UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

APR 15 1994

Report Nos.: 50-280/94-05 and 50-281/94-05

Licensee: Virginia Electric and Power Company

Docket Nos.: 50-280, 50-281 License Nos.: DPR-32, DPR-37

Facility Name: Surry 1 and 2

Inspection Conducted: February 14-18 and March 21-25, 1994

Inspectors: B. A. Parker — 04/14/94 Date Signed

B. A. Parker FOR D. B. Forbes — 04/14/94 Date Signed

Approved By: W. H. Rankin, Chief — 4/14/94 Date Signed
Facilities Radiation Protection Section
Division of Radiological Protection
and Emergency Preparedness Branch
Division of Radiation Safety and Safeguards

Scope:

This routine, announced inspection was conducted in the area of occupational radiation exposure during outage. Specific elements of the program examined included: organization and management control; audits and appraisals; training and qualification; external exposure control; internal exposure control; surveys, monitoring, and control of radioactive material; instrumentation; and maintaining occupational radiation exposure as low as reasonably achievable (ALARA).

Results:

Overall, the licensee's radiation protection program was well supported by both corporate and station management and was functioning effectively to protect the health and safety of plant personnel and the general public. Control of contamination and the ALARA program continued to be program strengths. One NRC-identified non-cited violation was identified for failure to properly control contaminated material (Paragraph 7).

REPORT DETAILS

1. Persons Contacted

+J. Abbott, Health Physics (HP) Technician
D. Anderson, Shift Supervisor, HP
*G. Belongia, HP Instructor, Nuclear Training
*W. Benthall, Supervisor, Licensing
*R. Bilyeu, Engineer, Licensing
+*M. Biron, Supervisor, Radiological Engineering
+D. Boone, Quality Assurance
*J. Butrick, Shift Supervisor, HP
B. Campbell, HP Site Coordinator, Numanco
Z. Edwards, HP Technician
E. Dilandro, HP Technician
B. Dorsey, Supervisor, Exposure Control
J. Hill, Radwaste Facility Coordinator, Radwaste
+*D. Erickson, Superintendent, Radiation Protection
A. Fields, Senior Technician, Decontamination
*M. Kansler, Station Manager
+*D. Miller, Supervisor, HP Operations
*R. Morgan, Staff Quality Specialist, Quality Assurance
L. Morris, Superintendent, Radwaste
*J. O'Hanlon, Vice-President, Nuclear Operations
+*M. Olin, Supervisor, HP Technical Services
+*J. Price, Assistant Station Manager
L. Ragland, Shift Supervisor, HP
R. Schau, HP Instrument Technician
+S. Scheibe, HP Technician
*E. Smith, Jr., Manager, Quality Assurance
*T. Sowers, Superintendent, Engineering
T. Steed, ALARA Coordinator
+*W. Thornton, Director, HP and Chemistry (Corporate)
C. Verelle, HP Technician
J. Wright, HP Technician

Other licensee employees contacted during this inspection included: craftsmen, engineers, operators, contract personnel, and administrative personnel.

Nuclear Regulatory Commission

M. Branch, Senior Resident Inspector
*S. Tingen, Resident Inspector
+J. York, Resident Inspector

*Attended Exit Interview conducted on February 18, 1994.

+Attended Exit Interview conducted on March 25, 1994.

2. Organization and Management Controls (83729)

The inspector reviewed the staffing of the radiation protection (RP) organization as related to lines of authority and noted no changes since the previous inspection conducted November 15-19, 1993, and documented in NRC Inspection Report (IR) 93-25. The inspector noted that at the time of the inspection, the licensee maintained an adequate level of staffing for the outage with an approximate return rate of 95 percent utility contract returnees.

At the time of inspection, the licensee was approximately mid-way into a planned 64-day refueling outage on Unit 1. Along with typical and routine outage maintenance, the outage also included required 10-year inservice inspection (ISI) work.

No violations or deviations were identified.

3. Audits and Appraisals (83729)

The inspector reviewed the licensee's internal program for self-identification of weaknesses as it related to the RP program and the appropriateness of corrective actions taken. The program included Station Deficiency Reports (SDRs) and Radiation Problem Reports (RPRs). Both systems were utilized by the licensee to document, investigate, and track items of concern. The SDR system was a plant-wide system for identification of concerns, while the RPR was a lower-tier system utilized mainly by the RP organization to identify a variety of minor concerns. The inspector noted that nine SDRs had been identified and assigned to the RP group for investigation and corrective action during 1993, while 92 RPRs were initiated in 1993. In 1994, four RP-related SDRs and five RPRs had been generated at the time of inspection.

The inspector reviewed selected RPRs from 1993 and 1994 and noted that the licensee was identifying substantive items of concern and was following through with appropriate corrective actions to prevent recurrence. Many of the reviewed RPRs dealt with problems associated with the use of digital alarming dosimeters (DADs), such as damaged or dropped DADs or problems with radiofrequency (RF) radiation. No significant concerns arose from the review of RPRs. The inspector also selected SDRs from 1994 and noted no significant concerns, with one exception which is discussed in Paragraph 7 of this report.

The inspector reviewed Radiological Protection Audit 93-08 conducted by the Quality Assurance (QA) department during the period July 7 - August 5, 1993. The audit encompassed a variety of areas within the RP program and utilized both performance and compliance based auditing techniques. The most significant finding identified by the auditors was apparent inattention to detail due to a number of minor administrative errors. The inspector noted the audit to be comprehensive with substantive findings, recommendations, and comments.

Based on the inspectors review of the various levels of audits and appraisals performed by the licensee, the inspector determined the audit and appraisal program was considered to be adequate in identifying potential issues.

No violations or deviations were identified.

4. Training and Qualification (83729)

10 CFR 19.12 requires, in part, that the licensee instruct all individuals working in or frequenting any portion of a restricted area in the health protection problems associated with exposure to radioactive material or radiation; in precautions or procedures to minimize exposure; in the purpose and function of protection devices employed; in the applicable provisions of the Commission regulations; in the individual's responsibilities; and in the availability of radiation exposure data.

The inspector reviewed the licensee's program for providing training to both general plant workers and HP technicians. The inspector was informed that licensee employees received Nuclear Employee Training (NET) prior to beginning work activities, and were required to complete an abbreviated retraining annually. As of January 1, 1994, the licensee implemented new retraining requirements. Classroom training and testing changed from annual, for Virginia Power employees, to once every three years. Retraining during the interim two years would consist of an annual self-study of the NET manual with a signed certification from the employee indicating that the manual had been reviewed. Contract employees' retraining was unchanged, remaining as annual classroom training and testing. All testing required a passing grade of 70 percent. Licensee training representatives indicated that some mechanism may be established that would randomly ensure that the self-studies were being accomplished as designed. They also indicated that a computer-based NET might also be developed to facilitate training and make it easier to obtain, accomplish, and audit. No concerns were noted.

The inspector also reviewed continuing training to be presented to the RP staff in 1994 and identified no concerns. The inspector noted that the continuing training, as planned, would consist of 92 hours, 44 hours, and 24 hours for HP Technicians, HP Specialists, and Decontamination Technicians, respectively. The inspector noted that each training session required completion of comprehensive written examinations with at least 70 percent correct, as well as satisfactory demonstration of applicable tasks as presented during the training. The inspector reviewed training outlines and noted that the material included review of industry events, lessons learned from prior outages, job coverage in high risk exposure areas, emergency response, implementation of the revised computer system, and revised 10 CFR Part 20, specifically to address procedural changes resulting from the revisions. Any less-than-satisfactory performance was treated on a

case-by-case basis, usually receiving one-on-one retraining and retesting with different tests.

No violations or deviations were identified.

5. External Exposure Control (83729)

10 CFR 20.1201 (a) requires each licensee to control the occupational dose to individual adults, except for planned special exposures under 20.1206, to the following dose limits:

(1) An annual limit, which is the more limiting of:

(i) The total effective dose equivalent being equal to 5 rems; or
(ii) The sum of the deep-dose equivalent and the committed dose equivalent to any individual organ or tissue other than the lens of the eye being equal to 50 rems;

(2) The annual limits to the lens of the eye, to the skin, and to the extremities, which are:

(i) An eye dose equivalent of 15 rems; and
(ii) A shallow-dose equivalent of 50 rems to the skin or to any extremity.

10 CFR 20.1501(c)(1) and (2) requires that dosimeters used to comply with 10 CFR 20.1201 shall be processed and evaluated by a processor accredited by the National Voluntary Laboratory Accreditation Program (NVLAP) for the types of radiation being monitored.

10 CFR 20.1502(a) requires each licensee to monitor occupational exposure to radiation and supply and require the use of individual monitoring devices by:

(1) Adults likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the limits in 10 CFR 20.1201(a);

(2) Minors and declared pregnant women likely to receive, in one year for sources external to the body, a dose in excess of 10 percent of any of the applicable limits of 10 CFR 20.1207 or 20.1208; and

(3) Individuals entering a high or very high radiation area.

a. Personnel Dosimetry

During tours of the plant, the inspector observed personnel wearing appropriate monitoring devices on the location of the body as specified by Radiation Work Permits (RWPs). The inspector reviewed and discussed the licensee's dosimetry

program with site personnel and determined licensee dosimetry was being processed under NVLAP certification.

The inspector discussed the licensee's system used for tracking dose as well as other worker information, the Personnel Radiation Exposure Management System (PREMS), and recent problems associated with it. The licensee developed PREMS as part of the change to revised 10 CFR Part 20 and, during the inspection, problems related to the switchover were somewhat compounded by the outage and the continuous need and use of the PREMS system. The DAD system would not interface with PREMS and PREMS periodically "crashed" due to memory problems, forcing the licensee to control access to and exit from the radiologically-controlled area (RCA) with the DADs manually. Overall, the licensee responded well to the problems and no significant concerns were noted.

The inspector noted that the licensee used DADs primarily for daily dose tracking, with approximately 1500 active DADs being kept onsite for routine exposure monitoring. The problems associated with DADs, which were captured by the RPR system, were not significant considering the thousands of entries made into the RCA. The inspector was informed that the licensee expected the DAD dose to be one to five percent higher than the TLD dose during a typical quarter. Correlation results were especially good when individual quarterly doses less than 100 millirem were excluded from the correlation calculation due to high margins of error. For example, in the third quarter of 1993, total TLD dose was approximately one and a half percent higher than the total DAD dose for the same period. However, when the individual doses less than 100 millirem were not counted, the DAD dose exceeded the TLD dose by a few percent as designed.

b. Whole Body Exposure

The inspector discussed the cumulative whole body exposures for plant and contractor employees. Licensee representatives stated and the inspector confirmed by a selected review of dosimetry records that all whole body exposures assigned since the previous NRC inspection of this area were within 10 CFR Part 20 limits. The inspector reviewed licensee followup actions to an administrative overexposure which occurred in June of 1992 as discussed and documented in Inspection Report 50-280, 281/92-16. Based on a review of licensee dosimetry records and discussions with licensee representatives the inspector determined all exposures received since this event have been within licensee administrative exposure control limits.

c. Personnel Contamination Control

The inspector discussed Personnel Contamination Events (PCEs) with cognizant licensee personnel and reviewed licensee procedure HP-6.1.20, "Personnel Contamination Monitoring and Decontamination," Rev. 2, dated November 6, 1990. In 1993, the licensee experienced 99 PCEs, and 152 PCEs had occurred in 1994 as of March 25, 1994. The inspector reviewed selected PCE reports and noted that these PCEs were attributable to varying craft personnel and work events. A number of PCEs had resulted from clothing coming in contact with low level radioactive particles (hot particles). The licensee had detected approximately three "tight" leaking fuel pins which may have contributed to a number of the hot particle PCEs. Some of the PCEs were attributable to poor work practices; however, other root causes were identified which were not worker controlled. A review of the PCEs did not indicate any adverse trends.

The inspector reviewed a January 1994 PCE that involved the contamination of a worker's finger. The contamination was not readily removable. Initially, the licensee thought the contamination may have been inside the hand, perhaps via a wound, but subsequent investigation ruled out that possibility. A wound was never found and multiple attempts were made to decontaminate the finger, but none were very successful. Whole body counts showed no internal intake, and eventually, 156 hours after the individual had initially alarmed a personnel monitor, the contamination was no longer detectable. The licensee investigated the event and concluded that the radioactive material consisted of a highly-soluble salt-like compound containing cesium and iodine isotopes and was readily absorbed by the skin of the hand. Two different dose calculations were performed and both calculated skin doses in the 600-700 millirem range. Internal dose was estimated to be less than 0.1 millirem from absorption. Based on the findings, the licensee assigned the individual an extremity dose of 703 millirem. The inspector's review of the issue identified no significant concerns.

No violations or deviations were identified.

6. Internal Exposure Control (83729)

10 CFR 20.1204(a)(3) requires, in part, that the licensee, as appropriate, use measurements of radioactivity in the body, measurements of radioactivity excreted from the body, or any combination of such measurements as may be necessary for timely detection and assessment of individual intakes of radioactivity by exposed individuals.

The inspector reviewed selected licensee procedures which provided guidance as to when to perform special bioassays, for bioassay evaluation, and for subsequent calculation of internal exposures. The inspector noted that special bioassays were required to be performed for facial PCEs or detection of positive nasal swabs. For the PCE cases reviewed, special whole body analyses were conducted in accordance with procedural requirements, and all calculated intakes were less than 10 percent of annual limits of intake (ALIs). Discussion with licensee representatives indicated that Derived Air Concentration-hours (DAC-hrs) were tracked on an individual basis, and if 40 DAC-hrs were reached during the year, then an evaluation would be conducted and dose assignment made. Internal dose assignment was also made if a whole body count was "positive." As of February 17, 1994, the maximum individual internal dose tracked by the licensee was 2.5 millirem.

The licensee had experienced an increase in the number of low level positive uptakes from the 1993 Unit 2 outage as a result of respirator reduction efforts to reduce the overall dose. The inspector discussed with cognizant licensee representatives the engineering controls used to minimize respirator usage and thereby minimize Total Effective Dose Equivalent (TEDE) for workers. The 1994 Unit 1 outage provided greater challenges in the area of contamination control than did the past Unit 2 outage due to the required removal of contaminated insulation in Unit 1 to support the 10-year ISI work and the fact that the overall source term in Unit 1 was higher than Unit 2. No concerns were noted.

No violations or deviations were identified.

7. Surveys, Monitoring and Control of Contamination and Radioactive Material (83729)

10 CFR 20.1501(a) requires each licensee to make or cause to be made such surveys as (1) may be necessary for the licensee to comply with the regulations and (2) are reasonable under the circumstances to evaluate the extent of radioactive hazards that may be present.

The licensee continued to effectively control contamination at the source. At the end of 1993, the licensee maintained approximately 500 ft^2 of the RCA as contaminated. The licensee's 1994 goal was to eliminate contaminated square footage to at least 250 ft^2. During the inspection, contaminated square footage during the outage was in the 4500 ft^2 range, which was typical.

The inspector noted during tours of the plant that very few catch containments were needed as a means of controlling contamination. At the time of inspection, only six containments were in use for active leaks and a few others were in use for housekeeping and potential leak purposes. Also during tours, the licensee demonstrated the alarm on the laundry monitor used to identify protective clothing that was not

thoroughly decontaminated during the laundering process. Alarms prompted the laundry workers to pull the piece of clothing for relaundering, and if relaundering did not work, the clothing was either stored to allow the contamination to decay away or it was discarded as radioactive waste. The inspector also noted that high radiation areas (HRAs) were locked as required and other entry controls were in place as necessary. In addition, HRA keys were adequately controlled by RP and no major problems were noted. The inspector verified that incore detectors were "tagged out" in the control room to prevent movement of the highly irradiated components while personnel conducted outage activities in and around the incore detector room.

Licensee Procedure HP-8.0.40, "Contamination Surveys," dated August 15, 1988, specifies, in Step 4.6.1, that for items surveyed for unrestricted use, the unrestricted release criteria is (1) loose surface contamination less than 1,000 disintegrations per minute per 100 square centimeters (dpm/100 cm^2) beta-gamma activity and less than 20 dpm/100 cm^2 alpha, and (2) total contamination on any item (fixed plus removable) less than 5,000 dpm/100 cm^2. The inspector discussed survey documentation and supervisory reviews of surveys with selected HPs and HP supervisors regarding the maintenance and controls for survey records. The inspector reviewed selected surveys and discussed survey results with cognizant licensee personnel.

As discussed in Paragraph 3, review of SDRs revealed one concern related to control of contaminated material. Station Deviation No. 94-0391 was initiated on February 14, 1994, following notification from a vendor that some contaminated material had been inadvertently removed from the RCA by them on February 7, 1994. The contaminated material consisted of an acoustical sensor and its respective mount used to evaluate safety injection cold leg and accumulator check valves during the Unit 1 refueling outage. The vendor had brought in and used five of the sensors to do the testing, but mounts for the sensors had been permanently mounted on the piping during a past outage and left for future use to avoid further direct contact of the equipment with the piping. During this outage, however, when the testing was completed, one of the sensors was removed from the piping with the mount still attached. For an unknown reason, the vendor technician did not realize that one of the five sensors still had its mount attached. The vendor technician exited the RCA at the personnel decontamination area (PDA), whole body frisked, and presented the sensors to a HP technician for monitoring in the licensee's small article monitor (SAM). Not being intimately familiar with the equipment, the HP technician also did not realize one of the sensors had a mount attached and placed the articles in the monitor for surveying. The monitor gave a "clear" signal and the articles were removed. The vendor technician exited the PDA with the articles, and packaged and shipped them back to the vendor's office in Philadelphia, Pennsylvania. Upon returning to the office and opening the package, the vendor realized that one of the sensors still had a mount attached. The vendor thought the mount might be contaminated since it

had been in direct contact with the piping for a some period of time and decided to check it for contamination. The mount was unscrewed from the sensor and surveyed with a hand-held survey instrument. The vendor noted an increased count rate on the instrument and contacted the licensee on February 14, 1994. The licensee immediately dispatched a HP technician to the vendor's office in Philadelphia to conduct surveys and retrieve the material. The HP technician returned to the site with the material on February 15, 1994, and, after further analysis, found that the screw threads of both the sensor (male end) and the mount (female end) were slightly contaminated. Total contamination of the sensor mount was determined to be 10,000 dpm/100 cm^2, 4,000 dpm/100 cm^2 of which was removable. The sensor end had total contamination of 2,000 dpm/100 cm^2, with 1,000 dpm/100 cm^2 removable. The other four sensors were found to be free of contamination.

The licensee re-enacted the monitoring of the equipment in the SAM and found that the SAM would only alarm when the mount was unscrewed and separated from the sensor. This indicated that the mount provided enough shielding to prevent the SAM from detecting the low levels of contamination on the screw threads of the equipment when the item was originally removed from the RCA.

The inspector informed the licensee that the release of items above the unrestricted release criteria set forth in HP-8.0.40 constituted a violation of the procedure. However, based on the licensee's prompt response and corrective actions, and the unusual circumstances surrounding the isolated event, the criteria specified in Section VII.B of the enforcement policy were met and the violation was not cited (NCV 94-05-01).

Overall, the licensee's program to control and eliminate contamination was considered a program strength.

One non-cited violation was identified.

8. Instrumentation (83729)

During tours of the RCA, the inspector noted that all portable radiation and contamination monitoring instruments observed, including DADs, had calibration labels affixed to the instruments designating the instruments to be currently calibrated. The inspector interviewed cognizant licensee personnel involved in the calibration process and reviewed selected calibration records. During tours of the facility the inspector observed instrument storage and maintenance areas to be well maintained and observed selected personnel performing instrument pre-operational checks as required prior to signing the instrument check-out log book. The inspector discussed calibration frequencies and methods used by the licensee to retrieve instruments due for

calibration to minimize the risk of an instrument being used which could be out of calibration.

No violations or deviations were identified.

9. Operational and Administrative Controls (83729)

a. Radiation Work Permits (RWPs)

The inspector reviewed selected routine and special RWPs for adequacy of the radiation protection requirements based on work scope, location, and conditions. For the RWPs reviewed, the inspector noted that appropriate protective clothing, respiratory protection, and dosimetry were required. During tours of the plant, the inspector observed the adherence of plant workers to the RWP requirements and discussed the RWP requirements with selected plant workers.

The inspector found the licensee's program for RWP implementation to adequately address radiological protection concerns, and to provide for proper control measures.

b. Notices to Workers

10 CFR 19.11(a) and (b) require, in part, that the licensee post current copies of 10 CFR Part 19, Part 20, the license, license conditions, documents incorporated into the license, license amendments and operating procedures, or that a licensee post a notice describing these documents and where they be examined.

10 CFR 19.11(d) requires that a licensee post form NRC-3, Notice to Employees. Sufficient copies of the required forms are to be posted to permit licensee workers to observe them on the way to or from licensee activity locations.

During the inspection, the inspector verified that NRC Form-3 was posted properly at plant locations permitting adequate worker access. In addition, notices were posted referencing the location where the license, procedures, and supporting documents could be reviewed. The inspector interviewed selected licensee and contractor personnel and verified personnel were familiar with the requirements of 10 CFR 19.11(d).

No violations or deviations were identified.

10. Program to Maintain Occupational As Low As Reasonably Achievable (ALARA) (83729)

10 CFR 20.1101(b) requires that the licensee shall use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are As Low As Reasonably Achievable (ALARA).

The licensee's total collective dose goal for 1993 was originally 595 person-rem; however, due to the overall success of the Unit 2 outage early in the year, the licensee revised the goal to 395 person-rem. The licensee's total collective dose for 1993 came in under the goal at 392 person-rem despite some Unit 2 forced outage steam generator work performed at the end of the year.

The licensee's 1994 goal was set at 642 person-rem. This accounted for two outages during the year, both of which will include 10-year ISI work. At the time of inspection, the licensee's collective dose was approximately 230 person-rem, significantly below the anticipated level of 310 person-rem for that point in the year.

The inspector reviewed a number of dose reduction initiatives employed by the licensee, including better scheduling of scaffolding, refinements to shutdown chemistry, and enhancements of camera use, such as using RF cameras in containment. Also, the licensee continued to identify effective uses of shielding, including water shields, temporary lead blankets and bricks, and permanent shielding on operating systems.

The inspector reviewed the lower internals lift job that was conducted on January 13, 1994, and involved high dose rates around the reactor cavity. The job was performed under RWP 94-2-2050. Dose rates were anticipated to be as high as 1-10 R/hour general area during the lift with contact readings possibly reaching 150-1,000 R/hour. Teledose DADs (used in lieu of direct surveys) indicated, however, that the highest reading recorded was only 364 R/hour. Overall, the job expended approximately 2.7 person-rem, and exceeded the planned dose by approximately one person-rem. This was due to an error in placing the internals on its stand, requiring it to be relifted and replaced. However, the ALARA planning of the job was considered satisfactory and the controls utilized during the job to limit dose were excellent. A post-job debriefing provided a number of suggestions for improvement in executing the job, and those were placed into the historical data files for future reference by the licensee.

Respirator reduction continued to effectively reduce overall worker dose. In 1993, the licensee utilized approximately five-fold less respirators than in 1992, and the 1994 goal of 500 respirators used would be another approximately five-fold decrease over 1993 use. No significant increase in internal exposures was noted and engineering

controls were utilized to complement the reduction in respirator usage.

The inspector noted that the ALARA program continued to be a strength to the licensee's overall program. Strong management support and heavy worker involvement contributed to the continued successes in the area of ALARA.

No violations or deviations were identified.

11. Review of Previously Identified Inspection Findings (92702)

(Closed) VIO 50-280, 281/93-09-01: Failure to (1) provide positive control over an open locked high radiation area (LHRA) and, (2) allow an individual uninhibited egress from a high radiation area.

The inspector reviewed the licensee's corrective actions to the above violation. The corrective actions included using the event in worker training for lessons learned, changing the posting procedure to include the word "locked" on postings where necessary, and upgrading LHRA doors outside of containment such that they self-close/lock and have keyless egress. In addition, a procedural change was made such that LHRA doors that do not have the aforementioned upgrades (i.e. containment LHRA doors) must have continuous HP coverage while open and unlocked, and advanced radiation workers are no longer issued LHRA keys.

The inspector verified the inclusion of the event into training, the door upgrades, and the procedural changes. No problems were noted and this item is considered closed.

12. Exit Meeting

The inspector met with licensee representatives denoted in Paragraph 1 at the conclusion of inspection activities on February 18 and March 25, 1994. The inspector summarized the scope of the inspection findings including the NCV listed below. The licensee did not identify any documents or processes as being proprietary, and no dissenting comments were received from the licensee.

Item Number	Description and Reference
50-280, 281/94-05-01	NRC-identified non-cited violation for failure to properly control contaminated material (Paragraph 7).