UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

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Report Nos.: 50-321/94-04 and 50-366/94-04

Licensee: Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Docket Nos.: 50-321, 50-366 License Nos.: DPR-57, NPF-5

Facility Name: Hatch 1 and 2

Inspection Conducted: January 24-28, 1994

Inspector: Elizabeth B. Pharr 2/23/94
E. B. Pharr Date Signed

Accompanying Personnel: W. T. Loo

Approved by: William H. Rankin 2/25/94
W. H. Rankin, Chief Date Signed
Facilities Radiation Protection Section
Radiological Protection and Emergency Preparedness Section
Division of Radiation Safety and Safeguards

## SUMMARY

Scope:

This routine, unannounced inspection was conducted in the area of occupational radiation exposure. Specific areas examined included: organization and management controls, training and qualifications, external exposure control, internal exposure control, control of radioactive materials, contamination, and surveys, and maintaining occupational exposures as low as reasonably achievable (ALARA).

Results:

Overall, the inspector found the licensee's program to be functioning adequately to protect the health and safety of plant workers and the public. The licensee appeared to be effectively implementing revised 10 CFR Part 20 requirements through training and procedural changes. Training, audits, and the Deficiency Card (DC) system appeared to adequately stress the importance of a strong Health Physics (HP) compliance attitude as well as to seek areas of improvement. The licensee appeared to have effective control of personnel access to high radiation areas with stringent key and access control programs. The inspector noted that the licensee had set a challenging collective exposure goal of 800 person-rem for 1994, with two outages planned during the

course of the year. Appropriate measures were being planned for the upcoming Unit 2 outage to deal with anticipated problems associated with suspected leaking fuel assemblies. Additionally, two previous inspection findings were closed based on information gathered during the inspection.

# REPORT DETAILS

1. Persons Contacted

Licensee Employees

*O. Fraser, Site Supervisor, Safety Audit and Engineering Review
*M. Googe, Manager, Outages and Planning
*J. Hammonds, Supervisor, Regulatory Compliance
*W. Kirkley, Manager, Health Physics (HP) and Chemistry
*M. Link, Supervisor, HP
*B. Manning, Plant Chemist
*T. Moore, Assistant General Manager, Operations
*R. Ott, Supervisor, Training
*J. Payne, Engineer, Nuclear Safety and Compliance (NSC)
*D. Read, Assistant General Manager, Support
*J. Reddick, Supervisor, HP
*G. Riner, Plant Health Physicist
*D. Smith, Superintendent, HP
L Sumner, General Manager
*S. Tipps, Manager, NSC
*P. Wells, Manager, Operations

Other licensee employees contacted during this inspection included engineers, technicians, and administrative personnel.

Nuclear Regulatory Commission

E. Christnot, Resident Inspector
*W. Rogers, Service Water System Team Leader
*L. Wert, Senior Resident Inspector

*Denotes attendance at January 28, 1994, Exit Meeting

2. Organization and Management Controls (83750)

During the onsite inspection, the inspector reviewed the licensee's staffing and organization for the Health Physics (HP) Department. No significant changes were noted in the organizational structure since the previous inspection conducted August 9-13, 1993, and documented in NRC Inspection Report (IR) 50-321, -366/93-16. The HP organization remained relatively stable, maintaining a staff of 67. This included managers, supervisors, foremen, specialists, and technicians.

The inspector was also informed that the licensee was presently reviewing resumes for additional contractor HP staffing necessary to compliment the licensee's staff during the upcoming Unit 2 outage planned for March 1994. The licensee plans to employ approximately 85 contractors during this outage. This number is approximately 20 less than previous outages, mainly due to the licensee's advent of the automated Digital Alarming Dosimeter (DAD) system which will decrease the licensee's need for clerical and junior technician staff. The inspector was also informed that the licensee does not plan to employ

any contractor that does not have Boiling Water Reactor (BWR) experience, and anticipates a return rate of contractors from previous site outages of at least 80 percent.

Based on discussions with licensee representatives and observations of activities in progress, no concerns were identified regarding the licensee's organization and staffing. The present HP organization and staffing levels appeared adequate to support ongoing activities, while plans for contract HP staffing appeared appropriate for planned outage activities.

No violations or deviations were identified.

3. Audits and Appraisals (83750)

a. Safety Audit and Engineering Review (SAER) Audits

10 CFR 20.1101 requires the licensee to periodically (at least annually) review the radiation protection program content and implementation.

Section 17.2.18, Audits, of the Hatch Unit 2 Final Safety Analysis Report requires, in part, that audits of HP and radiation protection (RP) be performed under the cognizance of the Safety Review Board at least once per 24 months, unless more frequent audits are necessary due to certain specified conditions.

The inspector discussed the audit program with licensee representatives within the SAER Department and determined that the audit frequency for "Health Physics and Radiation Protection" had been changed from 24 months to annually to meet the new 10 CFR Part 20 requirements. Through further discussions with licensee representatives, the inspector was informed that an HP audit had been scheduled to be performed within the next few months. Through those discussions, the inspector determined that the upcoming HP audit elements were to include:

- Radiation and Contamination Control, including Drywell/Traversing Incore Probe (TIP) Room Access; Use and Care of Vacuum Cleaners; and the Respiratory Protection Program,

- Personnel Dosimetry Program, including Radiation Exposure Limits, and the Bioassay Program,

- ALARA Program, and

- HP Response to a Radiological Fire.

In addition, the inspector was informed by SAER representatives that the upcoming HP audit would review the licensee's implementation of revised 10 CFR Part 20 requirements.

The inspector noted that the proposed elements for the upcoming SAER HP audit were appropriate for evaluating the effectiveness of specific program areas. The inspector informed licensee representatives that the completed audit would be reviewed during future inspections.

No violations or deviations were identified.

b. Deficiency Card System

The inspector selectively reviewed the deficiency cards (DCs) reported since July, 1993, and determined that approximately 45 DCs involved radiological concerns. Through further review of DCs and discussions with licensee representatives, the inspector noted an incident in which a licensee employee entered the Radiologically Controlled Area (RCA) without proper dosimetry. On numerous occasions the licensee had informed the individual that he was due for his annual whole body count (WBC). After several unsuccessful attempts by dosimetry personnel to ensure that this individual obtain his annual WBC, HP pulled his thermoluminescent dosimeter (TLD) from service. However, the individual entered the RCA without his TLD, but wore his self reading pocket dosimeter (SRPD). Twenty minutes later, the individual was identified as not wearing his TLD and escorted out of the RCA. As a result of this incident, the licensee took disciplinary actions against the individual for not obtaining a WBC and for entering the RCA without proper dosimetry. Based on discussions with licensee representatives and review of other DCs, the inspector noted that this incident appeared to be an isolated event. However, to prevent future incidents of this nature and to strengthen their access control program, the licensee changed its policy and procedures to include pulling an individual's protected area identification badge along with the TLD to ensure that individuals obtain a WBC or complete other requirements as needed for RCA access.

Based on discussions between the inspector and licensee representatives and a review of records, it appeared that the licensee was adequately identifying areas of concern and taking actions to correct those items. Furthermore, no adverse trends were noted since the last inspection.

No violations or deviations were identified.

4. Training and Qualifications (83750)

10 CFR 19.12 requires the licensee to instruct all individuals working in or frequenting any portions of the restricted areas in the health protection aspects associated with exposure to radioactive material or radiation, in precautions or procedures to minimize exposure, and in the

purpose and function of protection devices employed, applicable provisions of Commission regulations, individuals' responsibilities and the availability of radiation exposure data.

The inspector reviewed the current lesson plans and training modules in use for General Employee Training (GET) as provided to licensee and contract employees. Through discussions with training representatives and a review of training lesson plans, the inspector determined that Lesson Plan No. GE-IH-10294-01, dated January 4, 1994, "GET Requalification", for licensee and contractor employees had been revised to include the changes for the new 10 CFR Part 20 requirements. The inspector noted that the course was conducted with the aide of audiovisual slides to include a review of 10 CFR Part 20 changes related to terminology, dose limits, high radiation area postings and controls, and the decreased use of respiratory protective equipment. In addition, the licensee issued Departmental Directive, GM-93-14, dated December 3, 1993, to ensure that all licensee employees received training related to the new 10 CFR Part 20 requirements. The inspector also determined that the licensee had a videotape presentation available to all employees for additional review on the new 10 CFR Part 20 requirements.

The inspector also reviewed the continuing training program as provided to the HP staff. Based on discussions and a review of records, the inspector determined that Lesson Plan No. HP-ST-92300-00, dated September 25, 1992, "10 CFR 20 Changes to Health Physics Procedures", had been developed for use in HP continuing training. The lesson plan reviewed the licensee's procedural changes as they related to the new 10 CFR Part 20 requirements.

Additionally, the inspector noted that the licensee had developed a videotape addressing proper use of the licensee's, soon to be implemented, DAD system. Training representatives stated that this videotape was being updated to include the new 10 CFR Part 20 requirements and would be a part of GET. In addition, training representatives stated that the updated videotape would be available for use by February, 1994 and issued under a Departmental Directive for viewing by all licensee employees. This licensee initiative would ensure that all employees be familiar with the DAD system prior to the upcoming Unit 2 Refueling Outage.

The inspector reviewed training records for selected licensee employees, to include HP technicians, and noted successful completion of GET and HP continuing training, as appropriate. Overall, the inspector found the RP training material, as revised to include new 10 CFR Part 20 requirements and terminology, presented to both general employees and HP technicians to be thorough and well prepared.

No violations or deviations were identified.

5. External Exposure Control (83750)

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

(1) An annual limit, which is more limiting of : (i) the total effective dose equivalent (TEDE) being equal to 5 rems: or (ii) the sum of the deep-dose equivalent and the committed dose equivalent to any 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 20.1208 (a) requires that the dose to the embryo/fetus not exceed 500 millirem during the entire pregnancy due to occupational exposure of a declared pregnant woman.

10 CFR 20.1502(a) requires each licensee to monitor occupational exposure to radiation and to supply and require the use of individual monitoring devices, as applicable.

a. Program Implementation

The inspector reviewed a licensee procedure related to external exposure controls and monitoring, 60AC-HPX-001-0S, Radiation Exposure Limits, Revision (Rev.) 4, to verify that it had been updated to incorporate revised 10 CFR Part 20 requirements and terminology. The inspector verified that this procedure had been revised and reflected the new regulatory annual exposure limits as well as those administrative limits utilized by the licensee to ensure personnel do not exceed the federal limits on annual exposure. The inspector was informed that rather than limit minors to ten percent of the applicable exposure limits, as required by the regulations, the licensee's procedure did not allow persons under the age of 18 to be occupationally exposed. The inspector noted that the licensee established initial limits of 1000 millirem per year (mrem/yr), Total Effective Dose Equivalent; 3000 mrem/yr, Eye Dose Equivalent; and 10,000 mrem/yr, Shallow Dose Equivalent. The inspector also noted that the licensee established margins in order to alert personnel of potential situations in which administrative limits may be exceeded. The licensee had also made provisions for management approvals allowing individuals to exceed established administrative exposure limits. The licensee also noted that although the licensee had appropriate procedural guidance for allowing Planned Special Exposures (PSEs), licensee representatives informed the inspector that as a plant policy the licensee did not plan the use of PSEs.

The inspector further noted that the licensee had a Declared Pregnant Woman (DPW) policy in which they limited dose to women who officially declared their pregnancy to 500 mrem over the entire gestation period. During discussions with a DPW onsite and other licensee representatives, the inspector was informed that although not a procedural requirement, DPWs were encouraged to limit their activities in High Radiation Areas (HRAs), Airborne Radioactivity Areas, and Contamination Areas. The inspector reviewed exposure records for the DPW and verified that the licensee was appropriately limiting the individual's dose in accordance with their procedures and regulatory guidance.

The inspector discussed with licensee representatives their dosimetry and exposure monitoring programs in response to new 10 CFR Part 20 requirements. The inspector was informed that procedures required monitoring for all individuals making routine entries into the RCA. Additionally, the inspector noted that since recent years, with the advent of the licensee's hydrogen injection program, the licensee had implemented an "environmental monitoring" program for personnel who worked outside the RCA . These individuals did not make entries into the RCA but worked in close enough proximity to the RCA that increased dose rates resulting from increased hydrogen injection could potentially result in the individuals exceeding ten percent of the annual exposure limits, thus requiring the licensee to provide monitoring for the individuals. At the time of the onsite inspection the inspector noted that the licensee was continuing to indirectly monitor personnel exposures by way of their "environmental monitoring" program; however, this monitoring program had not yet indicated the need for providing personnel monitoring to these individuals.

The inspector also noted that the licensee continued to provide TLDs to individuals requiring personnel monitoring. Licensee procedures required annual evaluations to determine the need for personnel monitoring. For 1994 the licensee had decided to provide external exposure monitoring and tracking of dose for all individuals making routine entries into the RCA. The licensee used the TLD for primary monitoring and a SRPD for secondary monitoring. Personnel TLDs were read monthly, while SRPDs were read daily and used as a means for tracking individual's cumulative exposure. The inspector was also informed that the licensee planned to soon implement a DAD system which would replace the SRPD as a secondary monitoring capability. The inspector noted during plant tours that workers wore dosimetry as required. The inspector also noted that the licensee had previously implemented the use of DADs for all HRA entries and other special cases.

The inspector verified that the licensee had appropriately updated their external exposure control and monitoring procedures to be consistent with new 10 CFR Part 20 requirements. The inspector

also noted that the licensee appeared to be appropriately providing monitoring equipment and controlling exposure to plant personnel.

No violations or deviations were identified.

b. Skin/Extremity Monitoring and Assessments

The inspector noted that the licensee ended 1993 with a total of 147 personnel contamination reports (PCRs). The 1993 goal was 181 PCRs. The inspector also selectively reviewed the licensee's 1993 PCRs and in general, no adverse trends were noted. The inspector verified that in accordance with procedures the licensee was appropriately performing skin dose assessments when contamination greater than 20,000 disintegrations per minute (dpm) per probe area was detected on the skin and/or clothing. The only exception to the rule was the bottom of the shoes, where at least 100,000 dpm/probe area was required to trigger an assessment. The inspector also noted that the licensee utilized the updated version of VARSKIN to calculate skin doses and, for conservatism, most of the assessments were treated as point sources. Of those selected 1993 PCRs reviewed by the inspector, the maximum noted skin dose was due to a hot particle contamination on an individual's sock. Based on the licensee assessment, using VARSKIN, the individual was assigned a skin dose of approximately 1.5 rem. The inspector noted that no regulatory limits were exceeded and no problems were identified with the licensee's procedures or methods.

The inspector also reviewed an incident which occurred on June 8, 1993 in which an individual working on the licensee's refueling floor was attempting to change the spring of a hydraulic cutting tool. The tool had been used to cut up Local Power Range Monitors, which were stored in the Spent Fuel Pool, and during the process of changing out the spring a metal sliver from the contaminated tool became imbedded in the individual's finger. HP technicians measured 70,000 dpm with a pancake probe at the wound. The individual was taken to the hospital where the sliver was removed from the finger. After the sliver was removed the wound was again surveyed and determined to be less than 100 counts per minute (CPM) per the probe area. The irradiated sliver was brought back to the plant where isotopic analyses were performed. Also the licensee performed followup WBCs and urinalyses for the individual and determined that residual contamination appeared to remain in the finger wound but an uptake by the individual did not appear to have occurred. Isotopic analyses were also performed of the individual's finger. Assuming a stay time of two hours, the time from which the metal sliver was imbedded in the individual's finger to the time of removal at the hospital, a volume of one cubic centimeter, and using a point source geometry, dose calculations were performed to determine both the beta and gamma components for the nuclides present in the contaminated sliver.

The estimated maximum dose due to the presence of the sliver was 239 millirad. A dose estimate was also performed for the residual contamination determined to remain in the finger following the sliver removal. Calculations were based on the conservative assumption that the contamination was incorporated into the finger tissue and permanently retained there. The total dose was therefore determined to be 38 rads. The inspector reviewed the individual's exposure records and verified that the individual had been appropriately assigned an extremity dose for the applicable 1993 quarters based on the initial contamination, as well as fractions of his lifetime dose due to the residual contamination, using MIRD methodology. The individual was assigned the remainder of the dose during 1994 in order to minimize the administrative burden of recording dose in future years. The inspector was also informed that HP had discussed with the individual the dose assessment, his dose assignment, and the radiological risks of the incident. Additionally, since the individual was a contractor, he was provided with a document which explained the dose assessment and assignment used by the licensee for use at other nuclear sites the contractor may visit. The inspector noted that no regulatory limits were exceeded and no problems were identified with the licensee's methods for determining or assigning the worker's dose.

No violations or deviations were identified.

6. Internal Exposure Control (83750)

10 CFR 20.1204 states that for purposes of assessing dose used to determine compliance with occupational dose equivalent limits, the licensee, when required to monitor internal exposure, shall take suitable and timely measurements of concentrations of radioactive materials in air, quantities of radionuclides in the body, quantities of radionuclides excreted from the body, or combinations of these measurements. When specific information on the behavior of the material in an individual is known that information may be used to calculate the Committed Effective Dose Equivalent (CEDE).

10 CFR 20.1502(b) requires each licensee to monitor the occupational intake of radioactive material by and assess the committed effective dose equivalent to:

(1) Adults likely to receive, in one year, an intake in excess of 10 percent of the applicable ALI in Table 1, Columns 1 and 2 of Appendix B to 10 CFR 20.1001-20.2401; and

(2) Minors and DPWs likely to receive, in one year, a committed effective dose equivalent in excess of 0.05 rem.

The inspector reviewed 60AC-HPX-003-OS, Bioassay Program, Rev. 3, dated January 1, 1994, which established responsibilities and methods used to control, monitor, and evaluate internal occupational radiation exposure. The inspector verified that the procedure had been appropriately updated

to include revised 10 CFR Part 20 terminology and dose limits. During discussions with licensee representatives the inspector was informed that the licensee had evaluated historical air sample and internal exposure data to determine the need for monitoring internal exposures. The inspector noted that the licensee review revealed no doses which exceeded 10 percent of the Annual Limit on Intake (ALI). However, the inspector noted that the licensee procedure required tracking of Derived Air Concentration-hours (DAC-hr) when personnel entered an airborne area. Airborne areas were posted at 0.3 DAC. Accrual of four DAC-hrs in one week required a WBC for the worker. Additionally, the licensee required initial baseline bioassays, annual WBCs for personnel who had accessed bioassay areas, and attempted termination bioassays. The inspector noted that the procedure also had provisions for more frequent WBCs as necessary.

The inspector also was informed that the licensee had reduced their respirator usage during the past year. At the time of the inspection, the licensee had used less than five respirators during 1994. The inspector noted that licensee procedures provided guidance for selection of respiratory protection devices so as to keep the worker's TEDE ALARA. In addition, the inspector noted that the licensee was gathering historical air sample data from prior outages and routine operations, which would reflect the actual airborne radioactivity levels associated with various tasks. Once completed this data would be made available to the HP technician staff to aid them in their decisions as to the need for respiratory protection devices, based on prior results. The inspector also noted that licensee procedures gave the licensee provisions to allow respiratory protection equipment usage for areas where the airborne activity was less than 0.3 DAC if consistent with ALARA considerations of the workers' TEDE.

The inspector verified that the licensee had appropriately updated applicable procedures to be consistent with new 10 CFR Part 20 requirements related to internal exposure limits and monitoring. The inspector also noted that the licensee appeared to be appropriately monitoring and controlling internal exposures for plant personnel.

No violations or deviations were identified.

7. Surveys, Monitoring, and Control of Radioactive Material and Contamination (83750)

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.

During plant tours, the inspector observed appropriate housekeeping and contamination control practices. The inspector noted that during 1993 the licensee had reduced their average contaminated area to approximately one percent of the RCA, whereas their average contaminated area during 1992 was approximately two percent of the total RCA. The

inspector also noted that the licensee was currently involved in painting upgrades of the facility floor and wall surfaces. These efforts were expected to further reduce the contaminated area within the plant, as well as facilitate future decontaminations efforts, as necessary.

The inspector noted that the licensee's posting and control of radiation areas, high radiation areas, airborne radioactivity areas, contamination areas, radioactive material areas, and the labeling of radioactive material was adequate. The inspector observed selected Locked High Radiation Areas (LHRA) throughout the Reactor and Turbine Buildings and verified that they were maintained locked as required. The inspector noted that the licensee had properly barricaded and enclosed their posted Very High Radiation Areas (VHRA) so as to prevent unauthorized or inadvertent entry into the areas. The inspector also toured the licensee's refueling floor and noted that additional controls had recently been implemented which provided a locking mechanism for highly radioactive items being stored in the spent fuel pool. The inspector discussed with HP and operations staff and reviewed procedures relating to access and key controls for their LHRAs and VHRAs. The inspector noted that the VHRAs were individually keyed and all keys for normal access to both LHRAs and VHRAs were stored in the HP office with issue controlled by the HP staff. The inspector noted that the operations staff kept a master key for the LHRAs to provide them access during emergency conditions. The inspector also noted that both the HP and operations staff kept logs to document issuance and return of HRA keys. These logs were checked at the end of each shift to verify that all HRA keys were accounted for. The inspector noted that licensee controls appeared to be appropriate for preventing unauthorized access to posted LHRAs and VHRAs.

The inspector also observed work activities which involved opening the Unit 2 TIP drive boxes to gather torque and calibration data. The inspector reviewed the Radiation Work Permit (RWP) and attended the pre-job briefing and noted that both stressed proper HP controls since there was a high potential for airborne contamination when the TIP drive boxes were opened. The inspector noted that the work area was properly controlled with a tent and a HEPA-filtered ventilation unit to prevent the spread of contamination and minimize airborne radioactivity. The inspector also noted that air sampling, as well as radiation and contamination surveys, were properly performed, with appropriate dosimetry and respiratory protection equipment being provided to the workers. The inspector noted that the workers' exposures were maintained ALARA, with good interaction between HP and workers being observed by the inspector during job planning, the pre-job ALARA briefing, and the work evolution.

No violations or deviations were identified.

8. Maintaining Occupational Exposure As Low As Reasonably Achievable (ALARA) (83750)

10 CFR 20.1101(b) states each 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 inspector reviewed the licensee's program for maintaining exposures ALARA. The licensee ended 1993 with a total collective dose of 669 person-rem. The 1993 Level 5, or stretch, goal was 630 person-rem. The inspector noted that approximately 60 unplanned outage days had been a significant contributor to the licensee exceeding the Level 5 goal. The licensee experienced a 30 day forced outage early in 1993 in order to complete an extensive fuel inspection due to a debris-induced fuel leaker. This outage added approximately 25 person-rem to the 1993 collective dose that was not planned for. Additionally, the inspector noted that the licensee experienced several more unplanned outages during the year which resulted in approximately 25 forced outage days and approximately 24 person-rem.

The licensee's Level 5 collective dose goal for 1994 was 800 person-rem. The inspector was informed that during 1994 the licensee plans to complete two refueling outages. Although outage dose goals had not been finalized yet, the inspector was informed that for both outages the most extensive collective exposure evolutions were expected to be activities associated with InService Inspections (ISI), to include both insulation removal and re-installation and associated shielding packages. The inspector was informed that for the upcoming Unit 2 spring outage no Control Rod Drive (CRD) changeouts were anticipated, which eliminated a potential significant exposure contributor. However, the licensee planned to change out 168 fuel bundles which, due to leaking fuel assemblies during the present fuel cycle, posed the problems of increased contamination and hot particles. The inspector noted that the licensee was prepared to implement additional controls in the event of such problems, to include strippable paint, Elmers glue, HEPA filtration/ventilation units, and hot particle zones and boundaries.

The inspector also reviewed the ALARA suggestions with licensee representatives and found that the licensee had received six ALARA suggestions for the period August, 1993, to January, 1994. The Plant Alara Review Committee had reviewed five of the six suggestions and had taken actions to implement three of the suggestions. In particular, one of the licensee's actions included changing their procedures to eliminate entry into the main turbine enclosures, a HRA, by individuals who perform monthly shaft voltage readings on the main turbines. Rather than having an individual enter the main turbine enclosures, the licensee is considering performing this task using remote equipment, thereby reducing the exposure an individual would receive had they entered the HRA.

The inspector informed licensee representatives that their program for maintaining personnel exposures ALARA during routine operations and outage activities appeared to be functioning adequately. The inspector also informed licensee representatives that a strong ALARA program would be required to achieve their challenging annual exposure goal of 800 person-rem for the current year.

No violations or deviations were identified.

9. Followup of Previously Identified Inspection Findings (92702)

a. (Closed) 50-321, 366/93-07-01: Unauthorized entry by an individual into a posted High Radiation Area.

In response to the subject violation, the licensee appropriately disciplined the worker in accordance with their Positive Discipline program. Also, a memorandum from the Plant Manager was issued to the plant staff to heighten their knowledge of the importance of compliance with radiation postings. Additionally, and in response to previous violations of a similar nature, the licensee continues to stress the access requirements for posted HRAs and the consequences of failure to adhere to those requirements in GET, and continues the use of large, conspicuous signs for HRAs throughout the plant.

The inspector informed licensee representatives that this item would be considered closed based on the appropriateness of their corrective actions.

b. (Closed) 50-321, 366/93-16-01: Preventing access to a posted Very High Radiation Area.

In response to the subject violation, regarding the unlocked ladder providing access to a posted VHRA, the licensee immediately cut the permanent ladder from the wall. Additionally, in order to comply with regulatory guidance relating to revised 10 CFR Part 20, the licensee had totally enclosed the point of access to their posted VHRAs to prevent inappropriate or inadvertent access to the area.

The inspector informed licensee representatives that this item would be considered closed based on the appropriateness of their corrective actions.

10. Exit Meeting

The inspector met with licensee representatives as denoted in Paragraph 1 at the conclusion of the inspection on January 28, 1994. The inspector summarized the scope and findings of the inspection. Dissenting comments were not received from the licensee. Additionally, the licensee did not identify any documents or processes reviewed by the inspector as proprietary.