UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

February 24, 2000

MEMORANDUM TO: Brent Clayton, Enforcement/Investigations Officer, EICS

FROM: Cynthia D. Pederson, Director, DNMS

SUBJECT: ALLEGATION FOLLOW-UP: ABB COMBUSTION ENGINEERING, INC. (RIII-A-99-0029)

An allegation review board was held on September 13, 1999, and recommended that the Fuel Cycle Branch (FCB) call the concerned individual (CI) to obtain additional information for Issues 8, 9, 14, 18, 25-37. After several unsuccessful attempts to contact the CI by phone and driving to the CI's last known address during the inspection at ABB Combustion Engineering, Inc., (ABB) in November 1999, a FCB inspector subsequently made contact with the CI by phone on November 16, 1999, and obtained the required additional information. Once we obtained this additional information a FCB inspector followed up on the 17 concerns during a November 29 through December 3, 1999, inspection at the facility. The inspector concluded that two of the concerns were substantiated. The inspector concluded that of the remaining 15 concerns, four were partially substantiated and 11 were not substantiated. The results of our evaluation to the concerns are as follows:

Concern #8

The CI discovered that the production operators were not following procedures. The CI also discovered that production supervisors would on occasion tell the operators to violate the procedure if it were necessary to get the production out. Most operators were guilty of this violation. Operators in the ERBIA and the Pellet Plant would fill out the batch records ahead of time, even before the batch had been run and cans of uranium were stacked on top of each other. Supervisors would tell their staff to not listen to the health physics (HP) staff. The CI complained about these issues to Kevin Funke, Enos Criddle, and Bill Sharkey.

Review of Concern #8

The inspector observed that the plant staff conducted operations in accordance with the required criticality and radiation protection procedures. Procedure manuals were observed at numerous locations throughout the plant and minor updates (Temporary Shop Instructions) were posted near the applicable work location. Check sheets and inventory logs used with specific procedures were completed and available in the immediate area of the operation. Specifically, the inspector reviewed ongoing production activities in the ERBIA and Pellet Plant and observed that the operators were accurately documenting the required information on their specific batch records.

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At the time of the inspection the inspector did not observe any cans of uranium stacked on top of each other. The inspector discussed with several operators applicable special nuclear material (SNM) criticality controls for their assigned areas. The ERBIA and Pellet Plant operators were cognizant of spacing and stacking requirements for SNM powder cans, pellet boats, and pellet pans; what areas were approved for the storage of vacuum cleaners; the limitations on the type of contaminated waste that could be discarded in contaminated trash containers and moderation controls for SNM powder stored in secured hoppers. In the red room, operators were knowledgeable of SNM spacing requirements and mass limitations for contaminated high efficiency particulate air (HEPA) filters, SNM mass limits, criticality controls and chemical safety issues associated with equipment operations. The inspector noted that the selected operations observed were conducted in accordance with the licensee's procedures and in a safe manner.

The inspector observed HP technicians perform routine contamination surveys and the actions taken to address elevated contaminated areas. The inspector accompanied two HP technicians during a special survey of the Pellet Plant, ERBIA Plant, and Red Room. Survey results identified several specific locations which required decontamination in accordance with the licensee's procedural requirements but below specified action limits of the licensee. The inspector noted that plant staff decontaminated the elevated areas or secured the areas until decontamination could be completed. Oxide and Pellet Plant supervisors explained that at times they believed some of the remote areas surveyed around equipment by HP technicians did not represent a significant safety issue when they find isolated areas of contamination. However, they stated that HP Manager would stop an operation when survey results justified the action.

The inspector interviewed three operators and discussed the practice for documenting batch records in the ERBIA and Pellet Plant. The operators explained that recording the quantity of product produced was recorded after the product was finished. In addition, operators explained that to the best of their knowledge this practice had always been followed. The operators indicated that customer representatives were continuously reviewing their processes for quality control issues and believed they would have identified documentation errors had an operator completed a batch record before the batch was finished.

Conclusion

The inspector determined that operations were performed in accordance with applicable procedures and found no indication that the batch records were falsified or that production staff would not follow HP requirements when issues are brought to their attention. These concerns could not be substantiated. As such, we recommend that Office of Investigation (OI) not initiate an investigation and the concern be closed based on the results of the inspection effort already completed.

Concern #9

Operators would not turn on their lapel monitors (air samplers) during their work hours which resulted in low lapel sample results and caused the plant's yearly dose record to be faulty. The yearly record for the last 5 ½ years should be a lot higher.

Review of Concern #9

The inspector reviewed previous NRC inspection reports that involved activities associated with the use of lapel air samplers. On October 21, 1998, the NRC issued the licensee a violation because management failed to ensure that plant staff had lapel air samplers turned on while uranium handling operations were in progress. This violation was documented in NRC Inspection Report (IR) 070-00036/98004(DNMS). In addition, the inspector continued to randomly check to ensure that the plant staff lapel samplers were turned on during routine operations.

As a follow up to the lapel air sample violation, NRC IR 070-00036/99002(DNMS) documented that the inspector interviewed plant staff and observed that workers were properly wearing the lapel air samplers per HP Procedure No. 303, "Lapel Air Sampling." The inspector reviewed the lapel air sampling program, observed and interviewed operations staff at various work stations to evaluate the effectiveness of the monitoring program. The inspector observed that workers were properly wearing the lapel air samplers per HP Procedure No. 303. The sample heads of the lapel air samplers were clipped to the workers' lapels on the outside of smocks or coveralls, were properly positioned in the breathing zone, and were turned on. The workers appeared to understand their responsibilities for operation of the samplers. Each worker was assigned a sampler. The lapel air sampler calibration period was 6 months and the samplers observed were within the calibration period.

The inspector reviewed the collective site dose between 1994 and 1999 with the Nuclear Regulatory Assurance (NRA) Manager. The inspectors noted that the collective dose decreased from 168 rem in 1994 to 114 rem in 1997 and then increased to 138 rem in 1998 and 142 rem in 1999. The NRA Manager stated that several factors may have contributed to the drop in collective site dose 1997 which included operators not turning on their lapel air samples, less man hours worked, and the processing of higher uranium 235 enriched products. The increase in collective doses in 1998 and 1999 could have contributed to plant staff ensuring that their lapel air samplers were operating when working in the plant.

Conclusion

The concern was substantiated. In 1998 the NRC identified a violation and the licensee was issued a Notice of Violation because plant management failed to ensure that plant staff had lapel air samplers turned on while performing uranium handling operations. The collective site dose increased after corrective actions were implemented for a violation that addressed plant staff not turning on their lapel air samples in the controlled area. Subsequent inspection activities identified that plant staff were operating the lapel air samplers in accordance with their procedural requirements, which included ensuring that the samplers were turned on when working in the plant.

Concern #14

The CI indicated that the laundry room operators were adding clean (uncontaminated) water to contaminated laundry water samples to lower the assay value and the contaminated laundry water was subsequently flushed into the Joachim Creek that bordered ABB's property. Nothing was ever done about this.

Review of Concern #14

The inspector reviewed the laundry processing system, including water flow from the laundry through the sanitary treatment plant to the outfall, and reviewed selected data from the licensee's effluent monitoring reports.

The inspector's review concluded that waste water from the laundry process is mixed with a polymer and pumped through a filter press to a holding tank. The filter press cake is incinerated in the recycle recovery process. The holding tank is sampled daily by the HP staff. From the holding tank, the laundry process water is sent to the sanitary treatment plant along with the site sewage. The treatment plant effluent, plus water from storm drains, ultimately flows into the Joachim Creek. Sludge from the sewage treatment plant is mixed with polymer and dewatered in a filter press. The solid (contaminated) residue is shipped to a vendor for offsite disposal.

Effluent release data was reviewed from sampling points two (Joachim Creek-upstream), three (Joachim Creek-confluence), and four (Joachim Creek-downstream). These samples operate continuously and collect a representative sample of all water flowing through the stream at the sampling location. The licensee approach for sampling effluents was consistent with industrial practices and within regulatory requirements. All records of sample activity met the release criteria required by 10 CFR 20, Appendix B, Table 2 for liquid effluents.

Conclusion

The licensee's liquid effluents releases were within the NRC release limits. No problems were observed with the laundry facility operations, and the licensee representatives were knowledgeable about the process. The inspector could not substantiate the concern.

Concern #18

The CI was concerned about trash not being frisked before going in the trash container. Trash items were checked on day shift, but when someone wanted to throw something away on the back shifts, they didn't check with the HP Department. The CI found numerous items in the trash that were well over the limit. The CI proposed to keep a log of the trash items being thrown away in the clean trash. Nothing was ever done about this.

Review of Concern #18

During routine inspections in April 1999 and November 1999, the inspectors observed an impromptu survey of the general disposal receptacle for contamination. The debris monitored

for contamination included wood, cardboard, spent office supplies, paper, and food packaging. No contaminated debris was identified during these surveys. In discussions with the inspector, three HP technicians explained that debris in the general disposal receptacle was randomly checked for contamination and they could not recall ever finding an item contaminated above their release limit. The inspector conducted a random review of radiation survey records and noted that the HP staff infrequently surveyed the general disposal receptacle but found no examples where contaminated debris had been identified.

Conclusion

At the time of this inspection and the previous inspection the inspectors found that the debris surveyed in the general trash receptacle was not contaminated. The inspector could not substantiate this concern based on the random review of radiation survey records or observations made during the inspection.

Concern #25

Potential problems with people taking things home, bringing guns and knives into the plant, and alcohol and drugs being used while on duty.

Review of Concern #25

The inspector reviewed if plant staff were taking licensee equipment from the site. Plant staff and four security guards commented that they were unaware of employees removing company equipment or supplies from the site. The security guards stated that employees entered and exited one security gate which was monitored by a security guard at all times and if an employee attempted to remove equipment from the site they would be identified. However, this would not prevent the removal of small items that would fit inobtrusively in a pants pocket or lunch box. The inspector reviewed the daily security logs between January 1998 and February 2000 and did not identify an issue with the inappropriate removal of equipment from the site. The NRA Manager stated that an employee would be terminated if willfully found stealing plant equipment or supplies from the company. On one occasion, the NRC was notified that mercury had been removed from the site. This material was subsequently returned to the site.

The inspector discussed with selected plant staff infractions of the security plan. The security force staff explained that guns, alcohol, and drugs are not allowed in the plant; and if identified, the issue would be immediately addressed and disciplinary action would be taken. The licensee also indicated that they do not even allow smoking cigarettes, cigars or pipes inside the process buildings. The security force staff also indicated that many plant staff carried legal size small pocket knives. The NRA Manager stated that they do not have a formal fitness for duty requirement for employment at the plant but anyone found using drugs or alcohol at the facility would be prosecuted and/or disciplinary action taken against the individual(s) involved. Two HP technicians explained that during their random tours of the facility they had never identified a worker using alcohol or drugs, or carrying a fire arm. The inspector reviewed the daily security logs between January 1998 and February 2000 and no infractions of the security plan were noted.

Conclusion

The inspector concluded that the plant staff was currently complying with the security plan and there were insufficient details to corroborate any facts associated with people bringing guns and knives into the plant or using alcohol or drugs while on duty. On one occasion, the NRC was aware of a case where mercury had been removed from the site. Based on the above the concern was partially substantiated.

Concern #26

Plant staff was exiting the plant with uranium on their hands, hair, clothing, and shoes after management discontinued the radiological monitoring of plant staff in the guard area.

Review of Concern #26

The inspector reviewed HP survey results, observed impromptu clean room and employee radiological surveys, and noted plant staff's radiological monitoring techniques. The inspector noted an adverse trend in the number of clean side elevated radiological survey results for the change rooms. Specifically, survey records indicated elevated uranium contamination levels for the shoe holders on the clean side of the change rooms. In addition, the inspector noted that the licensee had reduced the frequency of checking employees for uranium contamination after leaving the restricted area. After discussions with the HP Manager, two impromptu radiological surveys were observed by the inspector. The first survey identified that 3 of 29 employees monitored had uranium contaminated hands in the lunch room. The second survey identified 11 uranium contaminated shoe holders on the clean side of the change rooms. In addition, the inspector observed two operators that did not frisk and other operators that did not perform a thorough full body frisk before leaving the change rooms. Special Nuclear Material Licensee No. SNM-33, Chapter 3.2.1, "Contamination Control," requires, employees to monitor for contamination prior to leaving the contaminated controlled area. Procedure 202, "Health Physics Controls," Section 1.2, requires, employees to wash their hands and monitor for contamination when leaving the controlled area. Contrary to these requirements, the inspectors noted three employees with contaminated hands outside the controlled area and observed two employees that failed to monitor for contamination when leaving the controlled area and a violation was documented in NRC Inspection Report 070-00036/2000-001.

The inspector noted clear area survey results. The inspector noted isolated routine contamination surveys identified a few low-level contamination issues in the lunch room, areas adjacent to the change rooms, office areas, and the main security portal and when identified the contamination was appropriately addressed but repetitive routine contamination surveys identified low level contamination on the clean side of the change rooms. The HP Manager stated the change room contamination issue would be addressed as part of the corrective action to the violation.

The inspector reviewed the licensee's initial response to the violation. The NRA Manager explained there would be several actions required to address the violation. These actions included additional training on radiological monitoring for employees, evaluating the configuration of the change rooms, and updating the posted survey guidance in the change

rooms. The HP Manager explained when plant staff was found contaminated in any unrestricted area, the issue would be immediately addressed in accordance with their decontamination procedures. The inspector will evaluate and inspect required corrective actions for the cited violation to ensure that employees perform thorough radiological surveys before leaving the controlled area.

Conclusion

The concern was substantiated. The inspector identified that employees were exiting the controlled area contaminated with uranium and a violation was cited.

Concern #27

A production operator wore contaminated underclothing under his coveralls in the clean area of the lunch room in 1996.

Review of Concern #27

The inspector observed change room activities while plant staff entered and left the contamination control area. As noted in the preceding issue, the inspector observed employees not performing required radiological surveys thoroughly when exiting a contamination control area and noted three employees had contaminated hands in the lunch room during an impromptu survey. A violation was cited in IR 070/2000-001 for the failure of employees to monitor their hands when exiting a contamination control area.

The inspector noted several weaknesses in change room activities which may have contributed to poor employee monitoring practices. The inspector noted that the contamination control training module addressed washing hands thoroughly with soap and warm water, using decontamination foam or radiac wash to assist in decontamination efforts when required, drying hands thoroughly before monitoring, frisking one hand clean before picking up the detector head, and surveying all exposed areas. None of these monitoring issues were included on the postings in the change rooms. The inspector observed that the survey instrument used to frisk for contamination was located at the change room exit doors which supported the observed practice of operators monitoring for uranium contamination after doffing plant coveralls and donning their personnel clothing. This practice does not ensure that underclothing was free of contamination. However, ten operators stated that they always take a shower prior to leaving the facility and most used company supplied underclothing in the contaminated control area. In discussions with the inspectors, ten operators, two HP technicians, and HP Manager stated that they did not recall a production operator that wore contaminated underclothing in the clean area of the lunch room in 1996. In response to the identified change room HP weaknesses, the HP Manager stated change room posting would be enhanced to specify all required contamination monitoring actions and the configuration of the change room would be evaluated.

Conclusion

The inspector concluded that plant staff was not adequately monitoring for contamination before exiting the contamination control area. The location of the radiological monitor and

posted guidance did not support the required actions to adequately monitor for contamination in the change rooms. However, there was insufficient evidence to substantiate that operators had worn contaminated underclothing in the clean area in the past.

Concern #28

Plant staff concerns documented in the shift turnover logbooks might be unavailable because the logbooks could be missing due to entries made by plant staff about possible problems identified during the shift, e.g., spills, contamination and radiation survey results.

Review of Concern #28

The inspector reviewed each logbook location and discussed their availability with plant staff. Logbooks were observed in the oxide plant control room, Pellet Plant supervisor's office, HP office, and maintenance shop supervisor's office. The logbook entries included production activities, process equipment availability, task completed, and regulatory issues. Regulatory issues addressed in the production and maintenance logbooks pertained to contaminated areas secured, equipment operational issues, and small uranium hexafluoride leaks identified. HP logs included contamination survey, lapel sample results, and environmental survey results and radiation worker permits. The inspector observed that the current HP monthly logs were located next to the HP desks and past monthly logs were filed in the HP file. Plant staff explained that logbooks were located in designated areas and did not recall any previous issue about them not being available.

Conclusion

The inspector was unable to substantiate the concern. On the day of the inspection the logbooks were available and were used to communicate issues important to safety between shifts. The inspector did not identify a current availability issue regarding the logbooks.

Concern #29

Used filter media are stored in boxes and barrels and the licensee does not have any record that would indicate what is in the box.

Review of Concern #29

The inspector observed activities associated with the disposal of spent filter media. The majority of filter media was comprised of spent HEPA filters. Red Room operators receive spent HEPA filters in clear plastic bags. Subsequently, the operators measured the uranium quantity of each filter, tagged the filter with the measured uranium quantity, and log each filter's uranium quantity on the staged pallet log sheet. The staged filters were disassembled, compacted, placed in a 55-gallon steel drum with an unique identification number. [Ex. 4] The plant staff retained the total quantity of uranium-235 for each unique drum in the material awaiting disposition function of the Hematite Accountability Management Information System (HAMIS). In addition, operators affix the material accountability log sheets

to the drum. During discussions with the inspector, an operator explained that on a couple occasions in the past the affixed drum log sheets had been inadvertently lost but that the HAMIS computer program was the official material control and accountability (MC&A) record. The inspector verified that the quantity of uranium-235 for selected drums was entered accurately into HAMIS.

Conclusion

The inspector partially substantiated the concern. In the past, log sheets used to track the uranium-235 quantity disposed of in waste drums and boxes may have been lost during handling. However, the inspector determined that the log sheet was not the official record but rather the HAMIS computer program was used to track all SNM material, which included the quantity of uranium-235 inside the barrel and a description of the items in the barrel.

Concern #30

Supervisors failed to keep track of the inventory in their respective departments. Material previously shipped was still logged in the computer inventory.

Review of Concern #30

The NRC preforms routine inspections of the MC&A programs at the licensee's facility. The most recent MC&A inspection was conducted during the week of October 25, 1999. The inspection results identified that the program meets regulatory requirements for the control of SNM. Specifically, biannually inspectors randomly select 50 SNM items throughout the process and verified that the HAMIS program accurately specifies the material status. Previous problems identified with the MC&A program have been addressed and were considered closed. The October 25-28, 1999, MC&A inspection did not identify any adverse trend in the MC&A program.

Conclusion

The concern was not substantiated. Through routine inspections, the inspectors concluded that the HAMIS program met regulatory requirements for determining the accuracy of the licensee's inventory of radioactive materials.

Concern #31

The NRA Manager does not want the HP staff to enforce the NRC regulations.

Review of Concern #31

The inspector reviewed the NRA Manager's actions concerning compliance with NRC regulations. In discussions with the inspector, four HP technicians stated that the NRA Manager, and HP Managers' expectations were to comply with all procedures and regulatory requirements. However, HP technicians indicated that certain production supervisors appeared frustrated when production areas were quarantined because of elevated contamination surveys.

Through record review, the inspector noted that the licensee took the appropriate compensatory actions to address elevated survey results and high lapel air samples.

Conclusion

The inspector concluded that there was insufficient evidence to substantiate the concern.

Concern #32

Operators assigned radioactive items to bogus locations throughout the plant. Bogus locations were not registered through the inventory program and HP is not aware of these storage locations.

Review of Concern #32

The NRC preforms routine inspections of the MC&A programs at the licensee's facility. The most recent MC&A inspection was conducted during the week of October 25, 1999. The inspection results identified that the program meets regulatory requirements for the control of SNM. Specifically, the inspector observed the storage of SNM for compliance with nuclear criticality safety/evaluation (NCSA/E) controls. The inspection activities included ensuring that SNM waste, powder, pellets, fuel assembles, and processing equipment were stored, moved, and processed within the controls established in the NCSA/E.

The inspector had identified minor issues with the storage of SNM in the past. The resolutions of these SNM issues were evaluated to ensure that the licensee took the appropriate and timely actions to correct the issues. However, recent inspection activities have not identified SNM storage issues or an adverse trend in the MC&A program.

Conclusion

The concern was not substantiated. The inspector concluded that the licensee MC&A program met license and regulatory requirements.

Concern #33

The maintenance department mechanics welded on contaminated equipment without respirators and without lapel air monitors turned on.

Review of Concern #33

The inspector reviewed the requirements for donning respirators and lapel air samplers while maintenance mechanics welded, cut, machined, and ground metal. The maintenance supervisor is responsible for evaluating which work tasks require a radiation work permit (RWP). The HP technicians develop the RWP which specifies the type of personnel protective equipment (PPE) required to perform the task. In discussions with the inspector, three HP technicians and the Maintenance Supervisor indicated that respirators are required when

welding, cutting, machining, or grinding contaminated metal. However, they stated that these activities do not require a respirator when working on clean (uncontaminated) metal. In addition, two maintenance mechanics explained they are allowed to don a respirator for any maintenance activity even if it is not required to be worn. The inspector observed a maintenance mechanic donning a respirator while welding a clean steal pipe. The maintenance mechanics that were interviewed could not recall a situation where a respirator was not donned when required.

During the inspection, the inspector discussed with plant staff and observed that the maintenance mechanics were properly wearing the lapel monitors in accordance with HP Procedure No. 303, "Lapel Air Sampling." During a welding process, the inspector noted that a maintenance mechanic had changed the lapel air sampler head to the appropriate filter media, properly positioned the head in the breathing zone, and the unit was operating.

Conclusion

The inspector concluded that maintenance mechanics presently donned respirators during contaminated metal fabrication and welding. The inspector could not substantiate that there had ever been a failure to don a respirator when required.

Concern #34

Plant staff has the practice of sweeping dirt from the contaminated side to the clear side.

Review of Concern #34

The inspector reviewed floor contamination survey results obtained at the change area step-off-pads, lunch room, and lavatories. The HP technicians routinely survey these areas for contamination and when contamination is identified, the area would be decontaminated. Once decontaminated, the HP technicians resurvey the area to ensure that the area is clean. The inspector reviewed a random sample of contamination survey log sheets and noted that plant staff took timely actions to decontaminate clean areas. Health Physics technicians explained that, if contaminated debris was swept into the clear side, contamination survey results would be consistently and extremely elevated. As documented in IR 070-00036/2000-001 and a previous concern, the inspectors noted routine and impromptu contamination surveys have identified repetitive low level contamination in the clean side of the change rooms. However, the inspectors associate this low level contamination with poor plant staff change-out practices.

Conclusion

The inspector was unable to substantiate the concern.

Concern #35

An operator on Line No. 2 of the Pellet Plant alarmed the continuous air monitor system (CAM) on occasion by holding uranium powder up to the CAM intake sampling point in order to keep from working.

Review of Concern #35

The inspector discussed this issue with several operators and three HP technicians regarding the causes for fixed air sample station activation in the Pellet Plant. Plant staff was knowledgeable of the required actions in response to fixed air sample activations and the health risk associated with airborne SNM material. Pellet Plant operators explained that fixed CAMs have activated due to minor process leaks in the past but were unaware of anyone ever intentionally activating a CAM. In review of the 1995 through 1997 Plant Safety Committee meeting minutes the inspector noted several issues that addressed equipment integrity concerns with the Pellet Plant operation. In response to these concerns, the licensee had upgraded the slugger presses, granulaters, and seed hoppers in the Pellet Plant. Several operators commented that fewer CAM activations occurred after the Pellet Plant was upgraded. One operator recalled several CAM activations for Pellet Plant Line No. 2 during one shift in or around 1996. The cause for the CAM activations was that the slugger had a defective component which allowed a small quantity of SNM to leak from the system. The inspector noted no adverse trends in lapel air sampler survey results for Pellet Plant operators.

Conclusion

The concern could not be substantiated. However, the inspector identified that during one shift the Pellet Plant CAM activated several times in or around 1996 due to a defective process component that leaked SNM. The inspector concluded that the licensee had replaced some Pellet Plant equipment which resulted in fewer CAM activations.

Concern #36

A certain plant employee exposed and pressed certain body parts against potentially contaminated surfaces to get another person's attention.

Review of Concern #36

The inspector randomly interviewed certain licensee employees and was unable to corroborate the details of this concern. The inspector also concluded that if this concern actually occurred as alleged, the employee should have performed a frisking survey prior to leaving the restricted area and should have identified any contamination on their body.

Conclusion

The inspector was unable to substantiate the concern.

Concern #37

Plant Safety Committee meetings were no longer held.

Review of Concern #37

The inspector reviewed the licensee's implementation of the Plant Safety Committee. The license requires that the committee meet at least each calendar quarter and review plant operations and selected safety requirements, etc. The minimum committee requirements included representatives from engineering, production, HP, and criticality safety. Committee meeting minutes (records) confirmed that the minimum staffing was present for quarterly meetings and topics were documented to address the functional areas outlined in the license. However, the inspector noted no operators or maintenance mechanics were presently on the committee. In discussion with the inspector, the NRA Manager explained that operators and maintenance mechanics were represented in the past but dropped-out of the committee in early 1998 because they believed their issues were not being addressed. The NRA Manager prioritizes actions recommended to the committee based on several factors which included the safety significance of the issue. In addition, the NRA Manager stated that the safety committee had spent a significant amount of time reviewing and approving engineering projects in the past 2 years and did not believe operators and maintenance mechanics were that interested in these type of activities. The inspector noted that the committee meeting minutes included issues involving the hydrogen fluoride wet scrubber, red room slab tank, and oxide plant reactor engineering projects. In discussions with the inspector, an operator, who had previously been on the committee, indicated that workers' issues were not addressed but could not give any specific examples. The NRA Manager explained that there would be an effort to attract operators and maintenance mechanics to the safety committee because they brought hands-on operational experience.

Conclusion

The concern could not be substantiated, but operators and maintenance mechanics discontinued their attendance at the meetings early in 1998. The inspector identified that the current Safety Committee membership and frequency of the meetings met the requirements in the license.

We now consider these issues closed.