



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

January 25, 2008

EN 43795
EN 43806

Mr. R. P. Cochrane, General Manager
BWX Technologies, Inc.
Nuclear Products Division
P.O. Box 785
Lynchburg, VA 24505-0785

SUBJECT: NRC INSPECTION REPORT NO. 70-27/2007-008

Dear Mr. Cochrane:

This refers to the inspection conducted from November 4 through December 31, 2007, at the Nuclear Products Division facility. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection included: Plant Operations, Management Organization and Controls, Maintenance and Surveillance, Radiation Protection, and Emergency Preparedness. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Within the scope of the inspection, no violations or deviations were identified.

By letter dated November 16, 2007, we received your reply to our Notice of Violation, 70-27/2007-06-03, which was issued on October 19, 2007. The reply met the requirements of 10 CFR 2.201 and your corrective actions were reviewed during this inspection period.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and enclosure will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/readingrm/adams.html>.

R. Cochrane

2

Should you have any questions concerning this letter, please contact us.

Sincerely,

/RA/

Douglas M. Collins, Director
Division of Fuel Facility Inspection

Docket No. 70-27
License No. SNM-42

Enclosure: NRC Inspection Report

cc w/encl:
Barry L. Cole
Manager, Licensing and Safety Analysis
BWX Technologies
P. O. Box 785
Lynchburg, VA 24505-0785

Leslie P. Foldesi, Director
Bureau of Radiological Health
Division of Health Hazards Control
Department of Health
1500 East Main Street, Room 240
Richmond, VA 23219

Distribution w/encl:
M. Adams, NMSS
A. Gooden, RII
P. Habighorst, NMSS
D. Jackson, NMSS
N. Rivera, NMSS
S. Subosits, RII
A. Snyder, NMSS

PUBLICLY AVAILABLE NON-PUBLICLY AVAILABLE SENSITIVE NON-SENSITIVE

ADAMS: X Yes ACCESSION NUMBER: _____

OFFICE	RII:DFFI	RII:DFFI					
SIGNATURE	A Gooden for	/RA/					
NAME	G. Wertz	A. Gooden					
DATE	01/25/2008	01/25/2008	1/ /2008	1/ /2008	1/ /2008	1/ /2008	1/ /2008
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: G:\REPORTS\DRAFT INSPECTION REPORT
FOLDER\BWXT\BWXT.IR.2007.008.REV.1_1.DOC

U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.: 70-27

License No.: SNM-42

Report No.: 70-27/2007-008

Licensee: BWX Technologies, Inc.

Facility: Nuclear Products Division

Location: Lynchburg, Virginia

Dates: November 4 through December 31, 2007

Inspectors: G. Wertz, Senior Resident Inspector
A. Gooden, Senior Fuel Facility Inspector

Approved by: Alphonsa Gooden, Acting Chief
Fuel Facilities Inspection Branch 1
Division of Fuel Facility Inspection

Enclosure

EXECUTIVE SUMMARY

BWX Technologies, Inc., Nuclear Products Division
NRC Inspection Report No. 70-27/2007-008

This inspection included periodic observations conducted by the Senior Resident Inspector during normal and off-normal shifts in the areas of Plant Operations, Management Organization and Controls, Maintenance and Surveillance, and Radiation Protection. A specialized inspection and review of documentation were conducted by a regional inspector in the area of Emergency Preparedness (December 3 through 6).

Plant Operations

- The facility was operated in accordance with approved procedures and nuclear criticality safety postings (Paragraph 2.a).
- On November 17, the emergency team promptly and effectively responded to a fire due to an electrical malfunction. Off-site assistance was requested and effectively responded to the scene. Control Room staff overcame a malfunction with the pager system and notified emergency response staff individually via telephone. No licensed material was involved in the fire and radiological surveys and smears were negative for any radioactive contamination. A root cause investigation team was formed to identify and correct the cause of the fire (Paragraph 2.b).
- On November 19 and 20, spent nuclear fuel at the Lynchburg Technology Center was transferred safely and in accordance with the radiation work permit requirements. Nuclear criticality safety and material control and accountability requirements were maintained (Paragraph 2.c).
- On December 13, the licensee effectively responded to an activation of the Facility Alarm System. Air surveys indicated the alarm was false. The system was removed from service for troubleshooting after an analysis properly identified the hazards and isolation requirements (Paragraph 2.d).

Management Organization and Controls

- The corrective actions involving an operator who was sprayed with potentially hazardous flush solution were adequate (Paragraph 3).

Maintenance and Surveillance

- On October 16, the licensee identified air leaking into an acid tank due to a failure of an air-supplied dump valve designated an Item Relied On For Safety (IROFS). The sleeves were replaced and an air snubber valve installed to limit the potential air intrusion into an acid tank. The air leak did not result in a failed IROFS since the safety function of the valve remained effective (Paragraph 4).

Radiation Protection

- On November 19, a spill of waste treatment sludge was properly controlled and cleaned. Radiological surveys indicated normal background activity levels. Government agency notifications were properly performed (Paragraph 5).

Emergency Preparedness

- Program changes had no impact on emergency preparedness. The Emergency Plan (EP) audit included both a compliance-based assessment and the observation of the emergency organizations' performance during emergency drills (Paragraph 6.a).
- The revised emergency procedures selected for review were adequate to implement the EP. The actions taken by the licensee in response to off normal events involving activation of the emergency organization and implementation of the plan and procedures was both timely and appropriate (Paragraph 6.b).
- Based on interviews and training documentation, emergency response training was adequate and all personnel selected for review was trained in accordance with procedures (Paragraph 6.c).
- Based on interviews and records reviewed the interface with offsite support groups was properly maintained (Paragraph 6.d).
- The licensee conducted exercises in accordance with the requirements of the EP. The performance of quarterly drills using realistic scenarios provided sufficient challenges to maintain the proficiency of the response organization (Paragraph 6.e).
- Based on the equipment operability checks and documentation for periodic maintenance, the reliability of selected equipment was good and the equipment was maintained in a state of operational readiness (Paragraph 6.f).

Permanent Plant Modification

- Based on the safety reviews, system walk-down, and interviews, controls were in place to protect the workers and environment such that the worst case accident would not result in exceeding the performance requirements in 10 CFR 70.61 (Paragraph 7).

Attachment:

Partial Listing of Persons Contacted

List of Items Opened, Closed and Discussed

Inspection Procedures Used

REPORT DETAILS

1. **Summary of Plant Status**

Routine fuel manufacturing operations and maintenance activities were conducted in the fuel process areas and in the Research Test Reactors and Targets (RTRT) facility. Uranium recovery was conducted in the Uranium Recovery (UR) facility.

The licensee informed the NRC, as described in Event Notification (EN) 43806 and in accordance with 10 CFR 70, Appendix A, of information they provided to the media concerning the disposal of licensed material.

Corporate Reorganization and Name Change

On November 27, the Babcock and Wilcox Companies, parent company to BWXT, publicly announced several planned organizational and name changes. The Babcock and Wilcox Companies will become the Babcock and Wilcox Company (B&W), Inc., and BWXT will become the B&W Nuclear Operations Group (NOG), Inc. A license amendment request was submitted on November 14, 2007, to reflect the name change. A public meeting was conducted on December 17, 2007, in Rockville, MD, in order to discuss the reorganization and fiduciary effect on the facility. The license amendment request remains in NRC review pending additional information from the licensee.

Management Changes

Effective October 1, David Faidley, the acting Nuclear Criticality Safety Manager, became the Nuclear Criticality Safety Manager.

Effective December 1, Barry Cole replaced Leah Morrell as the Manager of Safety & Licensing and Licensing Officer. Ms. Morrell became the Manager of Environmental Engineering.

Effective December 1, Mike Lansing replaced Larry Anthony as the Security Operations Section Manager. Mr. Anthony became the Security Compliance and Access Control Manager.

2. **Plant Operations (Inspection Procedure (IP) 88135)**

a. **Routine Operations**

(1) **Inspection Scope and Observations**

The inspectors observed special nuclear material (SNM) operations in the facility. Work observed was performed in accordance with approved operating procedures (OPs), nuclear criticality safety (NCS) postings, and radiation work permits (RWPs). The inspectors observed that controls used to contain dispersible radioactive material in material access areas (MAAs) were in proper working condition and that personal

protective clothing and dosimeters were properly worn. Routine fire safety tours verified that fire safety systems were maintained and housekeeping was sufficient to minimize fire risk. The emergency operations center (EOC) was maintained in state of readiness.

(2) Conclusions

The facility was operated in accordance with procedures and NCS postings.

b. Emergency Response to Electrical Fire

(1) Inspection Scope and Observations

On November 17, at 4:52 p.m., the control room received a fire alarm following a smoke detector activation. The on-site emergency(e)-team captain promptly responded to the scene and observed heavy smoke emanating from the vicinity of an electrical transformer. All personnel in the adjacent bays were immediately evacuated. The e-team captain requested off-site assistance, due to low on-site e-team staffing, from the Concord Volunteer Fire Department (CVFD) which arrived on-site at 5:18 p.m. The fire, which emanated from a shorted 480 volt fuse panel, had melted and caused some nearby combustible material (wood and plastic) to ignite and smolder. The e-team captain was aware that the fire posed an electrical hazard and briefed the responders appropriately. The smoldering remnants were extinguished with ABC fire extinguishers around 6:15 p.m. Smoke clearing activities then commenced. No SNM was involved in the fire. Smear and survey results by the e-team indicated no licensed material was present.

Also noteworthy was that the control room staff responded effectively and promptly following a malfunction of the EOC automated pager system and telephoned EOC members individually. The EOC staffing delay was minimized to approximately 13 minutes and did not reduce the overall EOC response effectiveness. The NRC resident inspector was notified at 5:30 p.m. (also via telephone), responded to the EOC shortly thereafter, and observed effective EOC response to the event.

Immediate event review by Industrial Engineering (IE) determined that the electrical surge was halted when the 12.4 kilovolt gang-operated switch disconnected the power supply transformer from the utility sub-station. Unusual Incident Report (UIR) 2022582 was then initiated for IE to determine the cause of the electrical fire and the adequacy of electrical protective devices.

(2) Conclusions

On November 17, the e-team promptly and effectively responded to a fire due to an electrical malfunction. Off-site assistance was requested and effectively responded to the scene. Control room staff overcame a malfunction with the pager system and notified emergency response staff individually via telephone. No licensed material was involved in the fire and radiological surveys and smears were negative for any radioactive contamination. A root cause investigation team was formed to identify and correct the cause of the fire.

c. Special Nuclear Material Transfer at the Lynchburg Technology Center

(1) Inspection Scope and Observations

On November 19 and 20, operators at the Lynchburg Technology Center (LTC) transferred spent nuclear fuel (SNF) in accordance with RWP LTC-07-35. The highest worker radiation exposure received, as measure by self-reading dosimeter, was 16 milli-Roentgen Equivalent Man (mR). The inspector observed the transfer activities, reviewed the NCS controls identified on NCS posting 15-40-005, and verified that the SNF material limits were maintained. The Material Accounting and Control (MC&A) records accurately reflected the transfer activity.

(2) Conclusions

On November 19 and 20, SNF at the LTC was transferred safely and in accordance with the RWP. NCS and MC&A requirements were maintained.

d. Disabling the Facility Alarm System for Troubleshooting

(1) Inspection Scope and Observations

On December 13, the Facility Alarm System (FAS), which detects the presence of hazardous gases and provides an audible and visible alarm to notify the workers to evacuate the building, activated unexpectedly. The emergency team responded promptly, verified the absence of any hazardous gases, and determined that the alarm was false. A troubleshooting investigation of the FAS was conducted the following day which involved removing the FAS audible and visible alarms from service. Change Request (CR) 1027700 was written to ensure an adequate safety review was performed prior to the removal of the alarm system. The FAS was designated an Item Relied On For Safety (IROFS). The inspectors reviewed the CR, Safety Analysis Report (SAR) Chapter 15.18, and the process used to isolate the hazardous gases from the building.

(2) Conclusions

On December 13, the licensee effectively responded to an activation of the FAS. Air surveys indicated the alarm was false. The FAS was removed from service for troubleshooting after an analysis properly identified the hazards and isolation requirements.

3. **Management Organization and Controls (IP 88135)**

a. Inspection Scope and Observations

The inspectors reviewed Unusual Incident Report 2021072 documenting an event on October 6, involving a UR operator who received facial contamination with a potentially hazardous flush solution. The operator had been flushing solids from a system when the flush hose clogged. The operator stopped the flush pump and removed his face shield to discuss the clogging situation with another operator when the flush hose came off the

pump. The flush solution was primarily water; however, as a precaution, the operator was treated by the emergency team and was unharmed. The area manager directed maintenance to verify that all hose clamps were properly secured. In addition, UR operators were retrained on the proper attachment of temporary hoses. The inspectors discussed the issue with the area manager and affected operator and concluded that the corrective actions (CAs) were adequate.

b. Conclusions

The CAs involving an operator who was sprayed with potentially hazardous flush solution were adequate.

4. **Maintenance and Surveillance (IP 88135)**

a. Inspection Scope and Observations

On October 16, operators noticed air bubbles coming from an acid treatment tank and promptly isolated the tank. The air-supplied dump valve (designated an IROFS) was removed for inspection which revealed significant degradation of the valve's internal air bladder (sleeve) which was the cause of the leak. Other acid tanks using the same valve were also removed from service. The cognizant engineer determined that the sleeve, which had recently been replaced using a different sleeve manufacturer, was not as chemically resistant as the original valve manufacturer's-supplied sleeve. The sleeves were replaced with original valve manufacturer-supplied sleeves. In addition, excess flow air valves were installed in the air supply lines to limit potential air intrusion into the acid tank should another sleeve fail. The work was done properly in accordance with CR 1027337 and a 10 CFR 70.72 evaluation was performed to ensure 10 CFR 70.61 performance requirements remained effective.

The inspector reviewed the risk significance of the event, observed the condition of the degraded sleeve and reviewed the acceptance testing following installation of the new sleeves. The safety function of the valve (to dump the contents of the tank) was unaffected by the air leak and the IROFS remained available. The testing results with the original valve manufacturer-supplied sleeves were satisfactory.

b. Conclusions

On October 16, the licensee identified air leaking into an acid tank due to a failure of an air-supplied dump valve (designated an IROFS). The sleeves were replaced and an air snubber valve installed to limit potential air intrusion into the tank. The air leak did not result in a failed IROFS since the safety function of the valve remained effective.

5. **Radiation Protection (IP 88135)**

a. **Inspection Scope and Observations**

On November 19, Waste Treatment (WT) operators noticed sewage sludge had leaked from a crack in a transfer pump casing and spilled down onto a gravel area. A small amount of material was observed in an adjacent drainage ditch which was then dyked to prevent offsite release. The spilled material was cleaned within 24 hours. Radiological surveys of the sludge were performed and the samples indicated natural background activity levels. Notification was provided to the Virginia Department of Environmental Quality and a concurrent report was provided to the NRC (refer to EN 43795). The event was captured in the licensee's CA program as UIR 2022642. The inspectors observed the spill area with the WT manager, inspected the failed pump, and reviewed the radiological survey data with the cognizant Health Physicist. No discrepancies were identified.

b. **Conclusions**

On November 19, a spill of waste treatment sludge was properly controlled and cleaned. Radiological surveys indicated normal background activity levels. Government agency notifications were properly performed.

6. **Emergency Preparedness (IP 88050)**

a. **Review of Program Changes (F3.01)**

(1) **Inspection Scope and Observations**

Changes to the Emergency Plan (EP), organization, facilities, and equipment were reviewed to assess the impact on the effectiveness of the program. The adequacy of the emergency preparedness audit required by Section 4.5 of the Plan was also evaluated. Since the last inspection (May 2006) no significant organization or facility changes had occurred.

Plan changes were submitted by letter in accordance with 10 CFR 70.32(i). The most recent changes were incorporated as Revision 19 to the Plan and were distributed to copy holders on May 1, 2007.

The audit program was implemented in accordance with Section 4.5 of the Plan. Audits were both performance based involving drill observations and compliance oriented to determine whether the program was being implemented in accordance with the license condition.

(2) Conclusions

Program changes had no impact on emergency preparedness. The EP audit included both a compliance-based assessment and the observation of the emergency organizations' performance during emergency drills.

b. Implementing Procedures (F3.02)(1) Inspection Scope and Observations

Changes to the Emergency Preparedness Manual (EPM) were reviewed for adequacy and to ensure that the revised procedures continue to implement the EP. Randomly selected procedure changes were considered procedure updates or enhancements and continued to implement the EP requirements. All changes were developed, reviewed, and approved in accordance with the change request procedures and requirements in Section 4 of the EP.

The implementation of the EP and implementing procedures in response to off normal events were reviewed for three (3) incidents in 2007. The actions taken by the licensee to classify, notify, and respond was considered timely and appropriate.

(2) Conclusions

The revised emergency procedures selected for review were adequate to implement the EP. The actions taken by the licensee in response to off normal events involving activation of the emergency organization and implementation of the plan and procedures was timely and appropriate.

c. Training and Staffing of Emergency Organization (F3.03)(1) Inspection Scope and Observations

Emergency response training was reviewed to determine if the licensee had provided adequate training to all personnel designated as the primary and/or alternate Emergency Director (ED), to other key personnel assigned to the emergency management organization (EMO), and members of the emergency team (ET).

The inspectors reviewed the training outline and class attendance roster sheets for personnel assigned to the EOC staff and members of the ET. Personnel training was current and in accordance with procedural requirements governing emergency response training. Emergency response training provided adequate information regarding roles, responsibilities, and recent changes to the Plan and EPM.

(2) Conclusions

Based on interviews and training documentation, emergency response training was adequate and all personnel selected for review was trained in accordance with procedures.

d. Offsite Support (F3.04)

(1) Inspection Scope and Observations

Licensee activities in the areas of training, agreements, and exercises were reviewed to determine if the licensee was periodically involving offsite support groups.

Interviews were conducted with representatives from the CVFD and Concord Rescue Squad. All agreements with offsite support groups were maintained current in accordance with Section 7.7 of the Plan. Regarding offsite support training, during calendar year 2007, annual training was provided in accordance with the Plan and procedures to the off-site support organizations. A site familiarization tour was provided to off-site fire support and rescue personnel. In addition, radiation safety training was provided to offsite response personnel and provided the appropriate level of understanding regarding the potential hazards that may be encountered during an onsite response.

(2) Conclusions

Based on interviews and records reviewed the interface with offsite support groups was properly maintained.

e. Drills and Exercises (F3.05)

(1) Inspection Scope and Observations

Section 4.3 of the EP required that biennially an emergency exercise be conducted. This area was reviewed for adequacy in testing both onsite and offsite emergency response capability. The effectiveness of the licensee's critique to self-identify areas of improvement was also reviewed.

The last biennial exercise was observed by NRC on June 13, 2007, and included offsite participation. In addition to the biennial exercise, the licensee conducted quarterly drills involving activation of the emergency organization. The licensee's drill frequency (quarterly) and the accident scenarios that were postulated provided sufficient challenges to maintain the proficiency of response personnel.

Critique items resulting from the drills and/or exercises were reviewed by the Emergency Preparedness Committee (EPC) and if needed tracked for corrective actions until completion.

(2) Conclusions

The licensee conducted exercises in accordance with the requirements of the EP. The performance of quarterly drills using realistic scenarios provided sufficient challenges to maintain the proficiency of the response organization.

f. Emergency Equipment and Facilities (F3.06)

(1) Inspection Scope and Observations

Emergency response equipment, instrumentation, and supplies used to evaluate and assess radiological conditions were examined to determine if maintained in a state of operational readiness.

The inspectors observed an inventory and operability check of equipment and noted that survey instruments were operational, and the response to a radiation check source was within the expected range based on the calculated source activity. The remaining equipment (respiratory protection, air samplers, dosimeters, etc.) and supplies were checked for shelf-life, reliability and quantity, and found to be maintained in a state of readiness. Documentation for periodic surveillance performed on emergency equipment, supplies, and emergency kits at selected locations was reviewed to verify that maintenance was being performed in accordance with procedures.

(2) Conclusions

Based on the equipment operability checks and documentation for periodic maintenance, the reliability of selected equipment was good and the equipment was maintained in a state of operational readiness.

7. Permanent Plant Modifications (IP 88070)

a. Inspection Scope and Observations

The radiological safety implications associated with the plant modification involving the redesigned high level dissolver was reviewed. The inspectors reviewed the licensee's 10 CFR 70.72 evaluation, the Radiation Protection Technical Work request, the safety evaluation report (SER), the safety analysis report (SAR), and performed a system walk-down with the system Engineer. The inspectors concluded that the redesign would not appear to result in the performance requirements in 10 CFR 70.61 not being met. Additional reviews of the plant modification were performed by NRC criticality safety inspectors (documented in Inspection Report 70-27/2007-205) and the NRC resident inspector (documented in Inspection Reports 70-27/2005-05 and 70-27/2006-01). Criticality safety, chemical safety and radiation protection requirements were properly evaluated, controls were installed and verified by safety engineers. Accident scenarios were evaluated and IROFS were identified and added to the applicable SAR.

b. Conclusions

Based on the safety reviews, system walk-down, and interviews, controls were in place to protect the workers and environment such that the worst case accident would not result in exceeding the performance requirements in 10 CFR 70.61.

8. **Followup of Previously Identified Issues (IP 88135)**

a. **Violation (VIO) 70-27/2007-06-03: Failure to Notify the NRC Within the Required Time of an Event Involving a Loss of IROFS**

The licensee revised the procedure used to review and evaluate safety events to include NRC notification when conditions were discovered where IROFS should have been implemented but were not. In addition, safety management reviewed this criterion for NRC notification for "loss or degradation of IROFS" with safety and licensing personnel. The inspectors reviewed the completed CAs, concluded that they were adequate, and the item was closed.

b. **VIO 70-27/2007-01-01: Failure to Maintain Container Control Area Entry Requirements**

The inspectors reviewed the completed CAs which included: 1) adding a new requirement in radiation protection (RP) procedure, RP-06, for operators assigned to monitor contractors to read and sign the RWP; 2) completing a lessons learned training session with all UR operators to understand the expectations for monitoring contractors; 3) revising the Container Control procedure, OP - 1019574, to enhance the container control requirements; 4) benchmarking other fuel facilities' container control programs; and 5) implementing additional container control training as a requirement for individuals authorized to access the UR area. The inspectors reviewed the CAs with cognizant operators and toured the UR facility. Operators understood the requirements. The inspectors concluded that the CAs were adequate and the item was closed.

9. **Exit Meeting**

The inspection scope and results were summarized on December 6, 2007, and January 11, 2008, with R. Cochrane, General Manager, and other members of the licensee's staff. Although proprietary information and processes were reviewed during this inspection, proprietary information was not included in this report. No dissenting comments were received from the licensee.

ATTACHMENT

1. LIST OF PERSONS CONTACTED

J. Burch, Manager, Operations
R. Cochrane, General Manager
J. Creasey, Manager, Uranium Processing
D. Faidley, Manager, Nuclear Criticality Safety
B. Cole, Manager, Licensing & Safety Analysis
T. Nicks, Manager, Security
C. Yates, Manager, Safety and Licensing
D. Spangler, Manager, Radiation Protection
M. Suwala, Manager, Nuclear Materials Control
D. Ward, Manager, Environment, Safety, Health and Safeguards
J. Calvert, Manager, Industrial Health and Safety

Other licensee employees contacted included engineers, technicians, production staff, security, and office personnel.

2. LIST OF ITEMS OPENED AND CLOSED

<u>Item Number</u>	<u>Status</u>	<u>Description</u>
70-27/2007-06-03	Closed	VIO - Failure to Notify the NRC Within the Required Time of an Event Involving a Loss of IROFS (Paragraph 8.a).
70-27/2007-01-01	Closed	VIO - Failure to Maintain Container Control Entry Requirements (Paragraph 8.b).

3. INSPECTION PROCEDURES USED

IP 88135	Resident Inspection Program for Category I Fuel Cycle Facilities
IP 88050	Emergency Preparedness
IP 88070	Permanent Plant Modifications