

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/89031(DRSS); 50-301/89031(DRSS)

Docket Nos. 50-266; 50-301

Licenses No. DPR-24; DPR-27

Licensee: Wisconsin Electric Power Company  
231 West Michigan, Room 308  
Milwaukee, WI 53201

Facility Name: Point Beach Nuclear Plant (PBNP)

Inspection At: PBNP; Units 1 and 2, Two Rivers, Wisconsin

Inspection Conducted: December 4-22, 1989

Inspector: C. F. Gill  
C. F. Gill

1/9/90  
Date

Accompanied  
By: D. Barss

Approved By: William Snell  
William Snell, Chief  
Radiological Controls and  
Emergency Preparedness  
Section

1/9/90  
Date

Inspection Summary

Inspection on December 4-22, 1989 (Reports No. 50-266/89031(DRSS);  
No. 50-301/89031(DRSS))

Areas Inspected: Routine, announced inspection of a hot particle event (93702) and the radwaste/transportation program, including: organization and management controls (IP 83750, 84750), training and qualifications (IP 83750, 84750), gaseous radwaste (IP 84750), liquid radwaste (IP 84750), solid radwaste (IP 83750, 84750), transportation activities (IP 83750), audits and appraisals (IP 83750, 84750), effluent reports (IP 84750), effluent control instrumentation (IP 84750), primary coolant radiochemistry (IP 84750), and air cleaning systems (IP 84750).

Results: The organizational structure, management controls, staffing levels, and upper management support for the radwaste/transportation program appeared generally adequate. The assessment of the personnel radiation dose associated

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with the April 3, 1989 hot particle event, the determination of root causes, and implementation of appropriate corrective actions need further and more extensive licensee efforts (Section 3). Inspector concerns were identified regarding the apparent violations of burial site license conditions by a licensee radwaste shipment (Section 9) and the lack of a formal release permit program for containment purge and forced vents (Section 6). No violations or deviations were identified.

## DETAILS

### 1. Persons Contacted

- #M. Baumann, Project Engineer, Radiological Design
- \*J. Bevelacqua, Health Physics Superintendent
- \*R. Bredvad, Plant Health Physicist
- W. Doolittle, Nuclear Specialist
- \*F. Flentje, Regulatory Administrative Specialist
- \*T. Fredricks, Chemistry Superintendent
- #\*C. Gates, Radwaste Supervisor
- D. Gesch, Nuclear Specialist
- #\*D. Johnson, Health Physics Superintendent
- J. Knorr, Regulatory Engineer
- \*G. Maxfield, Operations General Superintendent
- M. Moseman, Nuclear Specialist
- \*D. Stevens, Regulatory Specialist
  
- \*C. Vanderniet, NRC Senior Resident Inspector

The inspector also contacted other licensee employees.

\*Denotes those present at the onsite exit meeting on December 8, 1989.

#Denotes those contacted by telephone during the period December 11-22, 1989.

### 2. General

This inspection was conducted to review the radwaste/transportation program. The inspection included tours of the onsite facilities, observation of work in progress, review of records, and discussions with licensee personnel.

### 3. Licensee Action Previous Inspection Findings

(Closed) Violation (No. 266/89022-02; No. 301/89021-02)): Failure to maintain a procedure for measuring post-accident inplant radioiodine. Corrective actions outlined in the licensee's response dated December 8, 1989 were reviewed; no problems were noted.

(Closed) Violation (No. 266/89022-03; No. 301/89021-03)): Failure to meet high radiation area barrier and entry control procedural requirements. Corrective actions outlined in the licensee's response dated December 8, 1989 were reviewed; no problems were noted.

(Open) Unresolved Item (No. 266/89030-02)): Potential overexposure of a Health Physics Technologist (HPT). On November 15, the licensee notified the NRC via the ENS regarding a potential overexposure to the hand of a HPT. On April 3, 1989, while decontaminating the lower refueling cavity, a HPT found a small fuel fragment (.201 cm x .226 cm x .419 cm) which was picked up with a piece of duct tape held in the HPT's left hand, its presence on the tape was confirmed by a radiation monitor, and disposed of

in a plastic bag. On November 9, 1989, the HPT reportedly expressed his concern that a formal dose assessment had not assigned a dose to his hand for the April 3, 1989 event. The initial dose estimate was reported to the NRC on November 15, 1989, as 75 rem to the hand; this estimate was revised to 375 rem on November 17, 1989. Further refinement of the dose assessment by the end of the onsite inspection on December 8, 1989, indicated a maximum extremity dose to one square centimeter of the HPT's left hand of approximately 20 rem. In addition to the licensee's assessment, an independent dose assessment is being performed for the NRC by the Brookhaven National Laboratory. This independent assessment is not yet complete. (The quarterly extremity dose limitation pursuant to 10 CFR 20.101 is 18.75 rem to hands and forearms; feet and ankles.)

The inspector reviewed the video tape of the reenactment of the hot particle event, interviewed appropriate licensee personnel, and reviewed documentation and the licensee's dose assessment methodology. The video tape contained three reenactments of the event, which according to persons interviewed, were accurate representations of the April 3, 1989 event based on recollections of the persons involved. Based on an average of times associated with the three reenactments, the HPT held the fuel fragment (or the hand was in the near vicinity of the object) for about six seconds. Attenuation of the radiation from the fuel fragment would occur due to self absorption of beta radiation; shielding due to protective clothing on the hand (three rubber gloves and a cotton glove), the duct tape, and the natural dead skin layer on the surface of the hand; and the distance between the fuel fragment and the hand, including the air gaps in the gloves and between the duct tape and the outer rubber glove.

The licensee's preliminary analysis of the fuel fragment activity, based on the gamma contribution from the fuel fragment as measured on November 11, 1989, indicated approximately 40 millicuries. The isotopic composition indicated that the fuel fragment came from the core about one year before the event on April 3, 1989. By calculating the beta components of the fuel fragment, which cannot be measured by the licensee's gamma sensitive instrumentation, the licensee currently estimates the total activity was approximately 120 millicuries on April 3, 1989. At the exit meeting on December 8, 1989, the licensee indicated that several more weeks of analysis would be necessary before the dose assessment would be completed.

Interviews with licensee personnel indicate that notification of the April 3, 1989 event was made by the HPT to appropriate licensee personnel, and should have resulted in the dose assessment beginning immediately following the event. There are also claims that technologist personnel expressed concern regarding the need for a formal dose assessment to appropriate health physics professional staff personnel numerous times between April 3 and November 9, 1989, without adequate responsiveness. Because the apparent lack of responsiveness to a potential overexposure incident could represent a significant programmatic health physics problem, the licensee has assigned an incident investigation team consisting of non-plant personnel to ascertain why the HPT used an improper technique to retrieve the fuel fragment and why a dose assessment was not initiated

immediately on April 3, 1989. The team will identify any programmatic problems, the associated root causes, and propose corrective actions to prevent recurrence. The licensee stated at the exit meeting that the dose assessment, the incident investigation team report, and initiation of appropriate corrective actions are expected to be completed by the end of January 1990. Pending completion of the licensee's assessments, this matter remains an unresolved item.

4. Organizational and Management Controls (IP 83750, 84750)

The inspector reviewed the licensee's organization and management controls for the radwaste/transportation program, including: organizational structure; staffing; effectiveness of procedures and other management techniques used to implement the program; and experience concerning self-identification and correction of program implementation weaknesses.

The overall management of the radwaste/transportation program is the responsibility of the Health Physics Superintendent, who reports to the Plant Manager via the Operations General Superintendent. The implementation of the program is the responsibility of the Radwaste Supervisor, who is supported currently by four contract HPTs. The contract HPTs all have several years experience at Point Beach. The licensee stated that after additional plant HPTs complete the HPT training/qualification program, two plant HPTs will be assigned to the Radwaste Supervisor with augmentation by contract personnel, as deemed appropriate. The radwaste systems are operated by the operations department. The responsibility for the effluent radiation monitoring systems is shared between the functional areas of operations, radiation protection, instrumentation and control, and system engineering. The organization and management controls for the radwaste/transportation program appear adequate.

No violations or deviations were identified.

5. Training and Qualifications (IP 83750, 84750)

The inspector reviewed the training and qualification aspects of the licensee's radwaste/transportation program, including: changes in responsibilities, policies, programs and methods; qualifications of newly-hired or promoted personnel; and provisions for appropriate radwaste/transportation training of personnel.

The inspector reviewed the training and qualification requirements and selected qualification documentation for appropriate licensee personnel; no significant problems were noted. The contract HPTs assigned to the Radwaste Supervisor had completed the appropriate HP and radwaste handler OJT/qualification modules.

The HP Superintendent will be transferring to a licensee headquarters position in the near future. The replacement HP Superintendent had been hired and was onsite. At the end of an approximately two month transition period, the present HP Superintendent will assume his headquarters position and his replacement will assume the full responsibilities

as the HP Superintendent. The transition process appeared to be progressing smoothly and represented good licensee performance. Technical Specification (T/S) 15.6.3.3 specifies the education and experience requirements for the position of Health Physicist. The inspector verified that the replacement HP Superintendent met the requirements of T/S 15.6.3.3.

No violations or deviations were identified.

6. Gaseous Radioactive Radwaste (IP 84750)

The inspector reviewed the licensee's gaseous radwaste management program, including: changes in equipment and procedures; gaseous radioactive waste effluents for compliance with regulatory requirements; adequacy of required records, reports, and notifications; process and effluent monitors for compliance with maintenance, calibration, and operational requirements; and experience concerning identification and correction of programmatic weaknesses.

The inspector reviewed selected records of radioactive gaseous effluent releases and semiannual effluent reports for 1988 and 1989 to date. The pathways sampled and analyses performed appeared to comply with technical specification requirements. The gaseous effluent pathways and the sampling and monitoring program remained essentially as discussed in Section 5 of Inspection Reports No. 50-266/88022(DRSS); No. 50-301/88020(DRSS). In 1988, the plant total gaseous effluents released consisted of about 80.8, 2.66 E-3, and 126.3 curies of noble gas, radioiodine, and tritium, respectively; the corresponding values for the first half of 1989 were 9.81, 1.18 E-3, and 61.1 curies, respectively. Gaseous releases remained less than one percent of the annual T/S limits.

The inspector also reviewed the gaseous batch release permit program and selectively reviewed the associated documentation for past releases. Although no problems were identified with the radioactive waste gas decay tank discharge (WGDT) release permit program, the inspector noted several concerns regarding the release of airborne activity from the containment (purges or forced vents). The licensee has not established a release permit program for containment purges or forced vents. Although the containment atmosphere is sampled before a containment release, the licensee indicated that the sample is analyzed after the release is initiated and not used to ascertain the airborne isotopic concentration before allowing the release. The inspector discussed with the licensee that this practice appears contrary to the licensee's policy of requiring formal batch release permits for all liquid and WGDT effluent releases. The inspector also expressed concern regarding the apparent desirability of confirming that the effluent monitor setpoints for containment releases were appropriate for the isotopic components of a proposed containment release, the potential that depressurizing the containment

by a forced continuous vent system could release significantly more gaseous effluents than a pressure controlled intermittent system, and that the containment air cleanup system might not be used in an optimum manner to reduce airborne radioactive iodine/particulate concentrations before containment purge/vents. These concerns were discussed at the exit meeting and will be reviewed further during a future inspection (Open Item No. 266/89031-01; No. 301/89031-01).

No violations or deviations were identified; however, one open item was identified.

7. Liquid Radioactive Waste (IP 84750)

The inspector reviewed the licensee's liquid radwaste management program, including: changes in equipment and procedures; liquid radioactive waste effluents for compliance with regulatory requirements; adequacy of required records, reports, and notifications; process and effluent monitors for compliance with maintenance, calibration, and operational requirements; and experience concerning identification and correction of programmatic weaknesses.

The inspector reviewed selected records of radioactive liquid effluents released and semiannual effluent reports for 1988 and 1989 to date. The pathways sampled and analyses performed appeared to comply with technical specification requirements. The liquid effluent pathways and the sampling and monitoring program remained essentially as discussed in Section 4 of Inspection Reports No. 50-266/88022(DRSS); No. 50-301/88020(DRSS). In 1988, the plant total liquid effluent release consisted of about 0.0958 curies total activity (excluding tritium) and 354 curies of tritium; the corresponding values for the first half of 1989 were 0.0101 and 184 curies, respectively. Liquid releases remained less than one percent of the total activity (excluding tritium) annual T/S limit and averaged about 2% of the annual tritium T/S limit. The inspector also selectively reviewed the liquid batch release permit program and associated documentation for past releases; no significant problems were noted.

No violations or deviations were identified.

8. Solid Radwaste (IP 83750, 84750)

The inspector reviewed the licensee's solid radwaste management program, including: changes to equipment and procedures; processing, control, and storage of solid wastes; adequacy of required records, reports, and notifications; implementation of procedures to properly classify and characterize waste, prepare manifests, and mark packages; and experience concerning identification and correction of programmatic weaknesses.

The inspector reviewed selected portions of the licensee's solid radwaste generation, shipping, and burial records for 1983-1988 and 1989 to date. Licensee records indicated that approximately 25,095; 25,154; 9562; 3809; 6050; and 6920 cubic feet of solid radwaste were generated in

1983 through 1988, respectively. Although solid radwaste generation data for 1989 was not available, the licensee indicated that about 4400 cubic feet of solid radwaste from Point Beach is estimated to be buried at licensed disposal sites in 1989. The licensee's waste classification, solidification, and volume reduction programs remained essentially as discussed in Section 9 and 10 of Inspection Reports No. 50-266/88022(DRSS); No. 50-301/88020(DRSS). Although the licensee had made significant progress in reducing the volume of solid radwaste, the licensee estimated that a further ten percent reduction was likely by the use of better dry-active-waste (DAW) volume reduction techniques. Therefore, to further reduce the volume of DAW generated, the licensee has purchased a ventilated and filtered sorting chamber to segregate and survey DAW, a shredder, and a more powerful DAW compactor. The inspector toured the solid radwaste facility, including the temporary storage facility and shipment staging areas; no significant problems were noted.

No violations or deviations were identified.

9. Transportation Activities (IP 83750)

The inspector reviewed the licensee's transportation of radioactive materials program, including: determination whether written implementing procedures were adequate, maintained current, properly approved, and acceptably implemented; determination whether shipments were in compliance with NRC and DOT regulations and the licensee's quality assurance program; determination if there were any transportation incidents involving licensee shipments; adequacy of required records, reports, shipment documentation, and notifications; and experience concerning identification and correction of programmatic weaknesses.

The inspector selectively reviewed portions of the radwaste shipment records for 1988 and 1989. The information on the shipping papers appeared to satisfy NRC, DOT, and burial site requirements. The licensee had 23 shipments in 1988 and eight shipments in the first half of 1989 consisting of approximately 6,870 and 820 cubic feet, respectively.

In a letter dated June 29, 1989, the South Carolina Department of Health and Environmental Control notified the licensee that Point Beach Radioactive Waste Shipment No. 0689-142 was found to be improperly solidified in apparent violation of burial site license conditions. The shipment was classified as Radioactive Material, LSA, N.O.S., described as solid oxides deposited on evaporator bottoms solidified in cement, packaged in a steel liner, and transported in a 14-170 shipping cask. The burial site inspectors had conducted a punch test on the subject waste line on June 19, 1989. The punch test on the upper section determined the waste form to be satisfactory; however, as the punch testing tool was removed from the bottom section of the liner, a quantity of the waste in a paste form had adhered to the punch testing tool. Although no free standing water was observed and the waste did not flow freely, the onsite state inspectors concluded that the waste was not satisfactorily solidified and could not be accepted for burial at the Barnwell disposal site.



Upon notification of the discrepancy by telephone on June 19, 1989, the licensee began a review of the cause of the unsatisfactory waste form and began formulating corrective actions. The licensee concluded that the waste liner had been solidified in accordance with approved process control parameters by the processing vendor. According to the licensee, prior to solidifying the waste in the liner, a test sample of the actual waste was solidified in accordance with the process parameters on May 31, 1989. The licensee stated that this test sample satisfactorily cured within 36 hours. The waste was solidified in the liner on June 4, 1989. On June 6, 1989, a penetration test was conducted on the waste through the liner cap and the waste was observed to have properly solidified. The licensee concluded the waste had solidified to a free standing monolith and shipped the waste liner from Point Beach on the afternoon of June 6, 1989.

On June 20, 1989, representatives from the licensee's waste processing vendor inspected the waste liner at the Barnwell site and extracted a sample of the waste which had been removed with the punch testing tool. A vendor solidification supervisor inspected the liner using an external sounding technique. According to the licensee, the vendor concluded that the majority of the waste in the liner had properly cured. On June 21, 1989, the Point Beach HP Superintendent and the Radwaste Supervisor visited the Barnwell site to meet with the onsite state inspectors and regulatory specialists employed by the contractor site operator. The Point Beach representatives also met with the processing vendor solidification supervisor and chemist to determine probable root cause and to formulate corrective actions. The licensee concluded that, based on tests of a waste sample on June 20 through 21, 1989 by a vendor chemist that the waste would properly solidify with three-to-five weeks additional curing time. On June 22, 1989, the Point Beach representatives met with representatives of the South Carolina Department of Health and Environmental Control in their Columbia, S.C. offices to discuss the probable cause of the discrepancy (proper mixing and waste loading was evident; however, it was theorized that boron may have concentrated in the poorly solidified area of the liner retarding the curing process) and to announce the licensee's intention to withdraw the waste liner from the Barnwell site.

The waste liner was removed from the Barnwell disposal site on June 24, 1989, and arrived back at the Point Beach Nuclear Plant on June 27, 1989. Because the licensee also had stored onsite two other liners of solidified evaporator bottoms which used the same process parameters as the defective liner which had been shipped to Barnwell, the licensee's corrective action plan included confirming that all three liners were properly solidified before shipment to the burial site and to ensure that all evaporate waste in the future would conform to applicable acceptance criteria. The status of planned/completed actions are discussed below.

- A sounding test was performed on all three liners. The results of these tests indicated suspect areas in the liners where the waste may not have been completely solidified.

- Holes were drilled or cut in the sides of the liners at locations where the sounding tests indicated that the waste may not have completely solidified. One of the two liners that had not been shipped to Barnwell exhibited the release of free standing water when the liner integrity was violated during the drilling process. In order to exam the condition of the liner and the underlying waste form, a two by five foot section of the liner was removed and the contents of the liner were penetrated over a broad area to a significant depth. The same problems regarding improper curing were found in the contents of this liner as had been exhibited by the waste in the liner which had been shipped to Barnwell. The licensee stated that the free standing water was not contaminated and appeared to come from the region between the steel liner and the liner's epoxy coating, possibly due to improper curing of the coating. The liner with the liner panel still removed was undergoing accelerated curing by the use of heat lamps. During a plant tour, the inspector and the Radwaste Supervisor noted that the epoxy coating has partially separated from the liner panel, possibly due, in part, to the effect of the improper epoxy curing exacerbated by the use of the heat lamps. The licensee stated that no problem regarding epoxy curing was found on the other two liners. The licensee was continuing to work with their process vendor in an attempt to adequately solidify the waste in the liners and resolve any problems with the solidification and liner coating processes so that Barnwell would accept the liners and their contents for burial at that facility.
- The licensee stated that compressive strength tests had been conducted on the waste content of all three liners. The waste was classified as Class A unstable. Because there is no well defined acceptance criterion for compressive strength testing of unstable waste, the evaporator waste in the three liners were tested with the acceptance criterion established for stable waste. According to the licensee, all testing was done at a minimum compressive strength of 50 PSI and met applicable acceptance criteria.
- Following completion of further curing and any other testing or repair deemed appropriate, the licensee planned to reseal the liners and ship them for burial at the Barnwell facility after consultation with the processing vendor and State of South Carolina officials.
- In a letter to the South Carolina Department of Health and Environmental Control, dated July 18, 1989, the licensee committed to work with their waste processing vendor to review the evaporator waste process control parameters and solidification procedure prior to the next use. The licensee also stated that revisions to processing parameters and procedures would be made, as appropriate. The department was informed that the licensee was evaluating techniques which could be used to inspect or evaluate liners to verify that proper solidification of evaporator wastes had occurred and that the

licensee anticipated that these inspections or evaluation techniques would be added to their radioactive waste quality control program.

At the time of the onsite inspection the licensee had not resolved the problems with the solidification process and needed further discussions with the processing vendor and the burial site regarding disposition of the three subject liners of processed evaporated bottoms. This matter was discussed at the exit meeting and is considered an unresolved item, pending the outcome of the licensee's root cause analysis and ongoing discussions between the licensee, the processing vendor, and representatives of the State of South Carolina (Unresolved Item No. 266/89031-02; No. 301/89031-02).

No violations or deviations were identified by the inspector; however, one unresolved item was identified.

10. Audits and Appraisals (IP 83750, 84750)

The inspector reviewed reports of audits and appraisals conducted for or by the licensee including audits required by Technical Specifications. Also reviewed were management techniques used to implement and audit the program, and experience concerning identification and correction of programmatic weaknesses.

The inspector selectively reviewed portions of the QA audit and surveillance reports and corporate health physics group audit reports for 1988 and 1989. The licensee's QA and corporate HP audit/surveillance program appeared adequate to assess technical performance, compliance with requirements, and personnel training/qualification relating to the radwaste/transportation program. The QA and corporate HP auditors assigned to review this functional area appeared to have the necessary expertise and experience prerequisites. Interviews with appropriate licensee personnel indicated that responses to audit/surveillance findings were generally thorough, timely, and technically sound.

No violations or deviations were identified by the inspector.

11. Effluent Reports (IP 84750)

The inspector selectively reviewed radiological effluent analysis results to determine accuracy of data reported in the Semiannual Radioactive Effluent Release Reports for 1988 and the first half of 1989. Technical Specification 15.7.8.4.A specified the data to be reported in the Semiannual Radioactive Effluent Release Reports. All required information appeared to have been included in the reports with the possible exception of the total amount of solid radwaste shipped (in cubic feet) and estimated total radioactivity (in curies) shipped during each reporting period. Although the licensee reported these values for each individual shipment, the summary totals for each reporting period were not reported. This matter was discussed at the exit meeting; the licensee agreed to include this additional information in future reports to enhance the thoroughness of the reports.

No violations or deviations were identified.

12. Effluent Control Instrumentation (IP 84750)

Selected gaseous and liquid effluent/process monitor surveillance records for calendar year 1988 and 1989 to date were selectively reviewed for compliance with technical specification and procedural requirements for operability, trip setpoints, calibrations, and functional testing; no significant problems were identified. The setpoint, calibration, and surveillance programs were essentially as discussed in Section 7 of Inspection Reports No. 50-266/88022(DRSS); No. 50-304/88020(DRSS). The inspector also reviewed the reliability of these monitors by discussions with appropriate licensee personnel and reviewed out of service (OOS) data regarding these monitors. Although there were 108 monitor channels to maintain operable, it appeared that the licensee is exhibiting good performance by minimizing the number of channels out of service and the OOS time before repair or maintenance activities restored the channels to operable status. The inspector also toured the control room to observe the use of Radiation Monitoring System (RMS) status display and CRT diagnostic display stations, the use of routine periodic status of certain RMS readouts in determining indication of failed fuel or changing plant conditions, and the use of the RMS Alarm Setpoint and Response Book. The licensee appeared to have a well established and implemented program regarding RMS reliability and use of monitor indications in making operational decisions.

No violations or deviations were identified.

13. Primary Coolant Radiochemistry (IP 84750)

Technical Specification 15.3.1.C requires that the specific activity of the primary coolant not exceed one microcurie of I-131 dose equivalent per gram except under certain limiting conditions of operation. The inspector selectively reviewed the licensee's primary coolant radiochemistry results for 1988 and 1989 to date to determine compliance with the Technical Specification requirements for the I-131 dose equivalent (DEI-131) concentration. The selective review and discussion with licensee personnel indicated that the DEI-131 concentration for the primary system remained less than the applicable Technical Specification limit throughout the review period for both units.

No violations or deviations were identified.

14. Air Cleaning Systems (IP 84750)

Although technical specifications require only testing of control room filter systems, all systems are tested annually. The in-place testing includes DOP testing of HEPA filters, Freon in-place testing of charcoal adsorbers and laboratory testing of charcoal adsorber samples for methyl iodide removal efficiency. The ventilation systems tested included containment purge (1F11A, 2F11A, 1F11B, 2F11B), control room emergency ventilation (F16), auxiliary building ventilation (F20, F21, F23, F25, F29), drumming area ventilation (F26), combined air ejector vent (F30), and containment cleaning (1F32 and 2F32). The inspector verified that

the licensee had been complying with filter testing frequency and acceptance criteria as specified by Technical Specifications and plant procedures. The inspector also verified that the licensee was specifying that their laboratory testing vendor was testing charcoal adsorber samples for methyl iodide removal efficiency using the testing protocol recommended by NRC Information Notice No. 87-32, Deficiencies in the Testing of Nuclear Grade Activated Charcoal. During the exit meeting and during the inspection the inspector discussed with the licensee the apparent desirability of additional training for the Nuclear Specialist in charge of the air cleaning system filter testing program.

No violations or deviations were identified.

14. Exit Meeting (IP 30703)

The inspector met with licensee representatives (denoted in Section 1) at the conclusion of the onsite inspection December 8, 1989, and by telephone through December 22, 1989. The inspector summarized the scope and findings of the inspection. The inspector also discussed the likely informational content of the inspection report with regard to documents and processes reviewed by the inspector during the inspection. The licensee did not identify any such documents or processes as proprietary. The following matters were discussed specifically by the inspector:

- a. The potential overexposure to the hand of a Health Physics Technologist due to exposure to a hot particle (fuel fragment). The licensee stated that the dose assessment, the incident investigation team report, and initiation of appropriate corrective actions are expected to be completed by the end of January 1990. (Section 3)
- b. Inspector concerns regarding the lack of a formal release permit program for containment purge and forced vents. The licensee agreed to evaluate the adequacy of current policies regarding the release of radioactivity from the reactor containment structures, although no estimation of a completion date was established. (Section 6)
- c. The apparent violations of burial site license conditions by a licensee radwaste shipment. (Section 9)
- d. The apparent need to supplement data presented in the Semiannual Radioactive Effluent Release Reports. The licensee agreed to include this additional information in future reports to enhance the thoroughness of the reports. (Section 11)
- e. The apparent desirability of additional training for the Nuclear Specialist in charge of the air cleaning system filter testing program. (Section 14)