

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-461/90026(DRSS,

Docket No. 50-461

License No. NPF-62

Licensee: Illinois Power Company  
500 South 27th Street  
Decatur, IL 62525

Facility Name: Clinton Power Station

Inspection At: Clinton Site, Clinton, IL

Inspection Conducted: December 10 through 21, 1990

Inspector: *William Snell for*  
A. W. Markley

1/10/91  
Date

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

1/10/91  
Date

Inspection Summary

Inspection on December 10 through 21, 1990 (Report No. 50-461/90026(DRSS))

Areas Inspected: Routine announced inspection of the radwaste and transportation programs and outage radiation protection activities including: organization, management controls and training, audits and appraisals, external exposure control, control of radioactive materials, contamination, and surveys, and maintaining occupational exposures ALARA (IP 83750, 84750). The inspection also included: gaseous radwaste, liquid radwaste, solid waste and transportation, effluent reports, effluent control instrumentation, primary coolant chemistry and air cleaning systems (IP 83750, 84750).

Results: One violation was identified for a failure to control access to high radiation areas (Section 5.a). One violation was identified for a failure to evaluate the radiological hazards associated with maintenance of the A RHR pump discharge check valve (Section 6). An unresolved item was identified regarding the effectiveness of corrective actions associated with the high radiation access control problems with the low pressure core spray pump room (Section 5.a).

Weaknesses were identified in the areas of resolution of technical problems associated with the standby gas treatment system stack flow monitor (Section 11); housekeeping (Section 13); and contamination controls (Sections 6 and 13).

Strengths were identified in the areas of Radiation Work Permit systems (Section 5.b); radiological coverage in the drywell (Section 13); use of lead shielding in the drywell (Section 13); housekeeping in the general areas (Section 13); and effluent performance (Sections 7 and 8).

## DETAILS

### 1. Persons Contacted

- F. Armetta, Supervisor, Radwaste
- \* J. Bednarz, Principal Assistant to Vice President
- \* J. Bradburne, Supervisor, Radiological Engineering
- #J. Brownell, Project Specialist - Licensing
- \*#J. Cook, Manager, Clinton Power Station
- \* M. Dodds, Supervisor Radiological Operations
- \* R. Gill, Manager, Nuclear Training
- \* J. Hill, Radiation Protection Shift Supervisor
- \* G. Kephart, Supervisor, Radiological Support
- \* J. Manasker, Director, Planning and Programming
- \* R. McCampbell, Radiation Protection Shift Supervisor
- \*#D. Miller, Director, Plant Radiation Protection
- \* J. Miller, Manager, NSED
- \* K. Moore, Director Plant Technical
- \* R. Morgenstern, Manager, Scheduling and Outage Management
- \*#J. Nyswander, Supervisor, Radiological Environmental
- \* J. Perry, Vice President
- \*#R. Phares, Director, Licensing
- #M. Reandeau, Radiological Engineer
- \*#J. Sipek, Supervisor, Regional Regulator Interface
- \* F. Spangenberg, Manager, Licensing and Safety
- \* R. Weedon, Manager, Projects and Assessments
- \* R. Wyatt, Manager, Quality Assurance
  
- \* P. Brockman, Senior Resident Inspector
- #F. Brush, Resident Inspector

The inspectors also interviewed other licensee and contractor personnel during the course of the inspection.

\* Denotes those present at the interim exit meeting on December 13, 1990.

# Denotes those present at the telephone exit meeting on December 21, 1990.

### 2. General

This inspection was conducted to review aspects of the licensee's radiation protection, radwaste/radioactive material shipping and transportation programs. The inspection included tours of radiation controlled areas, auxiliary building, radwaste facilities, observations of licensee activities, review of representative records and discussions with licensee personnel.

### 3. Organizational, Management Controls and Training (IP 83750, 84750)

The inspectors reviewed the licensee's organization and management controls for the radwaste and shipping and transportation programs, including: organizational structure, staffing, delineation of authority and management techniques used to implement the program and experience

concerning self-identification and correction of program implementation weaknesses.

The radwaste management staff remains essentially as described in Inspection Report No. 50-461/89024(DRSS). The radiation protection staff also remains as described in Inspection Report No. 50-461/90022 (DRSS). There has been no turnover of personnel since the last inspection. The inspector discussed criteria used by the licensee to evaluate contract radiation protection technicians' experience and licensee experience with acquiring sufficient staff augmentation. The licensee indicated that since the prevailing wages were paid that obtaining staff augmentation usually was not a problem. However, the licensee did indicate that staffing during this outage was tighter than previous outages. New and contract personnel met or exceeded the qualification requirements of ANSI/ANS 3.1-1978 for the positions they occupy.

No violations or deviations were identified.

4. Audits, Surveillances and Self Assessments (IP 83750, 84750)

The inspectors reviewed the results of Quality Assurance audits and surveillances conducted by the licensee since the last inspection. Also reviewed was the extent and thoroughness of the audits and surveillances.

Two quality assurance audits and several surveillances were reviewed. One audit, in the radiation protection area, identified weaknesses in the area of procedural compliance and adequacy of procedures. Most audit findings were responded to in an adequate and timely manner. However, one audit finding, regarding documentation of vendor instruction for Respiratory Protection Specialists (Q38-90-12-01), required additional attention prior to closure.

No violations or deviations were identified.

5. External Exposure Control (IP 83750):

The inspector reviewed the licensee's external exposure control, including: changes in the program, use of radiation work permits (RWP) to determine whether requirements were met, planning and preparation for maintenance and refueling outage tasks including ALARA considerations and required records, reports and notifications.

a. High Radiation Area Violations

On December 10, 1990, during a tour of the radiation control area (RCA), a high radiation area door to the residual heat removal (RHR) A heat exchanger room was found unlocked by the inspector. The licensee reported to the inspector that the individual responsible for verifying that this door was locked had failed to do so. The licensee indicated that the individual had verbalized a disregard for high radiation area access controls. Licensee personnel stated that this individual's access to the RCA has been terminated.

On December 9, 1990, a resident inspector found a high radiation door to the fuel pool heat exchanger room blocked open with a canvas tool bag. Three workers were standing with their backs to the door approximately 12 feet away from the door. The inspector questioned the radiation protection (RP) technicians at the drywell checkpoint regarding this door. The inspector accompanied an RP technician who was dispatched to investigate. The RP technician questioned the three workers regarding the high radiation area door blockage and whether the workers were guarding the door. None of the workers indicated that they were guarding the door to the fuel pool heat exchanger room. Subsequent investigation by the licensee indicated that the workers had not obtained permission from the radiation protection technicians to block the door open.

On November 29, 1990, the licensee found the high radiation area door to the RHR B heat exchanger room blocked open. This door's latch had been taped over and the inner airlock door was blocked open by coiled hoses. The issues of secondary containment and fire protection associated with this door will be discussed in the resident inspector's inspection report. Corrective actions do not appear to have been adequate to prevent recurrence.

These are violations of procedure CPS 1905.21, High Radiation Area Key Control (Violation 461/90026-01).

Inspection Report No. 50-461/90011(DRP) identified two instances (May 25, 1990 and June 2, 1990) in which the licensee had found the high radiation door to the low pressure core spray (LPCS) pump room unlocked. During this inspection, a review of condition reports, prepared by the licensee, identified the same high radiation door to the LPCS pump room was found unlocked and unattended on October 13, 1990. The licensee indicated that additional information would be provided regarding corrective actions taken and their effectiveness. (Unresolved Item 461/90026-02)

It should be noted that the licensee has within its Technical Specifications, the standardized provisions for high radiation area access controls. However, the licensee has adopted more restrictive requirements in the form of procedure requirements. The licensee requires locking of high radiation areas at 100 mR/hr versus the control by RWP for areas greater than 100 mR/hr and less than 1,000 mR/hr and locking of areas greater than 1,000 mR/hr (as allowed by technical specifications). This administrative requirement places a burden upon plant resources both in terms of manpower and hardware utilized in verification activities as well as implementation of corrective actions. The licensee has indicated that procedures are currently in the revision process to address this issue.

b. Computerized Radiation Work Permit (RWP) System

The licensee has installed a computerized RWP system that has been utilized during this outage. This system tracks an entire job from

start to finish. Most jobs require many various work groups to participate in a given job, such as insulators, scaffolding crews, mechanical and/or electrical maintenance crews, etc.

Traditionally, this has been handled by the use of special instructions that were applicable to the task involved. This was usually characterized by large numbers of footnotes in the area that specified radiological protective clothing, dosimetry, and respiratory protective requirements. For the RWP user, this is frequently confusing and is a significant contributor to errors made by personnel in following RWP requirements.

The licensee's system still tracks a job from start to finish. However, each specific task or activity within the job is identified by a Step Number within the overall RWP. Each step specifies the radiological safety requirements for the specific task. Radiological protective requirements for removal and reinstallation of insulation, scaffold erection and dismantling, electrical work, and mechanical work are specified in separate RWP Steps. The worker need only find his task (Step) within the RWP and comply with the radiological controls established for his Step. There is no confusion over which controls are applicable to his job. While the number of terminals available to support outage activities were less than desirable and the human factors involved in the actual paperwork need work, the development and utilization of this type of RWP system is viewed as a significant improvement over traditional RWP systems.

One violation and one unresolved item were identified.

## 6. Airborne Radioactive Materials Event

### a. Initial Conditions and Description

On November 2, 1990, two individuals breached the A RHR discharge pump check valve. Per survey information dated 11/2/90, 10:30 AM and 7:30 PM general area radiation levels were 80 to 200 mR/hr, contact levels ranged from 300 mR/hr gamma and 2.8 rad/hr beta at the valve plane opening, 1 R/hr gamma and 12 rad/hr beta contact with the valve flapper and 40 to 400 mrad smearable contamination inside the valve. Breathing zone air sample results indicated 0% Maximum Permissible Concentration (MPC) during the system breach.

At 11:30 PM on November 2, 1990, the fuel building ventilation system shut down. This was not communicated to the Radiation Protection Office.

At 00:58 AM on November 3, 1990, two workers lifted the valve bonnet, performed an inspection of the valve internals and returned the valve bonnet to position. Air sample results for this task indicated 9% MPC.

At 11:20 AM on November 3, 1990, three maintenance workers commenced work on the RHR pump A discharge check valve. This work was to consist of the following activities: (1) lifting the

bonnet; (2) wiping down the valve internals (wetting techniques were utilized to reduce airborne potential); (3) cleaning the gasket seating area with scotch-brite; (4) cleaning the area outside the gasket seating area with a wire brush; (5) installation of the new gasket; and (6) lowering the valve bonnet into place.

Radiological conditions that existed at the start of job (11:20 AM) were as follows: (Per survey dated 11/3/90, 2:00 AM) 1.5 Mdpm/100 cm squared (56 mrad) smearable contamination on valve bonnet seating surface; 1 R/hr gamma & 4 rRad/hr beta on contact with swing check disk; 320 mR/hr gamma & 1.12 rRad/hr beta at plane of valve opening; and 120 mR/hr gamma & 480 mrad/hr beta at 18 inches from valve opening.

Workers wore respirators and a low volume air sample was taken for the duration of the job. The job ended at 12:20 PM. The air sample was not counted immediately since the technician did not expect an airborne condition since air sample results from the valve bonnet removal had been nominal and wetting of the valve internals had been performed during the job. Upon job completion, two valve workers were found to be contaminated at the respirator seal area. Air sample results (obtained at 1:30 PM from the job duration air sample) indicated that an airborne condition was experienced during the valve work. Results were  $8.85 \text{ E-8}$  microcuries per cubic centimeter (approximately 9.8 times the maximum permissible concentration (MPC)) with Mn-54 and Co-60 as the predominate nuclides.

Upon receipt of the air sample results, the licensee evacuated the affected areas (A RHR pump room and A RHR heat exchanger room), posted the areas as airborne radioactivity areas and obtained follow-up air samples from affected and adjacent areas. Air sample results (obtained at 2:21 PM) indicated 0.58 MPC present in the A RHR heat exchanger room. The licensee identified individuals who were working in the A RHR heat exchanger room during the period 11:20 AM through 2:21 PM. Whole body counts of the heat exchanger workers resulted in initial positive counts. Although subsequent whole body count results of exposed individuals indicated no uptakes in excess of 1% maximum permissible organ burden (MPOB), poor communication between radiation protection personnel and the potentially internally exposed individuals resulted in unnecessary heightened concerns by the workers.

b. Licensee Identified Problems

The licensee evaluation included: an assessment of ventilation conditions in the affected area; post-job information provided to the potentially exposed individuals; utilization of two whole body counting systems for performing the whole body counts on the potentially exposed workers; training of technicians on the whole body counting systems; and radiological work control.

The licensee identified a failure of control room personnel to communicate ventilation system status changes to radiation protection personnel. In addition, the licensee identified job control weaknesses. First, the area had not been preemptively posted as a potentially airborne radioactivity area requiring the use of respiratory protective equipment. The area in question was accessible through three doors. Other factors not evident were the use of filtered ventilation and/or alarming airborne radioactivity monitor in the vicinity of the work.

Poor communication between the radiation protection staff and the workers and uncertain work practices by the radiation protection staff also created unnecessary concern by the workers. Conflicting and pre-decisional information was provided to the workers regarding the reasons for doing multiple whole body counts on Fastscan and Whole Body Counter Chair systems. Selection criteria for using these systems were not well understood by the radiation protection shift management. This led the workers to be concerned about the radiation protection staff's ability to evaluate their potential exposure.

c. NRC Identified Root and Contributing Causes

The inspector reviewed event documentation, ALARA job planning documentation and interviewed radiation protection management and ALARA personnel. The root cause of this event was a failure to adequately evaluate and plan for the radiological hazards associated with the maintenance of the A RHR pump discharge check valve.

The ALARA planning documentation indicated that pre-job and post-job decontamination was not needed. The need for respirators was identified; however, the use of glovebags or containment structures was determined to be unnecessary. This work involved high levels of smearable contamination in a room that exhibited low levels of contamination which ranged from 3,000 to 20,000 dpm/100 cm squared.

Portable ventilation was to be used "As Necessary". Portable ventilation was not used on this job. The unique configuration of the RHR pump room and RHR heat exchanger rooms were not evaluated for the potential spread of airborne contamination. The air in these rooms communicates freely.

Radiological controls for the actual work involved in preparing the valve bonnet seating surface were inadequate. Decontamination of this surface was not planned. However, surveys indicated that surface contamination levels on the valve bonnet seat were of the order of 1.5 Mdpm/100 cm squared (56 mrad smearable). Wetting techniques were employed while the workers used scotch-brite pads to remove gasket residues. Wetting was also used during wire brushing of the area outside the the gasket residue. This produced a radioactively contaminated aerosol that caused the A RHR pump room and heat exchanger room to become airborne.

Air sampling methods utilized during this job were not effective in providing a prompt means of identification of airborne radiological hazards. A 3 cubic feet per minute (cfm) air sample was taken for the duration of the job (11:20 AM - 12:20 PM).

This sample was not counted until 1:30 PM. The failure to promptly identify airborne radiological hazards resulted in exposure of other workers to airborne radioactive materials. This also resulted in a failure to post the A RHR pump and heat exchanger rooms as airborne radioactivity areas. This created a situation in which personnel could have unknowingly entered and been exposed to airborne radioactive materials.

Although operations personnel failed to inform radiation protection of changes in use of installed ventilation systems, changes in job conditions were not recognized and evaluated. This event also identified weaknesses in communications between radiation protection personnel and the affected workers. This resulted in worker concerns regarding the accuracy of information provided to them and the radiation protection department's ability to evaluate their potential exposure. This latter concern was identified by the licensee.

Failure to evaluate the radiological hazards associated with the maintenance of the A RHR pump discharge check valve is a violation of 10 CFR 20.201(b). (Violation No. 461/90026-03)

#### 7. Gaseous Radioactive Wastes (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 operational requirements and experience concerning identification of programmatic weaknesses.

The inspector reviewed selected records of radioactive gaseous effluents releases and Semiannual Radioactive Effluent Release Reports for 1989 and the first half of 1990. The pathways sampled and analyses performed appeared to comply with Technical Specifications and/or Offsite Dose Calculation Manual requirements. In 1989, the plant total gaseous effluents released consisted of approximately 13, 2.33 E-4, and 0.87 curies of noble gas, radioiodine and tritium, respectively; the corresponding values for the first half of 1990 were 27, 1 E-4, and 1.1 curies, respectively. Gaseous releases remained less than one percent of annual limits.

During the review of the Semiannual Effluent Release Report for the second half of 1989, the inspector noted that the tritium release data was omitted from Table 4. This was identified to the licensee. The licensee initiated corrective action to report the tritium release data in an addendum to a future semiannual release report.

No violations or deviations were identified.



8. Liquid Radioactive Waste (IP 84750)

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

The inspector reviewed selected records of radioactive liquid effluents releases and Semiannual Radioactive Effluent Release Reports for 1989 and the first half of 1990. The pathways sampled and analyses performed appeared to comply with Technical Specifications and/or Offsite Dose Calculation Manual requirements. In 1989, the plant total liquid effluent release consisted of approximately 0.013 curies total activity (excluding tritium, alpha and dissolved noble gases) and 1.12 curies of tritium; the corresponding values for the first half of 1990 were approximately 0.003 and 0.069 curies, respectively. Liquid releases remained less than one percent of annual limits. The inspector also selectively reviewed the liquid batch release permit program and associated documentation for past releases; no problems were noted.

During the review of the Semiannual Effluent Release Report for the first half of 1990, the inspector noted that the percent of applicable liquid release limit information was erroneous. This was identified to the licensee. The licensee initiated corrective action to report the correct percent of applicable liquid release limit information in an addendum to a future semiannual release report.

No violations or deviations were identified.

9. Solid Radioactive Waste (IP 84750)

The inspector reviewed the licensee's solid radioactive waste management program, including: changes to equipment and procedures, processing and control of solid wastes, adequacy of required records, reports and notifications, performance of process control and quality assurance programs and experience in identification and correction of programmatic weaknesses.

The inspector reviewed selected portions of the licensee's solid radwaste processing, storage and shipping records for July 1989 through June 1990. Licensee records indicated that approximately 4,538 and 3,786 cubic feet of radioactive waste for each six months, respectively, were shipped offsite for further processing or burial. These radioactive wastes included 6,484 cubic feet of spent resins, filter sludges and evaporator bottoms and 1,840 cubic feet of dry compactable waste. Solid waste processing and shipping facilities appeared to be well organized and in good material condition.

No violations or deviations were identified.

10. Transportation of Radioactive Materials and Radwaste (IP 83750, 84750)

The inspector reviewed the licensee's transportation of radioactive materials program, including: adequacy and implementation of written procedures, radioactive materials and radwaste shipments for compliance with NRC and DOT regulations and the licensee's quality assurance program, review of transportation incidents involving licensee shipments (if any), adequacy of required records, reports, shipment documents and notifications and experience concerning identification and correction of programmatic weaknesses.

The inspector selectively reviewed radwaste and radioactive material shipment records for January 1990 to date. Shipping documentation, radiological surveys and procedure implementation appears to satisfy NRC, DOT and burial site requirements. The licensee is currently in the process of revising their shipping procedures to improve user friendliness and reduce the potential for making personnel errors.

No violations or deviations were identified.

11. Effluent Instrumentation (IP 84750)

The inspector reviewed the records for effluent control instrumentation surveillance/operability, including reports to the NRC required by Technical Specifications and/or Offsite Dose Calculation Manual.

During the review of the Semiannual Effluent Release Reports for the last half of 1989 and the first half of 1990, the inspector noted that the licensee had identified the Standby Gas Treatment System (SGTS) stack flow monitor (QUIX-PR051) as having been out of service since August 10, 1989. The licensee noted in the second half of the 1989 report that this monitor was expected to be repaired in April 1990. In the first half of the 1990 report, the licensee noted that this monitor was expected to be in service by the end of August 1990. The inspector inquired as to current status of this monitor and nature of the problems.

The licensee indicated that as of December 21, 1990 the SGTS stack flow monitor was still out of service. The licensee indicated that this monitor had initially experienced problems with electrical grounding. The licensee also indicated that this monitor appears to experience zero flow instabilities. This monitor provides indication of the SGTS stack flow that ranges from zero flow (system secured) to full system capacity flow. The licensee indicated, that when the system has been secured, there appears to be some ambient flow in the system that is sufficient to periodically provide indication and take the monitor out of the low flow alarm condition. This has resulted in intermittent low flow alarms. The licensee indicated that the repair/correction of this monitor is a low priority item. This matter will be reviewed by the resident inspectors.

No violations or deviations were identified.

12. Primary Coolant Radiochemistry (IP 84750)

Technical Specification 3.4.5 requires that the specific activity of the primary coolant not exceed two microcuries 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 the latter part of 1989 and 1990 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.

No violations or deviations were identified.

13. Plant Tours (IP 83750, 84750)

The inspector performed several tours of radiologically controlled areas. These included walk downs of drywell, containment building, auxiliary building, radwaste facilities and turbine building. The inspector observed the following:

- ° Radiation workers access and egress from the RCA: personnel use of frisking stations, portal monitors and radiation work permit access system were acceptable.
- ° Contamination monitoring, portable survey, area radiation monitoring instrumentation in use throughout the plant: instrumentation observed had been recently source checked and had current calibrations, as appropriate.
- ° Posting and labeling for radiation, high radiation, contaminated and radioactive material storage areas: posting and labeling were generally, with the exceptions listed below, in accordance with regulatory requirements and approved station procedures.

However, several instances were noted where contaminated area boundaries were found collapsed, materials were found extending through contaminated areas into clean areas and numerous occurrences of step off pads that required changing since the tacky layer was fully loaded. A double step off pad was found in the containment steam tunnel area that was no longer used. Personnel were permitted to ignore this step off pad and cross it without removing protective clothing. The inspector noted that surveys indicated a general rise in contamination levels in contaminated areas. This was acknowledged by the licensee and was further evidenced by the numbers of contamination events experienced. As of December 3, 1990, 45 clothing contamination events and 30 skin contamination events had been experienced versus goals of 39 and 20, respectively.

A radiation area door was found with its latch taped over. On the outside of this door the legal posting for a radiation area was found. On the inside of this door, a printed paper posting

indicated that personnel were to ensure that this high radiation area door was locked and closed. A high radiation area door was found locked upon entry; however, this door failed to shut and lock upon exit.

- ° Radiation protection coverage in the drywell was very good. The technicians were knowledgeable of ongoing and planned work activities, radiological conditions and RWP requirements. The inspector observed lead shielding installations in the drywell. The quality of workmanship in the temporary shielding installation was excellent.
- ° Housekeeping and material conditions in general areas and walkways were very good. However, housekeeping and material conditions behind closed doors and in less frequented areas were generally poor and had declined since the last inspection.
  - Problems were noted in the areas of tool and material control. There are numerous examples of tools and small equipment strewn about various work sites or bagged and lying in open areas throughout the auxiliary building where no visible work activities were ongoing.
  - Two safety hazards, one significant, were identified that involved unused electrical cords that were left plugged into wall receptacles and lack of lighting in airlock areas and some less frequented rooms in the auxiliary and radwaste buildings. One of these electrical cords was plugged into a wall receptacle with the other end of the electrical cord submerged in a puddle of water. The inspector and a licensee radiation protection technician just avoided stepping into this puddle of water at the last second.
  - Significant problems were noted in contaminated areas throughout the drywell, containment, auxiliary building and radwaste facilities. Within these areas, accumulations of dirt, debris and used protective clothing were found in most areas.

With respect to the other aforementioned problems, the licensee initiated corrective actions during the inspection. However, corrective actions were incomplete by the end of the inspection.

No violations or deviations were identified.

#### 14. Exit Interview (IP 83750)

The inspector met with licensee representatives (denoted in Section 1) following the inspection on December 13, 1990, and reexited by telephone on December 21, 1990, to discuss the scope and findings of the inspection.

During the exit interview, the inspector discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. Licensee representatives did not identify any such documents or processes as proprietary. The following matters were specifically discussed by the inspector:

- a. The apparent violations (Sections 5.a and 6)
- b. Inspector concerns regarding: Weaknesses in housekeeping (Section 13); and weaknesses in contamination controls (Sections 6 and 13).
- c. Inspector concerns regarding the operability of the SGTS stack flow monitor (Section 11).