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

FEB 17 1994

Report No.: 70-1113/94-02

Licensee: General Electric Company
Nuclear Energy Production
P. O. Box 780
Wilmington, NC 28402

Docket No.: 70-1113 License No.: SNM-1097

Facility Name: Nuclear Fuel and Components Manufacturing Plant

Inspection Conducted: January 10-14, and 18, 1994

Inspectors: R. B. Shortridge 2/17/94
R. B. Shortridge Date Signed

for B. A. Parker William H Rankin 2/17/94
Date Signed

Approved by: William H Rankin 2/17/94
W. H. Rankin, Chief Date Signed
Facilities Radiation Protection Section
Radiological Protection and Emergency Preparedness Branch
Division of Radiation Safety and Safeguards

SUMMARY

Scope:

This routine, unannounced inspection of the licensee's radiation protection (RP) program involved review of health physics (HP) activities including program organization and staffing; training and qualifications; surveys and monitoring; and radioactive material control. In addition, followup actions related to previously identified inspection findings were reviewed.

Results:

The licensee's radiological protection program activities appeared adequate to protect the health and safety of plant workers. Organizational changes were noted in both the Nuclear Safety Engineering and Radiation Protection groups which the licensee expected to enhance their capabilities.

The Compliance Auditing Group continued to identify issues for licensee followup. These identified issues and successful resolution of the findings appeared to be beneficial in improving the overall effectiveness of the licensee's RP program. Routine internal and external exposure programs were implemented with all personnel exposures less than 10 CFR Part 20 limits. An

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issue for followup was identified during the last inspection regarding continued air sampler plugging in certain areas of the Uranium Recycle Unit (URU). This item will remain open until area modifications are completed and effectiveness of the modifications are assessed. One violation was cited for inadequate surveys in that surveys (visual and physical) were not performed sufficiently to identify the radiological hazard. A second finding was characterized as an unresolved item (URI) in that selected items in audits performed by the Nuclear Safety Engineering group did not always appear to be properly classified, given correct priority, properly resolved, or completed in a timely manner.

REPORT DETAILS

1. Persons Contacted

*J. Bradbury, Regulatory Team
*R. Bragg, Production, Planning and New Product Introduction
*D. Brown, Team Leader, Environmental Processes, Chemical Product Line
*M. Chilton, Manager, Chemical Product Line
*F. Colenure, Setup Operator
*D. Dowker, Senior Program Manager, Procedures and Training
*N. Hall, Gadolinia Operator
*J. Harmon, Chief Technologist
*T. Hauser, Manager, Environmental Health and Safety and Nuclear Quality Assurance
*E. Howell, Gadolinia Operator
*L. Jordan, Rod Loader
*B. Kaiser, Manager, Fuel Fabrication Product Line
*R. Kennan, Program Manager, Compliance Auditing
*C. Kipp, General Manager, Nuclear Energy Production
*R. Lennon, Regulatory Compliance Auditor
*R. Lewis, Supervisor, Radiation Safety
*A. Mabry, Engineer, Nuclear Safety
*D. McCaughey, Regulatory Team, Fuel Manufacturing Operation
*M. Mobly, Setup Operator
*S. Murray, Manager, Radiation Safety
*D. Nance, Radiation Safety
*M. Nobles, Production Advisor, Ceramic
*M. O'Grady, Maintenance, Fuel Manufacturing Operation
*R. Pace, Regulatory Team, Fuel Manufacturing Operation
*E. Palmer, Maintenance Manager, Fuel Manufacturing Operation
*L. Pardue, A-Shift, Maintenance
*J. Pierce, Engineer, Fabrication Technical Resources
*C. Porter, Maintenance
*B. Robinson, Principle Nuclear Safety Engineer, Nuclear Safety Engineering
*B. Roughton, Supervisor, Maintenance
*J. Sauvinet, Jr., Gadolinia Operator
*S. Selby, Team Leader, UO_2 Production Team
*H. Strickler, Manager, Environmental Protection and Industrial Safety
*S. Sugg, Press Operator
*S. Talley, Area Coordinator
*V. Watson, Ceramic Maintenance
*F. Welfare, Manager, Criticality Safety Engineering
*J. Williams, Monitor, Radiation Protection
*T. Winslow, Manager, Emergency Preparedness, Security, Material Control and Accountability

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

*Denotes those present at the exit interview conducted on January 14, 1994

2. Radiation Protection Organization and Staffing (83822)

Chapter 2, Sections 2.2.1.4 and 2.2.1.5 of the License Application establish the responsibilities and general organization for the radiation safety and radiation protection functions.

The inspector reviewed and discussed with licensee representatives changes made to the organization since the last inspection of this area conducted September 13-17, 1993, and documented in Inspection Report (IR) 70-1113/93-09. The inspector was informed that the Nuclear Safety Engineering (NSE) and Radiation Protection (RP) groups were combined and reported to the Manager, Regulatory and Environmental, Health and Safety. This change was intended to provide an increased focus for health, safety, and quality assurance programs. Also, the inspector noted that a compliance auditing group was still performing an important performance-based audit function. The audit group consisted of a criticality safety engineer, a RP supervisor, and a quality assurance staff member. Since the last inspection, the RP Supervisor has resumed his previous duties in the RP operations section. Overall, the inspector did not note any concerns regarding the recent organizational and staffing changes. The staffing in both the NSE and RP areas appeared to be adequate.

No violations or deviations were identified.

3. Training and Qualifications (83822)

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

The inspector received site specific training provided to NRC inspectors and noted that the course content was appropriate. The practical factors training focused on how to enter and exit radiologically controlled areas (RCAs) and how to perform personal monitoring. The inspector did not note any weaknesses in training.

No violations or deviations were identified.

4. Surveys and Monitoring (83822)

10 CFR 20.1501(a), in part, states that each licensee shall make or cause to be made, surveys that -

(1) May be necessary for the licensee to comply with the regulations in this part; and,

(2) Are reasonable under the circumstances to evaluate -

- The extent of radiation levels;
- Concentrations or quantities of radioactive material; and
- The potential radiological hazards that could be present.

Nuclear Safety Instruction NSI O-6.0, Contamination Measurement and Control, Revision 26, dated December 7, 1993, lists the guidelines for conducting the contamination measurement program, evaluation and documentation of the results, and required action based upon the contamination survey findings. The procedure specifies the frequency of surveys in controlled areas to be conducted weekly and in uncontrolled areas monthly. Action levels are specified in the procedure for disposition of contaminated areas once they are identified. Several thresholds are listed establishing what and how soon the area or equipment has to be decontaminated. Equipment in controlled areas with levels of alpha contamination of 15,000 disintegrations per minute per 100 square centimeters (dpm/100 cm^2) is required to be cleaned (deconed) within eight hours, and if levels of alpha reach 25,000 dpm/100 cm^2, the equipment must be deconed immediately. Floor areas must be deconed within eight hours if levels of alpha contamination reach 5,000 dpm/100 cm^2 and, immediately if levels reach 10,000 dpm/100 cm^2 alpha.

The inspector toured the controlled areas of the plant a number of times during the inspection. The portion of the product line toured included from the fuel pellet presses, to green pellet storage, to the sintering furnaces, to sintered pellet storage, to the pellet grinders and on to the rod loading station. Uranium pellets were loaded in molybdenum trays at the pellet press and placed into the green pellet storage area. The trays were approximately twelve inches square by three inches deep and were specially designed for use in the sintering furnaces. The green pellet storage area was approximately eight feet by seventy feet with conveyor type rollers approximately ten to twelve inches wide positioned about seven to eight inches over a flat piece of sheet metal that ran full length under the rollers. The green pellet trays were removed from storage and rolled on pallets through the sintering furnace where the pellet volume was reduced by approximately 25 percent. The molybdenum trays with sintered pellets were then moved into the sintered pellet storage area, which was similar in design to the green pellet storage area.

During tours, the inspector noted weaknesses in the licensee's program to control contamination at various locations. On January 12, 1994, the inspector noted uranium pellets of different enrichments on the floor in the sintering furnace area and on and under the support structure of the furnaces where the molybdenum trays that carry the pellets entered the furnace doors. Fuel pellets were noted in these areas at Furnaces Number Two and Five. The largest number of uranium fuel pellets was a group of approximately 20 that was located under the door of Furnace Number Five. The inspector requested RP to perform contamination surveys on the furnaces and adjacent floor areas. Contamination on the sintering furnaces ranged from 2,400 dpm/100 cm^2 to 218,089 dpm/100 cm^2 alpha contamination. Surveys on the floor areas by the furnaces ranged from 666 dpm/100 cm^2 to 41,622 dpm/100 cm^2 alpha. RP recorded the surveys and indicated the areas to be cleaned in accordance with Procedure NSI O-6.0. The inspector was informed that immediate actions would be taken to decon the areas and equipment.

During the performance of the survey by RP, the inspector entered the adjacent room where the pellet grinders and the rod loading stations were located. The inspector noted five pellets on the floor area by the first grinding station. As soon as the inspector entered the area, personnel in the area began to pick up uranium fuel pellets off the floor.

The inspector was informed on January 13, 1994, that RP was not satisfied with the decon conducted in the furnace room and that decon efforts were still underway. The inspector requested a second survey in an attempt to characterize the radiological environment. Six smears of areas that had been deconed showed very high levels of alpha contamination. The area under the feed ram on Furnace Number Five showed levels of alpha contamination of 44,778 dpm/100 cm^2. An area on the floor of the Number Three Pellet Press area, where the pellet trays entered the wall to go to green pellet storage showed 64,794 dpm/100 cm^2 alpha. The inspector continued to inspect for loose uranium fuel pellets and continued to find them. Using a flashlight the inspector found, and identified to the area production supervisor, a large number of fuel pellets under the rollers in the green pellet storage area.

Fuel pellets going into the furnaces were frequently mounded above the top of the tray, but after sintering, the pellet level reached only about three quarters the height of the three inch high tray. While it was apparent how green pellets could possibly fall out of the molybdenum trays (mounded-up pellets and/or many broken, cracked, and deformed trays), it was not readily apparent how pellets managed to fall out of the same type trays after sintering. The inspector, however, found a number of sintered fuel pellets under the rollers in the sintered pellet storage area as well. Also on the second day of tours, the inspector found a fuel pellet in the aisle way of the grinder shop. The inspector requested personnel in the area to disposition the pellet, which they did.

During tours of the area on January 14, 1994, the inspector requested assistance from RP to conduct another survey for alpha contamination. Smears were taken in the furnace room and in the pellet press room and, again, showed high levels of alpha contamination. Alpha contamination levels ranged from 1,833 dpm/100 cm^2 to 89,224 dpm/100 cm^2. Of the 15 smears taken, four were above the action levels prescribed in Procedure NSI O-6.0. The inspector continued to find loose uranium fuel pellets in and around equipment. The largest number of pellets were observed on the sheet metal just under the many lines of rollers in both the green pellet storage and the sintered pellet storage areas. The areas are basically inaccessible without some disassembly. The inspector also found a large number of fuel pellets on the floor areas under the green and sintered pellet storage areas.

The inspector observed operators cleaning around and under a rod loading machine where finished fuel pellets were arranged according to enrichment and loaded manually into fuel rods. The inspector noted that inside the rod loading machine, a number of uranium fuel pellets and test pellets (non-fuel pellets) had collected on a ledge and informed the area superintendent. After investigating, the area superintendent informed the inspector that 21 uranium fuel pellets and a number of test pellets were removed from Rod Loading Station Number One. Also, an undetermined number of fuel pellets were removed from a similar ledge in the Number Two Rod Loading Station.

The inspector met with licensee representatives several times and discussed the above findings. The licensee was concerned about the loss of control over the fuel pellets and assured the inspector that the areas along the production line were being cleaned and would reemphasize to operators the need for keeping the areas clean. The licensee was also concerned about the inspector's assertion that a contamination limit be placed in Procedure NSI O-6.0 and used to maintain production area contamination levels. To this end, the licensee requested to discuss the issue with NRC Region II management in the near future. The inspector contacted both groups prior to leaving the site to establish a mutual time for the call.

The inspector reviewed actual weekly contamination surveys conducted from November 22, 1993 through January 13, 1994, for both the Furnace Room and Rod Load/Grinder Areas. The surveys for the Furnace Room averaged 8.4 smears on the floor and one smear on the equipment per week for the seven week period. The surveys for the Rod Load/Grinder Areas averaged 13.1 smears on floors and 2.1 smears on equipment per week over the same period. Alpha contamination levels for the Furnace Area ranged from 6 dpm/100 cm^2 to 2,634 dpm/100 cm^2 on the floor, and on equipment from 131 dpm/100 cm^2 to 9,088 dpm/100 cm^2. Correspondingly, alpha contamination levels in the Rod Load/Grinder Area were 129 to 6,225 dpm/100 cm^2 on the floor area and 941 to 11,357 dpm/100 cm^2 on equipment. Surveys taken by the licensee reflected much lower loose alpha surface contamination levels that those surveys directed by the inspector.

The inspector reviewed Procedure NSI O-6.0 to determine licensee requirements. The inspector found the procedure to have weaknesses and/or inadequacies in the following areas:

- The procedure did not establish specific numerical objective or establish a required target limit to attain regarding alpha contamination control.

- The stated purpose of the licensee's procedure was to provide guidelines for conducting contamination measurements, evaluation, documentation of the results, and required action based on the contamination survey findings. The document was not written to provide requirements. Many of the action verbs are "should" and "may" which do not require an action to be performed but merely suggests it be performed. The procedure established action levels to be performed after high levels of contamination was found. Appendix A is titled "Guidelines for Survey Frequencies" and lists the frequencies for contamination surveys of the various areas in the plant.

- Appendix A provided in a footnote that if operational conditions are such that a process line becomes idled for extended periods of time (i.e. annual shutdown, inventory, refurbishment, etc.), the frequencies and locations of routine surveys may be altered with the approval of the Manager of Radiation Protection/Safety. However, the procedure does not establish any method or means of documentation to allow this.

The contamination surveys by licensee personnel from November through January were all taken on a minimum frequency and did not probe or look for contamination levels in most areas except for the main aisle ways in the subject rooms. A very low average of smears per survey were taken on equipment and they did not probe for the extent of contamination either. Based on this, the inspector determined that the rooms having large areas approximately 70 feet by approximately 200 feet were inadequately surveyed. This was proven out by surveys requested by the inspector and the ease of finding very high levels of contamination on both floors and equipment. In addition, the inspector was visually able to find uranium fuel pellets outside approved containers, easily and frequently, at any time, all along the pellet production line.

The inspector determined that the procedure was inadequate in that it did not provide sufficient requirements to licensee personnel to routinely identify the radiological contamination hazard in the subject areas. The licensee was informed that the failure to characterize the radiological hazard present, as evidenced by the results of the NRC directed survey, would be considered a violation (VIO 70-1113/94-02-01).

One violation and no deviations were identified.

5. Management and Administrative Controls (83822)

Chapter 2, Section 2.8 of the License Application to SNM-1097 details guidance for performing nuclear safety inspections and radiation safety audits by selected site and outside groups.

On January 29, 1993, the licensee held a meeting to discuss recent changes to the Safety Audit Program. In response to a NRC violation (IR 92-16) an additional audit program was initiated. A Compliance Audit Group was established and three fulltime auditors selected to staff the group. The inspector reviewed this program and found the audits to be comprehensive and corrective actions performed in a timely manner. One member of the audit staff of three was reassigned to his former position of Operations Shift Supervisor in Radiation Protection. However, the inspector did not see any appreciable decrease in program effectiveness.

The inspector's review of the NSE audit program showed a number of weaknesses. The inspector reviewed audits performed in each quarter of 1993. Two thresholds were identified for bringing closure to identified issues, the first being a "finding" and the second a "potential non-compliance (PNC)." The items identified in the NSE audits were normally reviewed by the Manager of Licensing and Compliance and dispositioned as to which threshold the item would be placed under. Then the item was resolved by either Radiological Engineering or Criticality Engineering whichever was appropriate and the corrective action normally was completed by the cognizant shop. Quarterly audits were performed as follows:

93-01	March 1-8, 1993
93-02	May 17-24, 1993
93-03	August 23-27, 1993
93-04	November 22 - December 1, 1993

During the second quarter, the licensee identified an item in the Gadolinia Shop "that the Heating Ventilation Air Conditioning (HVAC) System, Mezzanine Area at Dump Stations #485 and #489, had an unsafe geometry in the ductwork and the basis for safety was unknown." The item was classified as a finding and a note was placed in corrective action section which read "NSE initiate immediate review of the safety basis to drive proper response action." The date of the finding was May 21, 1993. The inspector could not find where this had been corrected in the audits or corrective actions in the remainder of the second or third quarter. The item, however, was identified again in the fourth quarter audit on November 30, 1993. The finding was listed "HVAC Configuration Concern and indicated that in the overhead Gadolinia Mezzanine, the HVAC still has a non-safe geometry ahead of the primary HEPA filters." Nothing was listed in the corrective actions section of

this audit; however, under the finding was written that "this is a repeat observation of a condition identified in the second quarter 1993 audit." "At the time of the inspection, the condition has not been evaluated and no fix is formally identified or is their work in progress to correct the situation in the near future." The inspector requested a meeting with licensee personnel to determine the current status of what appeared to the inspector to be a safety concern. Licensee personnel stated that the item had been assigned to an engineer for resolution in December 1993, but the individual no longer worked for the company. During the meeting licensee personnel presented a number of criticality controls that they believed to be in place and they are listed:

- Moderation Controls - UO_2 power is dry; System enclosed to prevent/minimize water intrusion;

- Mass Controls - Roughing filters on hood exhaust; Hood design minimizes vacuum cleaner effect; Historical information (No significant UO2 powder accumulations in 20 years); Routine quarterly gamma surveys of ducts in question; Annual gamma scan for accountability; Enrichment is less than 4.0 percent U-235;

- Nuclear Poison - All UO_2 powder mixed with a poisonous oxide; and

- Problem Tracking System - Monthly tracking of unresolved items and committed actions to maintain management attention.

The inspector acknowledged the licensee's list of mitigating conditions and discussed the status of the item with Region II management. The inspector inquired of the licensee if any work had been performed regarding an engineering study to determine the safety basis for continuing operation of the system in which an NSE Auditor had determined the "basis for safety (as) unknown." The inspector was given a sheet of paper with the results of an engineering study of the entire HVAC system in the Gadolinia Shop. Shortly after the original audit item was issued, an NSE engineer was instructed to perform the engineering study. The inspector noted that the engineer evaluated and identified 17 locations in the room and stated that 12 of the locations had an unsafe geometry and did not meet current criticality safety requirements. The inspector discussed this weakness in the audit program with licensee personnel and determined that no work had been performed on the item to resolve it since it was first identified in May 1993. The inspector informed the licensee that the item would be tracked by the NRC as an unresolved item and would be resolved when the NRC was able to get more information on the issue (URI 70-1113/94-02-02).

On January 18, 1994, after the inspector had discussed his findings with Regional management, the project inspector contacted a licensee nuclear criticality safety representative to review the situation, and to determine if the systems were being operated in an unsafe manner. The discussion revealed that the ventilation ductwork and filter housing

requirements were changed for other process areas when higher enrichments were approved for those areas, and the existing HVAC systems in question are acceptable for lower enrichments. Changing to the new requirements, however, would be required before increasing the enrichment. After discussing the audit findings, the licensee representative stated that the conditions observed in the audit did not represent an immediate nuclear safety issue or problem. Based on the review of the information provided to the project inspector and discussions with the licensee's nuclear criticality specialist, the Region-based project inspector's assessment was that this did not present an immediate nuclear safety problem.

The inspector also identified several NSE audit items were reclassified from PNCs to findings that were not followed up on as stated when the finding was reclassified. PNC 93-02-03 noted two examples of a moderation control weakness: (1) two five-gallon containers of stripper were stored in the Powder Warehouse and, (2) a loose array of plastic sheeting and a five gallon container of stripper were stored in the small enclosed area off the grinder area. The PNC was reclassified as a finding as requested by the shop on July 6, 1993, with the note emphasizing that the item was followed up on during the next audit. PNC 93-02-04, Visible Contamination in the Press Area, noted contamination at Presses 2A, 1B, and 2B. One area was at a press not being routinely operated and outside containment. This should have been cleaned much earlier. A press brush and powder was outside the containment: the brush had not been cleaned free of loose contamination. The recommended action prior to reclassification was to clean the loose contamination outside the containment and this should be emphasized with the associate. The licensee disagreed with the Potential Noncompliance and reclassified it on June 22, 1993. This also had a stipulation to follow up on during the next audit. The inspector stated a concern to the licensee on the reclassification of what appeared valid Potential Noncompliances and notified the licensee that neither finding was followed up on during the next two quarterly audits. The inspector believes that had the second item discussed in this paragraph been resolved as intended by the system that the contamination issue discussed in Paragraph 4 of this report may have been less severe. The issues involving PNC 93-02-03 will be included in URI 70-1113/94-02-02.

One unresolved item was identified.

6. Program for Maintaining Exposures As Low As Reasonably Achievable (ALARA) (83822)

10 CFR 20.1101(b) requires that each licensee 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 ALARA Report for 1993, dated December 8, 1993. The report was part of the meeting minutes for the licensee's radiation safety committee, the Wilmington Safety Review Committee, which met on November 30, 1993. The report summarized the personnel dose for the year and discussed ALARA-related issues. The inspector noted that the report included a study conducted annually on extremity doses. The study involved monitoring the extremity doses of dozens of GE workers for a one month period. Past studies verified that extremity monitoring was not necessary based on the relatively low doses received by the workers during the studies. This most recent study supported the same conclusion. The extremity doses of 70 workers monitored in the study had doses that were zero to five percent of the NRC limit. Ten workers had doses that were five to ten percent of the limit, and no worker's extremity dose exceeded ten percent of the NRC limit.

The average worker's external dose for 1993 was approximately 30 millirem whole body and 40 millirem skin and extremity. The highest individual dose for the year was approximately 560 millirem to the whole body, skin and the extremities each. The maximum individual internal dose was approximately 440 MPC-hours, compared to a NRC limit of 2080 MPC-hours. The total workforce internal exposure was reported as 28,500 MPC-hours, compared to a combined NRC annual limit of 1,250,000 MPC-hours. The licensee performed approximately 750 lung counts, approximately 75 of which slightly exceeded the MDA. Only two of the 75 "positive" counts exceeded 150 micrograms of uranium. Approximately 7400 urine samples were analyzed in 1993 with only approximately 20 exceeding the licensee's action limit. None of the positive lung counts or urinalyses suggested a significant internal dose to a worker.

No violations or deviations were identified.

7. Procedure Review (83822)

The inspector reviewed the following procedures which were revised as part of the licensee's implementation of revised 10 CFR Part 20 on January 1, 1994:

- NSI O-1.0, Respiratory Protection - Training and Fitting, Rev. 21, dated January 1, 1994;
- NSI O-2.0, Bioassay (Excreta) - Program, Rev. 25, dated January 1, 1994;
- NSI O-4.0, Nuclear Safety Instrumentation, Rev. 31, dated December 23, 1993;
- NSI O-7.0, Radiation Thermoluminescent Dosimeter Badge Issuance and Control, Rev. 18, dated January 1, 1994;

- NSI O-20.0, Investigation of Lost/Damaged TLD Badge and Estimate of Exposure, Rev. 14, dated January 1, 1994;

- NSI E-6.0, Personnel Dose Reporting, Rev. 20, dated January 1, 1994.

No problems were identified from the review of procedural requirements, with the exception of Procedure NSI O-6.0 discussed in Paragraph 4.

No violations or deviations were identified.

8. Previously Identified Inspector Followup Items (92701)

(Open) Inspector Followup Item (IFI) 70-1113/92-02-01: During a previous inspection the inspector noted numerous documented cases of air sampler plugging problems in URU, particularly the Cross Flow Filter Room. Discussions with licensee representatives indicated that the plugging was attributed to the interaction of chemical fumes in the area resulting in the deposition of ammonium nitrate on the filters. During the current inspection, the inspector was informed that the licensee's continued actions in response to the plugging included: tracking of sampler clogging; increased filter surveillances; and application of a correction factor to sampler results to account for the reduced flow when samplers were found clogged. To date the licensee had also implemented a "dry floor policy" throughout URU and had initiated replacement of PVC piping with stainless steel. Additionally, the licensee had proposed a plan for corrective action which would include further upgrades and modifications throughout the system. The inspector was informed that funding for the proposed corrective plan was anticipated and that if such funding was indeed granted, the modifications should be completed sometime in 1994. The inspector informed licensee representatives that the effectiveness of the actions to correct the plugging problems would continue to be tracked as an IFI (IFI 70-1113/92-02-02) pending final resolution of the problem.

9. Exit Meeting (83822, 92701)

The inspector met with licensee representatives indicated in Paragraph 1 at the conclusion of the inspection on January 14, 1994. The inspector summarized the scope and findings of the inspection. Although proprietary documents and processes were reviewed during the inspection, the proprietary nature of these documents is not reflected in this report. Dissenting comments were not received from the licensee.

Type	Item Number	Status	Description and Reference
VIO	70-1113/94-02-01	Open	Failure of the licensee to perform surveys necessary to identify the radiological contamination hazard (Paragraph 4).

URI	70-1113/94-02-02	Open	More evaluation by NRC Region II is needed regarding criticality controls to properly characterize (Paragraph 5).
IFI	70-1113/92-02-02	Open	Update to air sampler plugging problems (Paragraph 8).