

U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No. 50-397/88-22

Docket No. 50-397

License No. NPF-21

Licensee: Washington Public Power Supply System
P. O. Box 968
Richland, Washington 99352

Facility Name: Washington Nuclear Project No. 2

Inspection at: WNP-2, Benton County, Washington

Inspection Conducted: June 6-9, 1988

Inspectors: GP Yuhas for
G. R. Cicotte, Radiation Specialist

6/29/88
Date Signed

GP Yuhas
G. P. Yuhas, Chief
Facilities Radiological Protection Section

6/29/88
Date Signed

Approved by: GP Yuhas
G. P. Yuhas, Chief
Facilities Radiological Protection Section

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Summary:

Inspection during period of June 6-9, 1988 (Report No. 50-397/88-22)

Areas Inspected: Reactive, unannounced inspection by two regionally based inspectors of the May 12, 1988 radioactive resin spill in the Radwaste Building, which resulted in the declaration of an Unusual Event. The inspection included a tour of the facility. Inspection procedures 30303, 93702, and 83724 were addressed.

Results: The licensee's evaluation of the event identified deficiencies in procedural guidance, plant drawings, component condition, emergency response, and operator performance. The inspection confirmed the licensee's findings. The inspection identified additional deficiencies in the areas of: operator knowledge of high radiation area access; and in control of high radiation areas greater than 1000mr/hr, which resulted in two apparent violations, of Technical Specifications 6.12.1 and 6.12.2, respectively. (see paragraphs 2 and 3).

DETAILS

1. Persons Contacted

J. W. Shannon, Deputy Managing Director
*C. M. Powers, Plant Manager
*J. W. Baker, Assistant Plant Manager
*M. C. Bartlett, Quality Assurance Supervisor
*L. Bradford, Health Physics Supervisor
*R. L. Corcoran, Operations Manager
*D. S. Feldman, Plant QA/QC Manager
*R. G. Graybeal, Health Physics/Chemistry Manager
*N. L. Hancock, Shift Manager
G. J. Kozlik, Shift Manager
*D. E. Larson, Radiological Programs/Instrument Calibration Manager
S. L. McKay, Assistant operations Manager
T. C. Messersmith, Shift Support Supervisor
G. C. Bishop, Radwaste Systems Engineer
*H. D. Rockey, Control Room Supervisor
*V. E. Shockley, Health Physics Support Supervisor

NRC Personnel

*A. D. Johnson, Regional Enforcement Officer
*R. C. Sorensen, Resident Inspector

In addition to the individuals identified above, the inspectors met and held discussions with other members of the licensee's staff and personnel.

*Denotes those present at the exit interview held on June 9, 1988.

2. Onsite Follow-up of Events at Operating Power Reactors

A. Introduction

On May 12, 1988, while recirculating radioactive resins from the Phase Separator Tank, in preparation for transfer to a contractor solidification unit, the licensee discovered a spill of approximately 2 cubic feet of radioactive resins on the floor of the Radwaste Building. The licensee determined the spill was the result of an improper valve lineup which allowed approximately 1000 gallons of resin slurry, including about 30 cubic feet of resin containing an estimated 230 curies of activity, to flow into the floor drain system. The spill resulted in a confirmed Area Radiation Monitor (ARM) alarm. The licensee declared an unusual event, which was terminated when the spill was cleaned up and radiation levels had returned to normal. A chronology of the event, based primarily on the licensee's evaluation, and confirmed by review of logs and interviews with personnel, follows:

May 12, 1988

1445	The Equipment Operator (EO) began preparation for transfer of contents of RWCU Phase Separator Tank RWCU-TM-104B by placing it in recirculation mode.
1615	The EO recorded a drop in tank level in his log.
1645	The EO began a search to determine the reason for a continued loss of level in 104B.
1710	The EO found a spill upon entry to the Waste Collector Tank Room on the 437' elevation of the Radwaste Building, of approximately $\frac{1}{2}$ to 2 cubic feet of resin around a floor scupper. He then attempted to determine source and isolation of the leak. The EO exited the room and informed the Shift Support Supervisor (SSS) and Health Physics (HP).
1725	The EO secured the recirculation.
1730	The EO, HP Technician, and the SSS returned to the spill scene. Liquid was still draining from the line. ARM-29, by the scene, was alarming with confirmed dose rates above the alarm setpoint. ARM-28, near the sump to which the drain would flow, was alarming but dose rates were below the setpoint.
1735	The Shift Manager (SM) went to the Radwaste Control Room to assist the SSS in isolating the leak.
1739	The HP reported the ARM alarm and dose rates to the HP Supervisor and Control Room.
1800	After searching plant diagrams and calling a Radwaste Systems Engineer, the SSS found the air operator controllers for valves RWCU-V-442 and 443, and noted that their position indication lights were defective. Valve controllers were placed to close, an air sound was heard by the EO, who returned to the scene and confirmed the spill had stopped.
1820	The SM stated he was informed of the ARM-29 alarm upon returning to the Control Room. The SM stated he then shifted his attention to classification of the event.
1840	The pump for sump W-3 was placed in Pull-To-Lock (actual drainage was to sump W-2).

- 1903 An Unusual Event (UE) was declared as a result of consultation with the Plant Manager.
- 2030 The spill was mostly cleaned up, and the UE terminated.

The inspectors discussed the event with the Assistant Plant Manager (APM), and asked if the licensee's evaluation was complete. The inspectors were presented with Interoffice Memorandum EP-AFK-88-032, Final Report for the May 12, 1988, Unusual Event at WNP-2, from Emergency Planning & Environmental Programs Manager to Assistant Managing Director of Operations, dated June 1, 1988. The inspectors noted that the report included a chronology and findings, with attachments from Security, Radwaste Operations, Operations, and Emergency Planning, but not from Health Physics (HP). The APM stated that the delay by the EO in identification of the tank inventory loss and in securing the recirculation were performance issues which were being addressed separately from the report.

B. Licensee Evaluation

The licensee's evaluation of the event identified the following as areas needing attention:

1. Material condition of radwaste systems, such as no identification on valves and position indication lights burned out or missing on the control units for RWCU-V-442 and 443, and other out of service systems. The licensee attributed this in part to the inactive status of portions of the solid radwaste system, and in part to no identification of RWCU V-442 in the procedure for recirculation of the Phase Separator Tank.
2. Emergency Planning identified concerns in the areas of off-site personnel response, distraction of Shift Manager (SM), and guidance as to significance of ARM alarms in Emergency Plan Implementing Procedure (EPIP) 13.1.1, Classifying The Emergency. Corrective Action Records (CARs) had been initiated to address the above issues. The licensee concluded that the SM delayed in declaring an UE due to his knowledge of a previously proposed change to EPIP 13.1.1, made effective May 23, 1988, allowing the SM to not declare an UE when the cause of a confirmed ARM alarm is determined to be the result of planned evolutions, such as RWCU resin transfers.
3. Plant drawings were incorrect, resulting in a delay in identification of the isolation valves. The report did not identify the specific drawings which were in error, but did note the fact that the drain was indicated as equipment drain (EDR) when it was a floor drain (FDR).
4. The ARM strip chart recorder was characterized in the report as "almost impossible to use" for trending ARM readings. The licensee stated they had determined the recorder needed to be upgraded.

5. Security personnel determined that there was no evidence to suggest that valves RWCU-V-443 and RWCU-V-442 were mispositioned other than inadvertently via the remote manual switches.

C. NRC Review

In assessing the evaluation by the licensee, the inspectors reviewed the following documents, in addition to the final report with attachments, noted in paragraph 2.A, above:

Plant Drawings M523, M531, M532, M540, M607 Sheet 1, and 4E001.

Control Room Operator's Log for May 12-13, 1988

Shift Manager's Log for May 12-13, 1988

Radwaste Control Room Log for May 12-13, 1988

Health Physics Log for May 12-June 7, 1988

Radiation Work Permits (total of 15) for routine & non-routine activities

- Licensee Procedures -
- 1.2.3 Use of Plant Procedures, Rev 12, 9-18-87
 - 2.11.1 Solid Waste Processing System Rev. 5, 12-22-86
 - 2.11.1 Checklist, completed 3-20-84
 - 11.2.7.1 Area Posting Revs. 0-5, Rev. 5 11-30-87
 - 11.2.7.3 Entry into and Egress from High Radiation Areas, Rev 4, 1-6-88
 - 7.4.3.7.1.15 Spent Fuel Pool Area Radiation Monitor-CFR, Rev 4, 7-28-86

Quality Assurance Surveillance Report (QASR) 2-87-278, Hi Hi Radiation Area Access Control, 8-27-87

Multipoint Recorder Track for ARM-RR-600 for May 12-13, 1988

Technical Manual 179018, Leeds & Northrup Company Speedomax W Multipoint Recorder Parts Catalog EPN ARM-RR-600

The inspectors made the following observations with respect to issues addressed by the licensee's evaluation:

1. The licensee had not used portions of the solid radwaste system originally described in the Safety Analysis Report, and had placed those sub-systems on inactive status. Examination of licensee procedure 2.11.1, revealed that the valve RWCU-V-443 was listed in the checklist as normally shut, and the position indication was shown as being on the 467' elevation, in the location where the licensee ultimately found the control unit.

The delay in identification of the appropriate isolation valves and the root cause of the misalignment of RWCU-V-443 and RWCU-V-442 were discussed with licensee representatives. Licensee procedure 2.11.1, Part 5, Procedure I, states in part:

"Note: This procedure covers the transfer of waste to and the receipt of water from the waste contractors Mobile Radwaste Processing Unit ..."

"... A. Preparation for Operations

Step 1) Complete the Solid Waste Processing System Valve Check List."

The licensee stated that valve line-ups are not normally performed on non-engineered safety feature (ESF) systems, unless major maintenance or modifications had been conducted. The licensee stated that plant policy was to perform a line-up of the system, typically at startup, and that the reference in 2.11.1 was to an on-file copy of the checklist. The inspectors asked licensee representatives where the policy was iterated, as it was not in Administrative Procedure 1.2.3, Use Of Plant Procedures. The licensee stated that the policy was known to all personnel. The licensee produced a copy of the valve line-up checklist specified in 2.11.1, which was performed March 20, 1984, and which the licensee stated was the most recent line-up available. The inspectors expressed concern that an unwritten plant policy would allow systems to be used for several years between verifications of the valve line-up.

The licensee stated at the exit interview that they would evaluate the need for valve line-ups on other systems (The licensee stated that 2.11.1 was re-performed in part as a corrective measure for the event), and document the valve line-up policy in the administrative procedures. The licensee's efforts will be examined in a subsequent inspection (50-397/88-22-01).

2. The licensee's evaluation of Emergency Planning addressed the issue of whether or not the event should have been classified. The licensee had initiated corrective actions in the form of CARs (See paragraph 2.B.2).

The inspectors made the following observations regarding the event:

No offsite release of radioactivity occurred. The discovery of the spill, assessment, and cleanup efforts resulted in approximately 0.180 person-rem cumulative radiation exposure. No loss of access control to plant systems appeared to have occurred. Sampling conducted by the licensee indicated no significant increase in airborne radioactivity.

The inspector found it interesting that the HP supervisor on shift at the time of the event stated he was not consulted as to the radiological significance, and was not aware that a UE declaration was contemplated until he heard the public address system announcement that a UE had been declared.

3. The inspectors noted that of the plant drawings available to the EOs and SSS, M607 Sheet 3, Flow Diagram, Steam and Liquid Sampling, Radwaste Building, showed RWCU-V-442 as draining to EDR, rather than to FDR. Also, M607 SH 3 does not identify RWCU-V-443, though the valve is shown. Flow Diagrams for Reactor Water Cleanup, Floor Drains, and Equipment Drains, all correctly identify the valves and drainage paths.

The licensee had initially incorrectly identified the drainage path as going to the EDR system via sump W-3, and had placed the pump for the sump in Pull-to-Lock to prevent further transfer of resin to the tank. A review of records showed that sump W-2, the sump to which the resin actually drained, had pumped several times to Floor Drain Tank FDR-T-6. The licensee stated that it was their conclusion that the approximately 1000 gallons of liquid decanted in the sump such that the resin remained in the sump. They stated they were waiting until modifications to the radwaste system were completed, so that the resin removal could be conducted. Surveys by the licensee showed normal levels in the vicinity of FDR-T-6 on May 13, 1988. On May 30, 1988, the licensee surveyed the area around FDR-T-6 and posted the area as being greater than 1000 mr/hr, that is, with a flashing yellow light. A review of licensee surveys after the event and a survey of the top of sump W-2 revealed that dose rates had dropped from about 40 mr/hr shortly after the event to 8 mr/hr. The inspectors concluded that the licensee had identified the sump to which the resin drained, but that the delay may have caused significant increases in radiation levels in the vicinity of FDR-T-6, concurrent with decreases in dose rates at sump W-2. The licensee's efforts to reduce system contamination will be examined in a subsequent inspection (50-397/88-22-02).

4. The inspectors were unable to determine from the ARM strip chart recorder ARM-RR-6000, when ARM Channel 29 began to alarm, or whether ARM Channel 28 did alarm. Control Room (CR) personnel do not always and did not in this case, notify HP personnel when ARM Channel 29 alarmed. The licensee stated that the alarm is actuated routinely during RWCU resin transfers, and that EPIP 13.1.1 was revised to reflect this (see paragraph 2.B.2).

Examination of the recorder revealed that the channels are divided into three banks of numbered data points, such that Point No. 1 would be displayed as three separate and differently colored tracks, Point No. 2 would be so displayed, and so on. The ink wheel colors had run together such that all three colors appeared the same, so that each set of three ARMs

appeared identical. The inspector was unable to identify a work request or design change to correct the problem. Surveillance procedure 7.4.3.7.1.15 does not address the recording function of ARM-RR-600, but does stipulate the test reading accuracy. The licensee stated at the exit interview that they would expend the appropriate level of effort to restore proper recorder function. This will be examined in a subsequent inspection (50-397/88-22-03).

5. The licensee had tentatively established the misalignment of the valves as occurring on about April 28, 1988, based on increased W-2 sump pump run times. The inspectors observed the system configuration and concluded that the Security Department's evaluation was appropriate.
- D. The inspectors noted the delays in operator action associated with the event. Although not included in the written evaluation, the licensee had identified that the EO had not monitored level in the Phase Separator Tank, and did not immediately isolate the recirculation pump when the inventory loss was noted. Both actions are specified in the limitations section of 2.11.1. Step 2.11.1.4.5 states:

"J. When a phase separator tank is on recirc, carefully monitor its level to ensure it does not go down. If it does, a leak is likely. Isolate the tank immediately."

The licensee was in the process of addressing this performance issue.

- E. In assessing work practices and radiological controls associated with the event, the inspectors discussed the event with personnel involved and reviewed RWPs, including RWP 2-88-0004. The EO used this RWP when conducting the Phase Separator recirculation evolution. This raised two concerns which were further inspected, as they had not been addressed in the licensee's evaluation.

RWP 2-88-00004, in part, contained the following information:

"WORK GROUP Operations"

"JOB LOCATION BLDG./ELEV. ALL LOCATION RCA "

"JOB DESCRIPTION Operations Department personnel to perform routine tours, inspections, P.M.'s, surveillances, valve line-ups, and other job tasks as required."

". . . RADIATION: 441 T/G/437R/W/548 Rx

GENERAL AKEA: 20 / 5.0 / 5.0* mrem/hr. . ."

". . . COMMENTS: *Radiological conditions will vary depending on Rx power, refer to status board or current survey map for each Bldg.

The status board referred to on the RWP was located at the entrance to the Radiologically Controlled Area (RCA). The board was noted to have an update listed as "4-18-88." The board indicated the area was a high radiation area between 100mr/hr and 1000mr/hr by a color-coded boundary on the board. The RWP specified a TLD and 0-500 mr self-reading pocket dosimeter (SRPD) as monitoring devices. Of the 15 similar RWPs reviewed, all those which allowed entry to high radiation areas specified dose rate monitoring or HP escort. The inspectors concluded that RWP 2-88-00004 would allow entry to high radiation areas without specifying such devices or controls required by Technical Specification 6.12.

At approximately 5:00 p.m. on May 12, 1988, while searching for the cause of the Phase Separator Tank level loss, the EO stated he entered the Waste Collector Tank Room, and observed the spill on the floor near the Chemical Waste Tanks. He then entered the area to search for the isolation valves to stop the spill of resin. The area he entered had been previously posted as a high radiation area, with a flashing yellow light as a warning device to indicate dose rates were greater than 1000mr/hr, from a valve located near the floor. Discussion with five EOs revealed that four of them were unaware of the purpose of the flashing yellow light. The fifth stated he thought training was deficient on the subject, although he was aware of the purpose of the light. They stated that they thought areas greater than 1000 mr/hr were always locked. The EO who entered the area stated he thought a high radiation area posting was for 10mr/hr, and the light was for 100mr/hr. Surveys performed later by the licensee in response to the event at 5:30 pm and 8:45 pm on May 12, 1988, indicated dose rates in the area of up to 1000mr/hr. The EO stated he received approximately 26 mr by SRPD in about 2 minutes. When this observation was brought to the attention of the HP/C Manager and the HP Supervisor, immediate steps were taken to correct the RWP to preclude entry to high radiation areas without the appropriate monitoring. They stated that they were not aware that the individual had entered the area without notifying HP personnel. When the EO reentered the area to search for the valve controllers, he was accompanied by an HP technician with a dose rate instrument. The inspectors noted that the licensee's evaluation of the event did not include an evaluation by the HP department. The licensee stated that no formal evaluation had been conducted by HP, but that the reports of the principle individuals had been reviewed. The inspectors expressed concern at the lack of knowledge of high radiation area controls by equipment operators. The licensee's training includes information as to the meaning of the signs and flashing light warning devices. The licensee stated at the exit interview that they would assess the extent of the problem of personnel not understanding the purpose of radiological postings.

Technical Specification 6.12.1 states, in part:

" ... each high radiation area in which the intensity of radiation is greater than 100 mrem/h but less than 1000 mrem/h shall be barricaded and conspicuously posted as a high radiation area ..."

Any individual or group of individuals permitted to enter such areas shall be provided with or accompanied by one or more of the following:

- a. A radiation monitoring device which continuously indicates the radiation dose rate in the area.
- b. A radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received ..."
- "c. A health physics qualified individual (i.e., qualified in radiation protection procedures) with a radiation dose rate monitoring device ..."

The failure to be accompanied or provided with a dose rate monitoring device in a high radiation area is an apparent violation of TS 6.12.1 (50-307/88-22-04).

The inspectors reviewed surveys conducted by the licensee, and noted the action taken to post the area around FDR-T-6 as greater than 1000mr/hr. The waste collector tank room, in which FDR-T-6 is located, has a shielded door, provided with a lock. The door was not locked by the licensee.

The inspectors noted that the licensee had placed flashing yellow lights as a warning device in several areas on the 437' and 467' elevations of the Radwaste Building, including the area surrounding FDR-T-6 (see paragraph 2.C.3).

A review of licensee procedure 11.2.7.1, Area Posting, revealed that the procedure did not specify that areas greater than 1000 mrem/hr have enclosures constructed, only that it be locked if the enclosure exists. Procedure 11.2.7.3 Entry into and Egress From High Radiation Areas, correctly specified actions to take to enter a very high radiation (greater than 1000mr/hr) area.

TS 6.12.2 states, in part:

" ... For individual areas accessible to personnel with radiation levels such that a major portion of the body could receive in 1 hour a dose in excess of 1000 mrem** that are located within large areas, such as the containment, where no enclosure exists for purposes of locking, and no enclosure can be reasonably constructed around the individual areas, then that area shall be barricaded, conspicuously posted, and a flashing light shall be activated as a warning device ..."

The inspectors and the licensee representative conducted surveys of the following areas, posted as areas greater than 1000 mrem/hr with flashing lights on June 3, 1988 using NRC Instrument, Model 36100, No. 8917, calibrated 4-26-1988, due 10-26-1988 and Licensee Instrument Model RO-2, RO-100, calibrated 5-24-1988, due 11-24-1988.

Radwaste Building Elevations:

467' East Valve Gallery RWCU Holdup Pump Room (Posted since 1986)
 467' West Valve Gallery RWCU Holdup Pump Room (Posted since 1986)
 437' Waste Storage Area (Locked enclosure-not surveyed)
 437' Waste Collector Tank Room (WCTR) by Chemical Waste Tanks
 (Posted Since 1987)
 437' WCTR by Floordrain Tank FDR-T-6 (Posted since 5-30-88)

The inspectors noted an additional light in the overhead of the main portion of the 437' elevation, which appeared consistent with the TS in that it was not reasonably subject to construction of an enclosure. The inspectors did not conduct a survey of the area.

All the above areas except by FDR-T-6 exhibited dose rates at 18 inches from the highest source of exposure of 700 to 1000 mr/hr. In the area of FDR-T-6, an area accessible to a major portion of the body measured from 1000 mr/hr to 1450 mr/hr with the NRC instrument. The licensee's survey measured 1000 mr/hr to 1400 mr/hr in the same area. All the above listed areas had the capability for a reasonably constructed enclosure. The WCTR had shielded doors capable of being locked.

The above observations were brought to the attention of the licensee. The HP Supervisor stated that it was his understanding of the TS that they had the option of using warning devices in lieu of locking the areas or constructing enclosures. The licensee had not initiated action to have any enclosures constructed in the above listed areas or rooms. The inspectors reminded the licensee that the locking of areas greater than 1000 mr/hr is in lieu of the control devices or alarm signals required in 10 CFR 20.203(c)(2), and that the warning devices are for areas that cannot be locked or reasonably enclosed. The licensee stated at the exit interview that they were evaluating whether action to lock or to reduce dose rates would be most appropriate. The inspectors informed the licensee that the timeliness of locking the areas was not the issue -- that the policy of placing lights instead of locking was what had led to the above noted situation.

The inspectors reviewed quality assurance audits to determine if the licensee has previously identified the area by FDR-T-6, or other similar areas previously identified as greater than 1000mr/hr, as needing to be locked or enclosed. Surveillance QASR 2-87-278, did not address this issue. (see paragraph 2.C)

Failure to lock the Waste Collector Tank Room or make reasonable efforts to construct an enclosure around the area by FDR-T-6 is an

apparent violation of Technical Specification 6.12.2 (50-397/88-22-05).

3. Facility Tour

The inspectors conducted tours of the Reactor, Turbine, and Radwaste Buildings. Independent radiation surveys were conducted using the NRC ion chamber survey instrument.

On the 467' elevation of the Radwaste Building, the inspectors noted that a radioactive source safe maintained by the Chemistry Department was unattended and unlocked. When brought to their attention, the licensee locked the safe and later performed an inventory. The Chemistry Supervisor stated that no sources were missing. The licensee determined that the safe had been inadvertently left unlocked by an individual not normally permitted access to the safe, but who had been given access for a specific task. The Chemistry Supervisor stated that the individual was instructed as to the proper method of locking the safe and the importance thereof.

The inspectors noted two hoses, originating from within the Radwaste Building were placed such that the open ends were over a storm drain outside. The other open ends were observed to be lashed to a handrail in the 467' elevation. When the inspectors expressed concern to the licensee that the unlabeled hoses might represent an unmonitored release path, the licensee stated the hoses were used for draining demineralized water.

With respect to the status board discussed in paragraph 2.E above, none of the status boards located at the entrance to the radiologically controlled area were observed to have indication of more recent updates. Status boards for the Reactor Building had labels indicating that the most recent information was contained in the RWP for the work and area.

In general housekeeping appeared good considering the outage condition. Approximately 50% of the protective gloves required to be used for contamination control, which the inspectors attempted to use exhibited leaks when tested. The defective gloves were discarded in accordance with the licensee's procedures. A spot check of workers confirmed they had been trained to check each glove prior to use.

While touring the 441' elevation of the Turbine Building, the inspectors noted that the radiation area posting and rope had been placed to one side of the doorway such that it did not impede access and could not be read. The HP Supervisor was informed. A survey revealed that no radiation areas, as defined in 10 CFR 20.202(b)(2), existed within the posted area. The licensee stated that the posting was being maintained for work control purposes. On the 437' elevation of the Radwaste Building, the inspectors noted that a radiation area boundary and posting had been removed at the entrance to a contaminated area. The area was still posted, however, by other signs visible from the entrance. These additional examples of personnel not replacing postings were brought to the attention of the licensee (see Inspection Report 50-397/88-12). The inspectors expressed concern that continued lack of attention to this

aspect of their program could result in personnel entering areas of greater hazard without benefit of the warnings that radiological postings are intended to provide. The licensee stated that increased emphasis was being applied to the problem. This aspect of the licensee's program will be addressed in subsequent inspections (50-397/88-22-06).

4. Exit Interview

The inspectors met with those individuals denoted in paragraph 1 at the conclusion of the inspection on June 9, 1988. The scope and findings of the inspection were summarized. The licensee was informed of the apparent violations listed in Paragraph 2.E., and was further informed that the issues associated with Emergency Preparedness would be addressed by NRC Region V.

The Chief, Facilities Radiological Protection Section emphasized the NRC policy regarding licensee identified findings as presented in 10 CFR 2 Appendix C with regard to his evaluation of this event. Specifically, had the licensee thoroughly reviewed the radiological aspects of the event perhaps they would have identified the apparent deficiency in equipment operator knowledge and control of very high radiation areas.

The Plant Manager stated that the Plant Review Committee had met and recognized the need to conduct additional review of this event.