMS:FCDB	HQTRS:NMSS:FCSS	C:FCDB
WLBritz	JSMcAnallen	DBSpitzberg
<b>/RA/</b>	<b>/RA/</b>	<b>/RA/</b>
4/16/03	4/17/03	4/18/03

OFFICIAL RECORD COPY

T=Telephone

E=E-mail

F=Fax

**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket No.: 70-1257

License No.: SNM-1227

Report No.: 70-1257/03-02

Licensee: Framatome ANP, Inc.

Facility: Framatome ANP, Inc.

Location: Richland, Washington

Dates: March 24-28, 2003

Inspector: Wayne L. Britz, Fuel Facility Inspector  
Fuel Cycle Decommissioning Branch

Accompanied by: Julia McAnallen, Nuclear Safety Intern  
Special Projects and Inspection Branch  
Division of Fuel Cycle Safety & Safeguards, NMSS

Approved By: D. Blair Spitzberg, Ph.D., Chief  
Fuel Cycle/Decommissioning Branch

Attachment: Supplemental Inspection Information

## EXECUTIVE SUMMARY

Framatome ANP, Inc.  
NRC Inspection Report 70-1257/03-02

This routine, announced inspection included a review of selected aspects of the licensee's program for radiological protection, training, and low-level waste storage. The inspection also included a followup of previous inspection findings.

### Radiation Protection (83822)

- The licensee was adequately implementing the radiation protection program. The workers were observed to be following the requirements of the radiation protection program and were knowledgeable about the program requirements. The licensee met the applicable requirements set forth in the license, regulations and procedures (Section 1).

### Training (88010)

- The inspectors found that the licensee has continued making improvements in the training materials and was current in its training of personnel. The training program was providing the training required by the regulations and the license for employee training (Section 2).

### Low-Level Waste Storage (84900)

- The waste storage facilities and activities were found to be in compliance with applicable license and regulatory requirements (Section 3).

### Follow up (92701)

- The inspector discussed the status of an Inspection Followup Item regarding Emergency Implementing Procedure 3.11, *Environmental Safety Liaisons*. This item concerned errors in the procedure affecting its ability to be effectively implemented. This item remains open because changes made to the procedure contained errors which could affect the accuracy of emergency dose calculations and emergency protective actions (Section 4).
- The inspectors reviewed the licensee's corrective actions committed to in response to the April 2-3, 2002, loss of criticality control event. Short term corrective actions had been completed as previously reported. The longer term corrective actions including restructuring the standard operating procedure program, continued development of standard work instructions and making procedures more readily accessible to operators were still in progress. The inspectors determined that the licensee's commitments as detailed in their letter to the NRC dated September 26, 2002, *Reply to a Notice of Violation*, were on schedule and that substantial progress had been made. This item will remain open until additional corrective actions are completed (Section 4).

- On February 20, 2003, a small fire occurred in the feed hopper of the solid waste uranium recovery incinerator involving a cardboard waste box, containing about 9.75 grams of U-235, which caught fire before it was fully fed into a waste incinerator. The licensee reported the event to the NRC Operations Center on February 20, 2003, per the 24-hour reporting requirement in 10 CFR 70.50(b), and submitted a thirty day follow-up report on March 21, 2003. The inspectors reviewed the licensee's *Root Cause Analysis: Exhaust System Fire at the SWUR Incinerator, 02-20-03*, dated February, 2003, the corrective actions completed and observed the operations of the incinerator with the licensee. The corrective actions taken appeared adequate (Section 4).

## Report Details

### Summary of Plant Status

The dry conversion facility (DCF), fuel rod downloading, engineering laboratory operations (ELO), lagoon uranium recovery (LUR), ammonia recovery facility (ARF), gadolinium recovery, modular extraction/recovery facility (MERF), solids processing facility (SPF) and the solid waste uranium recovery (SWUR) were in operation. The fuel pellet production process was not in operation.

### **1 Radiation Protection (83822)**

#### a. Inspection Scope

The inspectors reviewed the licensee's program for radiation protection to determine compliance with the regulatory requirements and evaluate the adequacy of certain aspects of the licensee's radiation protection program. The review included field observations and a review of the licensee's radiation protection program review and exposure control. This radiological protection inspection module is being reviewed in two different inspection periods. Radiation protection procedures; instruments and equipment; posting, labeling, and control; notifications and reports; surveys; and the As Low As Reasonably Achievable (ALARA) program will be emphasized during a future inspection.

#### b. Observations and Findings

Audits of the radiation protection program conducted by the licensee's Environmental Health, Safety, and Licensing group were reviewed for compliance with 10 CFR 20.1101, *Radiation Protection Programs*; License Condition 2.6, *Internal Audits and Inspections*, of the license application; and Chapter 2, Section 2.8.4, *Radiation Protection Program Audit*, of EMF-30, *Safety Manual*. The licensee's annual review of the radiation protection program content and implementation required for 10 CFR 20.1101 was documented in several audits performed during the year. The inspectors reviewed the past six months of the Routine Health Physics Audits, HP-1, which are performed monthly; the External Radiation Protection Program Audit (HP-3) dated February 28, 2003; the Annual Radiation Protection Program Audit (HP-4) dated December 12, 2002; the Airborne Activity Audit (HP-6) dated October 10, 2002; the Bioassay Audit (HP-10) dated October 1, 2002; the Dose Tracking Audit (HP-18) dated September 3, 2002; and the Respirator Program Evaluation (HP-19) dated May 23, 2002. The Annual Radiation Protection Program Audit reviewed the radiation protection audits and procedures for completeness and adequacy and for compliance with 10 CFR Part 20. There were no external independent radiation protection program audits performed. The licensee's Routine Health Physics Audits identified worker non-compliance issues and tracked corrective actions for the issues. The audits of the radiation protection program were found to be thorough and detailed.

The inspectors reviewed the licensee's respiratory protection program for compliance with 10 CFR 20.1703, *Use of individual respiratory protection equipment*. The inspection included interviews with plant personnel relevant to the respiratory protection program and examination of respiratory protection equipment, plant specific procedures, and applicable regulatory guidelines. The most recent internal audit of the respiratory protection program was performed in May, 2002. The inspection concluded that the licensee's respiratory protection program met requirements.

The licensee's respiratory protection program has a computerized check-in/check-out procedure for respirators and can track individual's dose and usage habits through the computerized system. In addition, the licensee has a health facility that performs respirator fit tests on site. Any employee who is not current in respiratory protection training or has exceeded the deadline for the annual fit test will be prevented from checking out a respirator by the computerized system. When the employee becomes current in both training and fit test requirements, he or she will be granted access to the computerized respirator check-in/check-out system again.

The inspectors reviewed the licensee's program for exposure control to determine compliance with License Conditions 3.2.5, *Radiation Exposure*, and 3.2.7, *Bioassay Program*, and the Safety Manual, EMF-30, Chapter 2, *Radiation Protection Standards*, and the supporting procedures.

The inspectors reviewed and discussed portions of the procedures relating to the in-vivo counting program, internal dose tracking system, lapel sampling and personnel dosimeter control program contained in EMF-1507, *Health Physics and Radiological Safety Procedures*, and the radiation protection record retention, general radiation protection rules and recommendations, external dosimetry program, bioassay program and internal dose tracking system procedures contained in EMF-1508, *Site Radiological Operating Procedures*. The inspectors reviewed and/or discussed the following with the licensee:

- the weekly air probe downloads and printouts;
- the record verification process by the employee or supervisor and revisions as necessary to best determine employee's internal dose;
- the National Volunteer Laboratory Accreditation Program status;
- the proper wearing of dosimetry on the body, with protective clothing, and for extremity purposes;
- coordination of termination lung burden counts;
- bioassays;
- highest total personnel exposures for the year and manual calculations of doses to verify computer programs.

The inspectors determined that the licensee's radiological exposure control program was effective.

The inspectors toured and reviewed the radiological preparations which were in process for the relocation and renovation of the ultrasonic equipment and cylinder wash area in the

UO<sub>2</sub> Building, and the radiological controls and zoning plans for the installation of the vibratory fuel rod loader in room 182. The inspectors observed the postings and work being performed under the activities. The inspectors found the personnel knowledgeable about the practical radiation protection programs and noted that the applicable radiation protection programs were being conducted in accordance with the regulations and procedures.

c. Conclusions

The licensee was adequately implementing the radiation protection program. The workers were observed to be following the requirements of the radiation protection program and were knowledgeable about the program requirements. The licensee met the applicable requirements set forth in the license, regulations and procedures.

**2 Operator Training/Retraining (88010)**

a. Inspection Scope

The inspectors reviewed the licensee's training program for various plant workers and the documentation of the training to determine compliance with the regulations and license requirements.

b. Observations and Findings

The inspectors reviewed the training improvement plan progress. Changes were being implemented as a result of the needs assessment which had been completed November 1, 2002, in response to commitments for corrective actions in the licensee's letter to the NRC dated September 26, 2002, *Reply to a Notice of Violation* (see section 4 of this report). The training program changes were discussed with the recently hired training manager. Two new personnel were brought into the training group and one more person will be selected to complete the staffing. The program changes include the establishment of a centralized training group, development of departmental guidelines, standardization of workstation qualification guides, simplifying the stand operating procedure format, selection of a new training database, better coordination of training records, establishment of a training review board, improved content of orientation and training classes, increased training department visibility and the control of the purchasing of outside training materials.

Draft instruction guides for new employee orientation and radiological safety worker training were reviewed by the inspectors. Also reviewed were EMF-2959, Revision 6, *Plant Operations Training Program*, and EMF-2876, Revision 1, *Framatome-ANP Training and Program Description*, both dated March 2003. *Plant Operations Training Program* defines the product center work stations, the training steps required to qualify or re-qualify for a work station, and provides written tests and skill demonstration requirements for the work stations. *Framatome-ANP Training and Program Description* provides the site with information for existing training procedures and provides guidelines for the administration of the training program.

Employee concerns regarding the handling of hydrofluoride acid were identified to management. The inspectors reviewed the training program presented to the plant workers which included a very complete classroom presentation and field demonstrations. The effort demonstrates the licensee's commitment to address worker identified issues and follow up with training when warranted.

Five recently hired employees were spot-checked to determine if they received new employee training for radiological protection and criticality safety. The training database showed that all five satisfied their training requirements. Five additional employees were spot-checked to determine if they were current in their annual refresher training for radiological protection and criticality safety. All five employees met the training requirements per the license and were current for all required training.

Some current training information was missing from the training database, but the training staff was able to adequately compensate for database discrepancies with additional paperwork or personnel file information.

The criticality safety team hired two new employees in the last year and, as part of the inspection, the employees were evaluated to determine if they met the requirements for their positions. The employees were found to be adequately qualified for their positions. The criticality safety qualification card was also inspected and determined to meet the requirements of the license.

The training program was reviewed for compliance with the requirements of 10 CFR 19.12, *Instructions to workers*, and the license application's Section 11.5, *Training*, and Section 12.5, *Radiation Safety Training*. The inspectors determined that the training program provided the initial training and followup training for radiological safety, criticality safety, respiratory protection, occupational health and safety, and instructions to workers as required.

c. Conclusions

The inspectors found that the licensee has continued making improvements in the training materials and was current in its training of personnel. The training program was providing the training required by the regulations and the license for employee training.

**3 Low-Level Radioactive Waste Storage (84900)**

a. Inspection Scope

The inspectors reviewed the licensee's low-level radioactive waste storage program to determine whether low-level radioactive wastes were being stored safely and in accordance with regulations and license conditions.

b. Observations and Findings

The inspectors toured the low-level radioactive waste (LLRW) storage areas, reviewed the storage by type of waste, wastes being prepared for shipment, wastes waiting for processing in the modular extraction/recovery facility (MERF) and solid waste uranium recovery facility (SWUR), and wastes waiting for compaction. The inspectors observed personnel inspecting drums of waste before shipping for container integrity during a prior inspection of radioactive waste management. The drums with deficiencies were removed and repacked. The licensee's inspections also included replacing labels for those that have deteriorated from outdoor storage. The signs, postings, labeling and condition of the containers were reviewed and found to be acceptable. During 2002 the radioactive waste inventory on site had been reduced from 60,841 cubic feet to 23,485 cubic feet representing a significant effort in the licensee's program to reduce legacy waste onsite. The licensee's goal for end of calendar year 2003 is 12,000 cubic feet of radioactive waste stored onsite.

The inspectors reviewed the computerized database for the waste records and the waste storage locations during a prior inspection of radioactive waste management. The waste storage database and the storage areas were reviewed and walked down with the licensee and were found to provide an accurate description and location of the wastes.

The waste storage facilities, records and activities were found to be in compliance with License Condition 6.4.2, *Solid Radioactive Waste*, and the Safety Manual, EMF-30, Section 2.2, *On-Site Transfers and Storage of Radioactive Material*, and Section 2.4, *Solid Waste*.

c. Conclusions

The waste storage facilities and activities were found to be in compliance with applicable license and regulatory requirements.

**4 Follow up (92701)**

(Discussed) IFI 70/1257/0106-02: The procedure should describe the correct radiological dose calculation programs and meteorological information sources which are intended to be used during emergencies.

A prior inspector review of Implementing Procedure 3.11, *Environmental Safety Liaisons*, found that the procedure's Appendix I, Section 3.0, *Releases to Air*, could not be implemented because information such as mixed layer depth, height of dispersed plume and the vertical off-centerline correction required for the atmospheric dispersion calculation were not available with the licensee's meteorological information system. This matter was discussed with licensee representatives and they indicated the intent to review the procedure for needed changes to describe the correct radiological dose calculation programs and meteorological information sources which are intended to be used during emergencies.

The inspector reviewed Revision 4 of Implementing Procedure 3.11 dated March 2002, however, Appendix I, Section 3.0, *Releases to Air*, had not been changed. This matter was discussed with licensee representatives and they indicated the change would be made as reported in NRC Inspection Report 70-1257/2002-07 dated November 26, 2002. The inspectors reviewed licensee's corrective actions to describe a method to calculate releases to air in Section 3.0 of Appendix I but found the actions unsatisfactory because formulas provided to model radiological releases to air were incorrect. This could result in errors in dose calculations used for determining emergency evacuations. This will remain an Inspection Followup Item.

(Discussed) VIO 70-1257/0203-01: Failure to maintain double contingency control for criticality safety; VIO 70-1257/0203-02, Failure to maintain configuration control for criticality safety; VIO 70-1257/0203-03, Operator failure to follow procedure requiring drum inspection and management failure to provide adequate supervision; VIO 70-1257/0203-04, Failure to identify necessary criticality safety controls in the CSA and CSS; VIO 70-1257/0203-05, Failure to include CSA and CSS requirements in the SOP.

On April 3, 2002, the licensee reported an event in accordance with NRC Bulletin 91-01 commitments concerning a loss of criticality safety control involving the filling of a 45-gallon drum with uranium oxide from 5-gallon safe batch containers. In this event, the 45-gallon drum selected for filling did not contain the requisite neutron absorber spider assembly, and the drum was filled without the primary criticality safety control.

The NRC dispatched a special team of three consisting of the Team Leader from Region IV and two experts in criticality safety from NRC Headquarters to investigate the incident to assure the root causes of the event were determined and that appropriate corrective actions were being taken by the licensee. The team inspection took place on site April 15-18, 2002. On June 13, 2002, the NRC described the results of its inspection in Inspection Report 70-1257/02-03 with the identification of the five apparent violations. Following a predecisional enforcement conference on July 26, 2002, the apparent violations were dispositioned by the NRC as a Severity Level III problem with five violations of NRC requirements.

The inspectors had previously reviewed the status of the response to NRC reactive team Inspection Report 70-1257/0203 dated June 13, 2002, and Notice of Violation and Proposed Imposition of Civil Penalty dated August 28, 2002. The inspectors had also previously reviewed the licensee's response and commitments for corrective actions as detailed in their letter to the NRC dated September 26, 2002, *Reply to a Notice of Violation*. The licensee had developed an action plan and status report which contained the topical headings of 1) management and supervisory accountability, 2) worker training and qualification, 3) procedural work-arounds, 4) adequacy of root cause evaluations, 5) requirements flow-down, and 6) configuration management system adequacy. Inspection Report 70-1257/2002-08 dated January 2, 2003, reported on the inspectors review of the correction actions taken as of December 6, 2002. The inspectors reviewed the status of corrective action items since that time. The implementation of the training program had been implemented as discussed in Section 2.b of this report. The establishment of a screening process to determine the applicability of the engineering change notification system was established and it was determined that there would be no

alternative methods for controlling minor engineering change notifications; i.e., just one system. Root cause analysis training for the analysts had been completed. Other items will be reviewed at the next inspection.

(Open) IFI 70-1257/0302-01: 10CFR 70.50(b) reportable event concerning an event involving a fire in the feed hopper to the solid waste uranium recovery incinerator (SWUR).

On February 20, 2003, a small fire occurred in the feed hopper of the solid waste uranium recovery incinerator involving a cardboard waste box, containing about 9.75 grams of U-235, which caught fire before it was fully fed into a waste incinerator. The box entered into the feed box area of the incinerator and the outer door closed, however, the inner door separating the feed box from the incinerator only partially opened and prevented the waste box from being fed into the incinerator. The waste box caught fire in the feed box area. The fire damaged the first of two HEPA (high efficiency particulate air) filters and the pre-filter in the ventilation system servicing the feed box and incinerator area. The second stage HEPA filter was undamaged. A fire deluge system installed in the ventilation duct upstream of the second HEPA filter did not actuate because temperatures remained below its activation threshold. The fire self-extinguished when the inner door was fully closed and the waste box and contents were consumed. There was no release of radioactive material from the facility as demonstrated by stack air sample results and samples taken from the roof and surroundings. The two employees in the facility were checked and no detectable contamination identified. Nasal smears on the employees were negative and preliminary area air sample results indicated no significant airborne activity. The licensee had completed an Incident Investigation Board (IIB) to investigate the event. The equipment had been shutdown until appropriate corrective actions had been completed. The licensee reported the event to the NRC Operations Center on February 20, 2003, per the 24-hour reporting requirement in 10 CFR 70.50(b), and submitted a thirty day follow-up report on March 21, 2003.

The inspectors reviewed Revision 1 of the licensee's *Root Cause Analysis: Exhaust System Fire at the SWUR Incinerator, 02-20-03*, dated February 2003. The following corrective actions had been identified:

- a. Install an appropriate spark arrester immediately downstream of the exhaust system inlet at the feed hopper.
- b. Revise the fire door preventative maintenance procedure to include a statement that requires that the actuator and manual brake release be fully functional before the equipment can be released for operation.
- c. Improve the attachment method for the feed hopper fire thermocouple.
- d. Add to the SWUR Alarms and Interlocks Document (EMF-1432) a description of when to activate the manual fire door brake release.
- e. Install an informative tag to the manual fire door brake release to describe its function.

- f. Revise the SWUR Alarms and Interlocks Document (EMF-1432) to more precisely define the proper setting for the incinerator exhaust fans in the event of a feed hopper fire.
- g. Revise the SWUR incinerator cleanout procedure (P66,1064) to require an inspection and cleanout of the feed hopper hood to prevent accumulation of combustible material.
- h. Evaluate the need for an additional spark-arresting screen at the HVAC (heating ventilation air conditioning) exhaust system intake above the feed hopper.
- i. Evaluate the potential need for fire-protective enhancements at all HVAC exhaust system intakes associated with elevated-temperature equipment.
- j. Evaluate the need for replacement of existing fiberglass HVAC exhaust system ductwork (over 6-inch diameter).
- k. Add a temperature readout for the feed hopper fire thermocouple.
- l. Review the system of notification for unusual conditions noted during a PM (preventative maintenance) to determine if there is a need for expedited communication to the Responsible Engineer.
- m. Revise the SWUR processing waste procedure (P66,880) to require that combustible material observed on the feed hopper be removed; add an appropriate access port and ensure that appropriate tools are made available for such removal.
- n. Review the SWUR Alarms and Interlocks Document (EMF-1432) to determine whether there are additional critical items of advice that should be made better available to the operator for urgent response.
- o. Implement measures to ensure that spark arrester pre-filters fall under the plant configuration control system and to ensure appropriate periodic cleaning.
- p. Management clarification of situations which require actuation of the fire alarm.
- q. Training of SWUR operators to ensure they understand that fire alarm actuation is required when significant and continuous smoke is observed in the incinerator room.

The inspectors reviewed the corrective actions with the licensee, observed the operations of the incinerator and reviewed the preventative maintenance order which was performed on the incinerator fire door prior to the event. Thirteen of the actions had been completed and four were in process with expected completion during April 2003. The corrective actions taken appeared adequate. This item remains open pending verification that all proposed corrective actions have been completed.

## **5 Exit Meeting Summary**

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on March 28, 2003. The licensee did not identify any of the information discussed at the meeting as proprietary.

## ATTACHMENT

### SUPPLEMENTAL INSPECTION INFORMATION PARTIAL LIST OF LICENSEE PERSONNEL CONTACTED

Doug A. Adkisson, Manager, Fuel Operations  
Rich K. Burklin, Manager, Radiation Protection  
Vince Gallacher, Manager, Waste Processing  
Ron Land, Manager, Operations Performance and Planning  
Bob Link, Site Manager  
Tami Longmire, Manager, Training  
Loren Maas, Manager, Licensing and Compliance  
Calvin D. Manning, Manager, Nuclear Criticality Safety  
Don Parker, Manager, Environmental Health, Safety and Licensing  
John H. Phillips, Technical Training  
Tom C. Probasco, Manager, Safety, Security and Emergency Preparedness  
Tim J. Tate, Supervisor, Radiological Safety

### INSPECTION PROCEDURES USED

83822	Radiation Protection
84900	Low Level Radioactive Waste Storage
88010	Operator Training/Retraining
92701	Follow up

OPEN, DISCUSSED AND CLOSED ITEMS

Opened

70-1257/0302-01	IFI	10CFR 70.50(b) reportable event concerning an event involving an unplanned fire in the feed hopper to the solid waste uranium recovery incinerator (SWUR)
-----------------	-----	---

Discussed

70/1257/0106-02	IFI	The procedure should describe the correct radiological dose calculation programs and meteorological information sources which are intended to be used during emergencies.
70-1257/0203-01	VIO	Failure to maintain double contingency control for criticality safety
70-1257/0203-02	VIO	Failure to maintain configuration control for criticality safety
70-1257/0203-03	VIO	Operator failure to follow procedure requiring drum inspection and management failure to provide adequate supervision
70-1257/0203-04	VIO	Failure to identify necessary criticality safety controls in the CSA and CSS
70-1257/0203-05	VIO	Failure to include CSA and CSS requirements in the SOP

Closed

None

LIST OF ACRONYMS USED

ADAMS	agencywide documents access and management systems
ADU	ammonium diuranate
ALARA	as low as reasonably achievable
ARF	ammonia recovery facility
CFR	Code of Federal Regulations
DCF	dry conversion facility
HVAC	heating ventilation air conditioning
HEPA	high efficiency particulate air
IIB	incident investigation board
IFI	inspector follow-up item
LLRW	low level radioactive waste
LUR	Lagoon Uranium Recovery
MERF	modular extraction/recovery facility
NMSS	Nuclear Material Safety and Safeguards
NRC	Nuclear Regulatory Commission
PARS	publicly available records
PDR	public document room
PED	plant emergency director
PERMT	Plant Emergency Response Management Team
PM	preventative maintenance
SNM	special nuclear material
SPF	Solids Processing Facility
SS&L	Safety, Security and Licensing
SWUR	Solid Waste Uranium Recovery facility
UO <sub>2</sub>	uranium dioxide