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

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Report Nos.: 50-348/92-01 and 50-364/92-01

Licensee: Alabama Power Company
600 North 18th Street
Birmingham, AL 35291-0400

Docket Nos.: 50-348 and 50-364 License Nos.: NPF-2 and NPF-8

Facility Name: Farley 1 and 2

Inspection Conducted: January 6-10, 1992

Inspector: R. B. Shortridge 2/3/92
R. B. Shortridge Date Signed

Accompanying Personnel: A. T. Boland

Approved by: J. P. Potter 2/3/92
J. P. Potter, 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 was conducted in the area of occupational radiation exposure. Specific areas examined included: organization and management controls, training and qualification, external exposure control, internal exposure control, control of radioactive materials and contamination, surveys and monitoring. In addition, one unresolved item was evaluated.

Results:

In the areas inspected, one violation of NRC regulations was noted in that the licensee's procedures did not fully comply with regulatory requirements for labeling radioactive material. Also, an issue was identified regarding the accreditation and quality assurance program for the licensee's dosimetry laboratory which operates as a sub-facility of a commercial vendor. Based on the inspectors' observation of selected elements of the radiation protection (RP) program, the licensee was providing adequate radiological protection to ensure the protection of the health and safety of plant personnel and the public.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*W. Bayne, Supervisor, Safety Audit Engineering and Review (SAER)
J. Bouillon, Supervisor, Dosimetry
*M. Graves, Supervisor, Health Physics
*J. Kale, Superintendent, Chemistry and Environment
*M. Mitchell, Superintendent, Health Physics
*J. Osterholtz, Technical Manager
*M. Stinson, Assistant General Plant Manager
*J. Walden, Lead Auditor, SAER
*W. Warren, Supervisor, Technical Training

Other licensee employees contacted during this inspection included craftsmen, engineers, operators, mechanics, security force members, technicians, and administrative personnel.

Other NRC Personnel

*M. Morgan, Resident Inspector

*Attended exit interview

2. Occupational Radiation Exposure and Radiation Protection (83750)

a. Organization and Management Controls

(1) Radiation Protection Organization

Technical Specification (TS) 6.2.1 details, in part, the establishment of onsite and offsite organizations for unit operation and requires that the lines of authority, responsibility, and communication be established and defined for the highest levels through intermediate levels to and including all operating organization positions.

The inspectors reviewed changes made to the licensee's RP organization since the last NRC inspection of this area during April 8-12, 1991, and documented in Inspection Report No. 50-348, 364/91-07. Cognizant licensee representatives stated that the overall reporting chain and management structure for the RP program has remained unchanged. Dosimetry continues to report to the Superintendent, Chemistry and Environment, and three supervisory positions continue to report directly to

the Health Physics Superintendent - the Radwaste Supervisor, the Plant Health Physicist, and the Health Physics Supervisor. However, in preparation for implementation of the new 10 CFR Part 20 the Plant Health Physicist and two technicians have been dedicated to the procedural development and implementation effort. To compensate for the personnel loss in the normal operating organization, the licensee employed three contractor technicians and temporarily promoted an experienced plant RP technician to Health Physics Foreman. In addition to these temporary staff changes, the Technical Manager, to whom the Health Physics Superintendent reports, was recently reassigned. The individual currently filling this position is the previous Farley Nuclear Plant (FNP) Operations Manager. Overall, the changes do not appear to adversely impact the RP organization. Other aspects of the RP organization, including technician staffing, have been stable and appear appropriate to support normal RP operations.

The inspectors discussed with licensee representatives the planned staffing for the upcoming Unit 2 outage scheduled to begin in March 1992. Licensee representatives stated that approximately 20 junior and 60 senior contractor technicians are being considered to supplement the plant organization during the outage. This level of additional technician support is consistent with previous outages; however, the overall adequacy of final staffing to support the specific Unit 2 outage activities will be reviewed during a future inspection.

(2) Audits

TS 6.5.2.8 requires audits of facility activities to be conducted under the Manager, Safety Audit and Engineering Review (SAER) encompassing the conformance of facility operation to the provisions contained within the TS and applicable license conditions at least once per 12 months.

The inspectors reviewed the most recent comprehensive audit of the RP program conducted June 1 through September 17, 1991. This audit fulfilled the TS required frequency for such audits. In addition, the inspectors reviewed the May 1991 limited audit of incore movement activities as well as corrective actions for selected audit findings.

Based on a review of the licensee audits and the

associated checklists used by SAER to evaluate the RP Program, the inspectors determined that the audits were detailed and were sufficient in scope to include the major radiation protection functional areas. No issues similar to the current inspection findings were noted. Non-compliances as well as areas for improvement (i.e., "comments" in the audit reports) were well documented, reported to licensee management, and tracked for completion of corrective actions. The inspectors noted that actions on selected deficient areas were both appropriate and timely.

Further, the inspectors noted that the lead auditor responsible for the September 1991 comprehensive RP audit was experienced in performing such audits and had a radiation protection background. The specific qualifications of this individual with respect to ANSI N45.2.23-1978 requirements were reviewed during a previous NRC inspection of the RP program documented in Inspection Report No. 50-348, 364/90-14.

(3) Radiological Incident Reporting System

The inspectors reviewed the licensee's RP internal program for identifying and correcting deficiencies and weaknesses related to the control of radioactive material. The program consisted of the Radiation Incident Report (RIR) and the Radiation Incident Warning (RIW) administered through Radiation Control Procedure FNP-0-RCP-10, Revision 19, dated December 11, 1990.

Procedure FNP-0-RCP-10 provides specific criteria for the generation of RIRs which include the following types of events: (1) violation of Radiation Work Permit (RWP) requirements; (2) attempt to falsify dosimetry records; (3) mispositioning of dosimetry resulting in greater than a 25 percent deviation in dose; (4) exceeding administrative exposure limits by a specified margin; (5)positive nasal swipes exceeding 200 dpm; (6) Personnel Contamination Events (PCEs) of $\geq$ 5000 dpm/100cm^2; and (7) failure to secure exclusion area doors. The RIR program includes a structure for documentation of the events, assessment of the event severity, management review, and followup. The RIW program includes identification and documentation of lower threshold events similar to those noted above (i.e., PCE $\geq$ 1000 dpm/cm^2). Repetitive individual RIWs result in the issuance of an RIR.

The following provides a breakdown of RIRs for the period January 1 through December 31, 1991:

RIR Type	Number of Events
Dosimetry	2
Area Contamination	3
Skin Contamination	54
Nasal Contamination	10
Wound Contamination	0
Clothing Contamination	63
RWP Violation	9
Exceed Admin. Exposure Limits	1
Other	9
Total Events	151

The inspectors reviewed selected RIRs for 1991 and noted no significant trends or indicators of programmatic problems. Several RIRs were discussed in detail with licensee representatives and are addressed in the appropriate topical section of this report. For the cases reviewed corrective actions appeared adequate, and the appropriate level of management attention appeared to be given to identified deficiencies.

b. Training and Qualification

During processing into the FNP facility, the inspectors were provided training normally given NRC personnel for site access. The inspectors noted that the instructors normally associated with General Employee Training (GET) and site access training had accepted jobs in other departments of the company. The Region-based inspectors were requested to review a plant security handbook and successfully complete a written examination. The inspectors told training personnel that this was normally not required for site access but they would comply with the licensee's request. Midway through the 40-60 minute training, licensee training personnel realized the mistake but did not redirect the inspectors to the site specific training normally provided. At the conclusion of the exam, the inspectors were requested to view a 45 minute video tape normally provided for site access, and were given a handout that was to reflect the content on the video.

The inspectors discussed the following observations with licensee representatives at the exit interview: (1) the training video incorrectly stated that emergency dose limits of 25 and 75 rem were NRC limits, (2) the video instructed a person to record a high range dosimeter

reading if the low range dosimeter was off scale but HP was not required to be notified, (3) changes in the training handout were entered in pen in the margin with arrows to the text to be inserted but the changes were not always entered in the same manner, and (4) the handout had numerous changes in the margin that had not been revised (retyped) since August 1990. Licensee representatives stated that they would review the inspectors' comments. In addition, the inspectors stated that more that two hours were taken during plant access processing and suggested that since much of the video tape contained generic material, (that is material that had previously been taught to NRC inspectors) that reducing the content to site specific information would be more efficient. In general, NRC expects licensees to limit the time for NRC inspector entry into the plant to two hours, including site specific training, security badging, and in-vivo counting.

c. External Exposure Control

10 CFR 20.101 requires that no licensee shall possess, use, or transfer licensed material in such a manner as to cause any individual in a restricted area to receive in any period of one calendar quarter a total occupational dose in excess of 1.25 rem to the whole body, head and trunk, active blood forming organs, lens of the eyes, or gonads; 18.75 rem to the hands and forearms, feet and ankles; and 7.5 rem to the skin of the whole body.

(1) Whole Body Exposure

The inspectors discussed with the licensee the January 1 through December 31, 1991, whole body cumulative exposures for both licensee and contractor personnel. Licensee representatives stated that the assigned whole body doses were within 10 CFR 20 limits, and that no 1991, annual whole body dose extensions had been granted to allow any person to receive in excess of the administrative limit of 4,200 mrem. The inspectors verified that the highest cumulative whole body exposure to an individual for 1991 was 4.130 rem, 3.41 rem of which was received at FNP. In addition, the highest whole body dose recorded for the fourth quarter of 1991 was 300 mrem.

A review of RIRs by the inspectors revealed that one administrative overexposure occurred on March 26, 1991 (RIR #91-0060). The incident involved a worker who exceeded the licensee's weekly, outage whole body administrative limit of 200 mrem without receiving a proper exposure extension. The individual's total weekly whole body dose, when recognized by health physics, was 255 mrem. The licensee's investigation of the event revealed that the individual believed that an extension had been obtained by a co-worker, when in fact it had not. The licensee followed up on the event and instituted corrective actions. The inspectors noted that this event appeared to be isolated and was not indicative of a programmatic weakness.

The inspectors noted that the site collective dose for 1991 was approximately 648 rem compared to an ALARA goal of 643 rem. Licensee representatives stated that approximately 55.5 rem of the collective dose expended during the April 1991 outage was unbudgeted. The site collective dose for 1989 and 1990 was 750 and 458, respectively, resulting in a site, (2-unit) three year average of approximately 618 rem (based on NUREG-0713 data).

(2) Neutron Exposure

Procedure FNP-0-RCP-01, General Guidance and Special Instructions to HP Personnel, Revision 23, dated November 6, 1991, provides the basis for the neutron dosimetry program. In addition, Procedure FNP-0-DOS-1, Personnel Monitoring, Revision 23, dated October 7, 1991, establishes quarterly administrative neutron exposure limits of 270 mrem and 1,000 mrem depending on whether stay-time calculations or neutron monitoring devices, respectively, are used to assign dose.

A review of the monthly neutron dosimetry reports for the year 1991 revealed that the highest individual cumulative neutron exposure for the year was 299 mrem. Neutron doses were primarily recorded based on "Rembali" measurements and stay time. Neutron dosimetry is required only when neutron exposures are expected to exceed 270 mrem. According to licensee representatives, special neutron dosimetry was issued in 1991 only during the month of June due to steam generator flow transmitter work being performed on the 155' level of containment. The inspectors did not note any anomalies associated with the neutron doses recorded

for this job. Further, the inspectors were informed that no neutron doses had been assigned for 1992. Based on the limited review of this area, the neutron dosimetry program appeared to be conducted in accordance with licensee procedures.

(3) Dose to the Lens of the Eye

10 CFR 20.401(a) requires, in part, that each licensee maintain records in accordance with the instructions contained in NRC Form 5, Current Occupational External Radiation Exposure, dated October 1981. NRC Form 5 requires that when the lens of the eye is not protected by shields with a tissue equivalent absorber thickness of 700mg/cm^2 the whole body dose is to include the dose delivered through a tissue equivalent absorber thickness of 300mg/cm^2.

The inspectors reviewed the licensee's program to account for beta dose to the lens of the eye. According to licensee representatives no correction factor for whole body dose at 300mg/cm^2 is incorporated into the dosimetry algorithm. Instead, the licensee performs beta surveys in accordance with Procedure FNP-O-RCP-357, Revision 18, dated January 2, 1991. Specifically, prior to initiation of steam generator work, TLD surveys are pe rmed at the following steam generator locations: (1) tubesheet at contact; (2) tubesheet at 6 inches; (3) divider plate contact; (4) bowl bottom at contact; (5) manway plane; and (6) centerline of the channelhead. At each of the locations, doses are determined using unshielded TLDs and TLDs shielded with various personnel protective equipment materials (i.e., glasses, gloves, coveralls, plastics, and hoods). The licensee then compares the unshielded and shielded value to determine any needed beta/lens of the eye correction factor.

The inspectors reviewed the steam generator TLD surveys performed during the March 1991 Unit 1 outage. The survey results indicated that the beta component of the steam generator radiation field was appropriately shielded by the various combinations of protective equipment. In particular, the hood and hood/glasses combination appeared to be satisfactory in shielding the lens of the eye from beta dose. Therefore, no dose algorithm correction would be necessary for the licensee's whole body TLD.

The inspectors also reviewed two beta TLD studies performed by a licensee vendor to evaluate the beta component of the steam generator radiation field. Based upon the licensee's TLD surveys discussed previously and the beta studies performed, the inspectors determined that the licensee's approach to beta dose assignment appeared appropriate. However, to ensure the accuracy of this methodology, this area will be reviewed in detail during a future inspection.

(4) Thermoluminescent Dosimetry Program

10 CFR 20.202(c) requires, in part, that dosimeters used to comply with 10 CFR 20.202(a) shall be processed and evaluated by a dosimetry processor holding current accreditation from the National Voluntary Laboratory Accreditation program (NVLAP) for the types of radiation for which the individual is monitored.

The FNP site utilizes a card dosimeter containing three TLD-700 chips. The density thicknesses for TLD measurements are 1,000mg/cm^2 and 20mg/cm^2 (the TLD analysis algorithm corrects the 20mg/cm^2 value to 7mg/cm^2 to report shallow dose).

Discussions with licensee personnel and a review of pertinent documentation revealed that FNP/Alabama Power Company holds NVLAP certification for categories II, IV, V, and VII as a sub-facility of a major vendor of dosimetry services; however, no vendor personnel are permanently assigned to the FNP site. In this arrangement, FNP conducts on-site processing of two of the TLD chips. The vendor, in turn, provides chip preparation, algorithm and data processing support, and technical support as well as analysis of a 100 percent of the third chips as a quality assurance check. According to licensee representatives, NVLAP had not been to FNP as part of the TLD accreditation process to-date; however, an onsite evaluation was anticipated during the 1992 renewal process.

The inspectors reviewed various aspects of the dosimetry processing program. The licensee provided documentation verifying that FNP TLD processors had undergone training by the vendor, and that periodic requalification was achieved by successful completion of 10 batch runs within 180 days of training expiration. The inspectors also discussed with licensee representatives the vendor's third chip cross-check. The licensee stated that the

vendor reads a 100 percent sample of third TLD chips using the licensee's equipment either onsite or at the Emergency Operations Facility, and that no recent discrepancies had been noted.

The inspectors discussed the TLD quality assurance program in detail with dosimetry personnel. In addition to the cross-checks, the licensee implements vendor supplied operating tolerance parameters for each TLD reading system, and these tolerance parameters have been incorporated into the licensee's TLD processing procedures. The licensee also maintained a copy of the vendor Quality Assurance Manual, dated February 27, 1984; however, dosimetry personnel stated that the manual was not used by FNP. The currentness of the QA manual could not be verified by the inspectors. The inspectors were informed of and reviewed documentation which verified, that the licensee had accepted the vendor QA program and that an inter-utility audit of the vendor had been performed in December 1990.

Due to the uniqueness of the sub-facility TLD processing concept, the inspectors were unable to determine that the FNP dosimetry laboratory was in complete compliance with NVLAP certification criteria particularly the interrelationship of the vendor and FNP Quality Assurance programs. Although no safety concerns were identified by the inspectors related to actual TLD processing or recorded doses, the licensee was informed that this area required further NRC evaluation and would be tracked as an Inspector Followup Item (IFI 50-348/92-01-01).

(5) Radiological Tours

10 CFR 20.202 requires each licensee to supply appropriate monitoring devices to specific individuals and requires the use of such equipment.

During tours of the Units 1 and 2 Auxiliary Buildings, and other radiologically controlled areas (RCA), the inspectors observed workers wearing digital alarming dosimeter (DADs) as required by station procedures. The inspectors noted that the licensee had upgraded their exposure control system by purchasing the DADs and an automated access/egress control system that automatically records worker exposure among other data. The licensee had made other changes to the facility regarding access/egress that aided in exposure control through the more efficient movement of workers. Just prior to exiting the RCA the licensee

installed four bag type contamination monitors to survey material for contamination. State of the art personnel contamination monitors had been installed to facilitate the egress of a large number of workers. The bag and personnel contamination monitors were located so they were easily monitored by HP personnel.

The inspectors performed radiation surveys during tours of the RCA and monitored locked high radiation area doors. The surveys made by the inspectors agreed with those posted by the licensee and all posted locked high radiation areas were locked as required.

d. Internal Exposure Control

The licensee's respiratory protection procedures require the collection of nasal smears for every employee following the use of a respirator. Nasal smears indicating greater than or equal to 200 dpm require investigation, RIR development, and followup bioassays to determine potential internal exposures.

For the period January 1 through December 31, 1991, the licensee reported ten positive nasal smears requiring followup. For those selected cases reviewed, the bioassays indicated that uptakes were less than three percent of the Maximum Permissible Organ Burden (MPOB); however, one case (RIR 91-0062) was reviewed in detail. On March 26, 1991, an individual working with a boring machine during the resistance temperature detector removal was sprayed in the face with coolant from the machine. Upon detection of contamination at the HP Control Point, decontamination and nasal smears were performed. Initial surveys indicated 10,000 dpm on the bridge of the nose and 1,900 dpm on the nasal smear. Successive whole body counts were performed over the next three days using both the standup counters (Auxiliary Building and Emergency Operations Facility) and the chair counter. The maximum uptakes measured were 1.263% MPOB for cobalt-60 and 0.56% MPOB for cobalt-58 using the chair counter. The licensee's actions and assessments for this event appeared satisfactory and no violations of regulatory requirements were noted.

Additionally, the inspectors reviewed selected records of routine and termination whole body counts. For those records reviewed, routine, whole body analysis appeared to be performed appropriately, and termination letters were provided within 30 days, as required.

e. Control of Radioactive Material and Contamination, Surveys and Monitoring

The licensee is required by 10 CFR 20.201(b), 20.401, and 20.403 to perform surveys and to maintain records of such surveys necessary to show compliance with regulatory limits.

The inspectors reviewed licensee surveys and performed surveys to verify the licensee results. No discrepancies were identified. During tours the inspectors noted that all radiation protection instrumentation was within current calibration dates.

The inspectors reviewed the licensee's program to control contamination at its source. The inspectors noted that 5.63 percent of RCA or 7,660 square feet (ft^2) of the 137,663 ft^2 total RCA is contaminated. The licensee maintains a two tier system for reporting and dealing with PCEs. Only when RIRs and RIWs are combined does one get a true picture of PCEs. The licensee experienced a total of 117 PCEs through December 31, 1991. The licensee's program to control contamination at its source continues to improve.

10 CFR 20.203(f)(1) and (2) require, in part, for containers, except as provided in paragraph (f)(3), that each container of licensed material shall bear a durable, clearly visible label identifying the radioactive contents. The label is to bear the radiation symbol and the words "CAUTION RADIOACTIVE MATERIAL" or "DANGER RADIOACTIVE MATERIAL". It shall also provide sufficient information (as appropriate, the information will include radiation levels, kinds of materials, estimate of activity, etc.) to permit individuals handling or using the containers, or working in the vicinity there of, to take precautions to avoid or minimize exposure

10 CFR 20.203(f)(3)(vi) states, in part, that labeling is not required for containers which are accessible (for example, containers in locations such as waterfilled canals, storage vaults, or hot cells) only to individuals authorized to handle or use them, or to work in the vicinity thereof, provided that the contents are identified to such individuals by a readily written record.

TS 6.11 states that procedures for radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained and adhered to for all operations involving personnel radiation exposure.

FNP-O-RCP-57, Radioactivity and Potentially Radioactive Material Handling, Revision 16, dated March 28, 1991, requires, in part, the following: (1) Item 3.1.1 - The label, bag, tag, or sign may include, at the HP Technician's discretion, information such that the person handling the material or working in the vicinity of the material can implement appropriate actions and precautions to minimize their exposure, (2) Item 3.1.1.1 - A contact maximum radiation level on the surface of radioactive material or container should be considered the minimum for personnel awareness; (3) Item 3.1.1.2 - Other information such as fixed/smearble radioactive contamination levels, isotopes, etc.; (further, the added note states - Radioactive Material located in a rad bag or within boundaries of an area posted as Radioactive Material do not require individual tags, labels, or signs;) and (4) Item 3.2 - When HP supervision determines that an item is a significant radiation hazard [e.g. greater than 100 mrem per hour (mr/hr) at 18 inches], requiring special measures to be implemented for positive control, the Radioactive Material Accountability System will be used.

During tours of the RCA, the inspectors noted that the licensee was placing tape on all items of radioactive material or potentially radioactive material. The tape bore the words "Caution Radioactive Material". During a tour with the Radiation Protection Manager (RPM) the inspectors noted in the New Fuel Storage Area that the sign posted as "Radioactive Material" at the entry way listed a gray box in the area as reading 45 mr/hr on contact and stated that filter system components were inside the area. However, a high integrity container and refueling tools were also stored in the area. The inspectors informed the licensee that while all items in the area appeared to have radioactive material tape, the tape on the items did not give a description of the material inside the container or the dose rate in many cases. The RPM stated that the primary method employed to identify radioactive material was to identify the items on a sign at the entry point to the area. The inspectors noted that other radioactive material was located in the area that was not described on the sign, such as, refueling tools and a high integrity container for radwaste.

During tours through the RCA over a three day period, the inspectors noted many (approximately 90 percent) items of radioactive material that were labeled as radioactive material but did not bear a description of the item or dose rate. In several areas of the plant, lead-lined drums stenciled with greater than 200 mr/hr

and less than 1000 mr/hr were near aisleways but had no labels and no current dose rate value. The inspectors did not locate any items of radioactive materials that had high dose rates which were not labeled, but did identify numerous items with low levels of radiation which had no description, and in many cases no dose rate.

Licensee representatives stated that individual containers of radioactive material were not required to be labeled because credit was taken for the exemption provided in 10 CFR 20.203(f)(3)(vi). Further, the licensee stated that postings at area entries were utilized to inform workers of individual containers of materials for which precautions should be taken. The inspectors noted that, although postings often provided identification and radiological information regarding a specific container within an area, all containers within a given area were not described nor was other radiological information always available. Therefore, the licensee was informed that the conditions of the labelling exemption were not being adequately implemented in that a written record was not readily available for all radioactive material containers accessible to workers.

The inspectors informed the licensee that the procedure requirements for labeling radioactive material in FNP-0-RCP-057, as referenced, were inadequate in that: in Item 3.1.1.1, "should" was used instead of "shall" as in 10 CFR 20.203; the note in Item 3.1.1.2 conflicted directly with the requirements of 10 CFR 20.203; and that in using the exemption provided in 20.203(f)(3)(vi) the licensee had not provided a written record that was readily available for all containers of radioactive material. The inspectors informed the licensee that the failure of the procedure to require labeling in accordance with the requirements of 10 CFR 20.203(f) was a violation of 10 CFR 20 and TS 6.11 (VIO 50-348/92-01-02 and 50-364/92-01-02).

The inspectors also discussed with licensee representatives the threshold for placing radioactive material into the accountability system. As provided by Item 3.2 of FNP-0-RCP-57, containers with a significant hazard potential (e.g., greater than 100 mR/hr at 18 inches) are entered into the accountability system which includes complete labeling with descriptive and inventory information. The inspectors expressed concern that the dose threshold appeared too high and that labeling at a lower hazard level would be appropriate to limit exposures. The licensee agreed to evaluate this requirement based on NRC's concern.

3. Licensee Action on Previous Inspection Findings (92701)

(Closed) Unresolved Item 50-348/90-34-01: Evaluation of events surrounding the presence of a contaminated desiccant column in a clean waste bag outside of the RCA.

The inspectors reviewed RIR #90-0098 and the subsequent followup actions by the licensee for this event. The event involved a desiccant column used by a contractor during steam generator helium leak detection operations being conducted from a trailer outside of the RCA, but within the Protected Area. Following completion of the operation, the column was separated from the connective tubing. The tubes were put inside containment; however, the column was separated and ultimately placed into a clean waste bag. HP found the contaminated column upon sorting/surveying trash prior to protected area release. The licensee discussed the circumstances surrounding the event with both contractor and FNP personnel and was unable to confirm exactly how the column got into the bag; however, to prevent recurrence, the contractor agreed to modify the procedures for break-down of the detection equipment to include sign-off by FNP health physics. This contractor procedure was incorporated into Procedure FNP-1-ETP-4292, Helium Leak Detection of Steam Generators, Revision 3, March 12, 1991. The licensee's actions with respect to this event were satisfactory.

4. Exit Meeting

The inspectors met with licensee representatives denoted in Paragraph 1 at the conclusion of the inspection on January 10, 1991. The inspector summarized the scope of the findings listed below. The licensee did not identify any documents given to the inspectors as proprietary.

Item Number	Description and Reference
50-348/92-01-01	IFI - Review QA requirements for the Dosimetry Laboratory (Paragraph 2.c.4)
50-348/92-01-02 and 50-364/92-01-02	Violation - Procedure was inadequate in specifying labeling of radioactive material. (Paragraph 2.e)