U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-461/88017(DRSS)

Docket No. 50-461 License No. NPF-62

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

Facility Name: Clinton Power Station, Unit 1

Inspection At: Clinton Site, Clinton, Illinois

Inspection Conducted: July 12-15, 1988

Inspector: M.A. Kunowski for
W. J. Slawinski

August 29, 1988
Date

Accompanying Inspector: W.W. Ogg
W. Ogg

Approved By: WD Shafer for
L. Robert Greger, Chief
Facilities Radiation Protection Section

8/11/88
Date

Inspection Summary

Inspection on July 12-15, 1988 (Report No. 50-461/88017(DRSS))
Areas Inspected: Routine, unannounced inspection of selected aspects of the radiological protection program and related allegations, including: organization, management controls and staffing (IP 83722), and external exposure controls (IP 83724). Also reviewed were the radiological aspects of two recent events, previous inspection findings (IP 92701), followup of a previously identified matter concerning process monitor calibrations, and of certain post accident sampling system capabilities.
Results: No violations or deviations were identified. The licensee's radiation protection program appears to be generally effective in controlling radiological work and occupational exposures. The radiological response to two recent events was good.

DETAILS

1. Persons Contacted

*K. Baker, Supervisor, I&E Interface
D. Brown, Supervisor, Radiological Controls
*R. Campbell, Manager, Quality Assurance
R. Chalifoux, Acting Supervisor, Radwaste
*J. Greenwood, Manager, Power Supply (Soyland/WIPCo)
*D. Hall, Vice President
*D. Hillyer, Assistant Plant Manager, Radiation Protection
*D. Holesinger, Assistant Plant Manager
*D. Holtzscher, Director, Nuclear Safety
*J. Howland, Corporate Health Physics
*A. MacDonald, Director, Nuclear Program Assessment
W. Manganaro, Supervisor, Radiological Operations
D. Miller, Supervisor, Radiological Support
*J. Miller, Manager, Scheduling and Outage Management
*R. Morgenstern, Assistant Plant Manager, Technical
*J. Perry, Manager, Nuclear Program Coordination
R. Ramanuja, Supervisor, Health Physics
*A. Ruwe, Director, Systems and Reliability Engineering
*R. Schaller, Assistant Plant Manager, Operations
*J. Weaver, Director, Licensing
*J. Wilson, Plant Manager
F. Wolking, Supervisor, Plant Radiation Protection
*R. Wyatt, Manager, Nuclear Training

*P. Hiland, NRC Senior Resident Inspector

The inspectors also contacted other licensee and contract employees.

*Denotes those present at the exit meeting on July 15, 1988.

2. General

This inspection was conducted to review the radiological aspects of two recent events, the licensee's investigation of a former employee's concerns, and an allegation related to security badge coding; this review included licensee activities concerning organization, management controls, and staffing, and external exposure controls. Also reviewed were open items, followup of a previously identified matter concerning process monitor calibrations, and review of post accident sampling system capabilities. The inspectors conducted contamination and direct surveys of selected plant radiologically controlled areas; no problems were noted. Area postings and general plant housekeeping were good.

3. Licensee Action on Previous Inspection Findings (IP 92701)

(Closed) Open Item (461/87028-01): Review staffing, staff stability, and qualifications of the radiation protection staff including availability of professional/technical health physics support personnel. This matter is described in Section 4.

(Open) Open Item (461/87028-03): Review personal dosimetry vendor's TLD calibration to account for the station's beta energy spectrum. This item remains open pending adjustment of the vendor's TLD calibration consistent with station's beta energy spectrum and, if necessary, resultant modification of previously recorded skin doses. See Section 5.

(Closed) Open Item (461/87037-02): Review actions taken to improve contamination (airborne) controls in the machine shop. The licensee has discontinued using the M&M shop installed exhaust system for radiological work. Instead, such work is performed in an enclosed local temporary containment which has capabilities for a dampered inlet filter and/or entrance plenum and includes: tacky surface floor covering to reduce the spread of contamination and high efficiency particulate air (HEPA) exhaust filtration system.

(Closed) Open Item (461/87037-04): Review actions to strengthen high radiation area key control. The inspectors confirmed that CPS Procedure No. 1905.21 "High Radiation Area Key Control" was revised to eliminate potential weaknesses in key control practices.

(Closed) Open Item (461/88005-01): Review and verify compliance with NUREG-0737, Item III.D.3.3, concerning inplant radiation monitoring. The inspectors verified that the licensee has abundant operable and calibrated sampling/analysis equipment necessary to meet the III.D.3.3 sampling requirements including remotely located portable analyzing equipment not listed in the Safety Evaluation Report (SER). Training of personnel to operate sampling equipment and analysis systems for determination of radioiodine during an accident situation was previously reviewed (Inspection Report No. 461/87016).

(Closed) Unresolved Item (461/88014-04): Review radiological aspects of radwaste evaporator/injured worker event. This matter is discussed in Section 7(a).

4. Organization, Management Controls, and Staffing (IP 83722)

The inspectors reviewed the licensee's organization and management controls for the radiation protection program including the organization structure and staffing, staff stability, effectiveness of procedures and other management techniques used to implement these programs and experience concerning self-identification and correction of program implementation weaknesses.

Effective July 18, 1988, the Assistant Plant Manager, Plant Radiation Protection transferred to operator license training and was replaced by the former Radiological Support Supervisor, who was also named as Radiation Protection Manager (RPM). The newly appointed RPM has been onsite a Radiological Support Supervisor for about six months. Prior to that he held a managerial position with the corporate staff of Pennsylvania Power and Light where his responsibilities included radiological, environmental, and emergency planning support activities. His other pertinent experience has been with Sargent and Lundy Engineers as a radiological protection design group leader. His actual applied radiation protection experience at a nuclear power plant appears minimal. The licensee was requested to supply additional information concerning the individual's applied nuclear facility experience for review to ensure the criteria specified in Regulatory Guide 1.8, September 1975 are satisfied (Open Item 461/88017-04).

Since previously reported (Inspection Report No. 461/87037), several radiation protection staff vacancies have been filled including all but one of the professional/technical support vacancies. The qualifications and experience of three recently hired professional/technical support group members were reviewed by the inspectors. No concerns were noted; the individuals appear to have more than adequate academic credentials and/or related experience necessary to support an operational radiation protection program. In addition, the licensee has recently filled several radiation protection operations technician vacancies and one of two Radiation Protection Shift Supervisor (RPSS) vacancies. The current radiation protection staff consists of 34 permanent operations technicians and five permanent RPSS's. According to the licensee, this is the full complement of technicians for routine operations. Although most (about 80%) of the technicians meet ANSI/ANS 3.1-1978 experience standards, about one-half have less than one year plant specific experience and little commercial operational plant experience.

As previously reported (Inspection Reports No. 461/87037 and 461/87028), the licensee had been experiencing considerable turnover of the radiation protection staff. However, since January 1988, this negative trend has improved. Three operations technicians have voluntarily resigned for various personal reasons; no other radiation protection staff terminations or transfers have occurred.

As a result of the licensee's aggressive recruiting, the radiation protection staff appears to be generally strengthened. The radiation protection program appears to have the necessary management support, staff and technical expertise to maintain an effective program provided station performance levels improve through continued staff stability.

The inspector discussed the intent of Generic Letter 82-12 requirements for limiting radiation protection staff hours of work to assure that, to the extent practicable, personnel are not assigned to shift duties while in a fatigued condition that could reduce their mental alertness or decision making ability. To meet Technical Specification 6.2.2(f), the licensee has established procedures to limit working hours of unit

staff (including the health physics staff) who perform safety-related functions. The procedure working hour limitations are consistent with Generic Letter 82-12 guidelines. The licensee also issued Administrative Practice No. 17 to provide corporate guidance on the use of overtime. Since that time when identified in Inspection Report No. 461/86068, technical specification working hour limits have been met by the radiation protection department; however, the resident inspector noted instances during the station's April 1988 maintenance outage when radiation protection staff working hours approached weekly limits. The licensee indicated that these instances were exceptions and heavy use of overtime is not routine.

No violations or deviations were identified.

5. External Exposure Controls (IP 83724)

The inspectors reviewed portions of the licensee's external exposure control and personal dosimetry programs, including dose tracking capabilities, adequacy of personnel and of the dosimetry program to meet routine and emergency needs, and required records and reports.

The licensee's personal dosimetry program remains essentially as previously described (Inspection Report No. 461/87028). For 1987, the station's total exposure was about 56 person-rem. In 1988 through June, about 88 person-rem has been expended. (The licensee began full power operations in late 1987.)

As previously described (Inspection Reports No. 461/87028 and 461/87037), the personal dosimetry vendor has not adjusted their TLD beta calibration to conform to the station's beta energy spectrum. The TLD analyses of beta (skin) exposures performed by the vendor continue to be based on the relatively energetic strontium-yttrium-90 beta energy spectrum and could yield a conservative determination of the licensee's skin exposures. However, worker beta (skin) exposures to date have not been significant (< 100 mrad). Recently the licensee developed methodologies for quantifying the plant's beta energy spectrum based on reactor coolant and radwaste process stream sampling and area surveys. An effective average beta energy of about 0.06 Mev has been calculated from coolant samples decayed 48 hours. Further analysis is planned as plant operations progress. A licensee audit of the vendor's TLD program is scheduled for this year; the vendor will be notified of necessary adjustments to the beta correction factor based on the licensee's beta spectrum analysis.

No violations or deviations were identified.

6. Area Radiation/Process Radiation (AR/PR) Monitor Operability and Calibration

Concerns relayed to the NRC Region III office (Allegation No. RIII-85-A-177) regarding the area and process monitor acceptance test program were partially reviewed previously as described in Inspection Report No. 461/86068. Further reviews of the licensee's calibrations of process and area monitors were made during this inspection. The acceptance tests of the area and process monitors were designed to demonstrate that the monitors

were operational in accordance with design specifications. Upon completion of the acceptance tests, the monitors were turned over to the plant staff specialists who then performed calibrations of the monitors. These calibrations were performed to verify acceptable operation of the monitors. Any significant errors introduced during the acceptance test program would be expected to be found during these calibrations. Currently, all area and process monitors have been successfully calibrated by the plant staff at least once. Initial calibrations were performed primarily in 1986, and in most cases were conducted within a few months after completion of acceptance tests. Although some problems were encountered during initial plant staff calibrations and warranted some detector or electrical component replacement or repair, these problems are not readily traceable to performance of the acceptance test program. Subsequent (plant staff) calibrations have been performed on technical specification required monitors; no significant calibration or operability problems attributable to the acceptance test program were identified.

During the inspection, the inspectors were informed of the licensee's tentative plans to discontinue use of several non-technical specification and non-regulatory required AR/PR system monitors primarily because of the extensive effort needed to maintain the equipment. The licensee is considering the elimination of about 40 area and continuous air monitors used primarily to define general radiological conditions in various plant areas. The licensee's ultimate decision is pending further evaluation of the necessity and usefulness of the monitors. This matter will be reviewed during a future inspection (Open Item 461/88017-01).

7. Event Followup

Discussed below are two recent licensee events which necessitated considerable involvement of the plant's radiation protection staff. The radiological aspects of these two events were reviewed during this inspection; no significant problems or weaknesses were noted with the radiation protection program.

a. Radwaste Evaporator/Injured Worker Event

Summary

On June 23, 1988, three CPS employees suffered burns, one seriously, while attempting to replace a sightglass from a radwaste evaporator in the Unit 2 Floor Drain Evaporator Room. The workers were sprayed with hot contaminated water and sludge estimated to be about 220-240°F.

One worker reportedly suffered second degree burns and low-level skin contamination and was transported to a local hospital for initial treatment and final decontamination and later transferred to a burn center in Springfield, Illinois. The other two workers received less severe burns and low-level skin contamination and were treated and decontaminated onsite and sent to a local hospital for observation. The licensee's evaluation showed the radiological effects to the

workers to be minimal. All three workers received low-level clothing and skin contamination which did not produce significant skin doses; whole body exposures were also not significant. Bioassays performed on the involved individuals showed only minor internal deposition for one worker.

Cause

The workers attempted to remove a sightglass from an evaporator which was in hot standby with its recirculation pump running. The station has redundant evaporators located in separate rooms (cubicles) adjacent to one another; doors for the two rooms are located next to each other and are clearly marked as Unit 1 and Unit 2 Floor Drain Evaporator Rooms. The Room Nos., R4-10 and R4-12, are marked next to the doors. The equipment identification numbers (EIN) are also labeled on each evaporator. The maintenance work request (MWR) which was being worked correctly called for the replacement of the sightglass on the Unit 1 evaporator (EIN 1WF08D) in Room R4-10; the RWP incorrectly listed the location of the work as Room R4-12 (which is the location of the Unit 2 evaporator (2WF08D)) even though it correctly listed the equipment identification number (EIN 1WF08D). Neither radiation protection personnel nor the maintenance workers noted the discrepancy between the room number and the EIN on the RWP. A significant contributing cause of the event appears to be the lack of a safety tagout procedure to require field verification of system tagouts by those actually performing the work.

Some of the specific causal factors contributing to this incident are as follows:

- The wrong room number was transcribed from the MWR onto the RWP by maintenance planning personnel. (The correct EIN was listed on both the MWR and RWP.)

- Maintenance planning supervision, mechanical maintenance supervision, the two repairmen/mechanics and two radiation protection technicians involved all overlooked the inconsistency between the room number and the EIN listed on the RWP.

- Although mechanical maintenance requested and received verification from radwaste that the system was drained and properly tagged-out, they did not accompany radwaste personnel during the verification or personally verify the evaporator they were to work on was drained. (Radwaste verified the Unit 1 system (1WF08D) was drained per the MWR and that the proper tagout was inplace.)

- Maintenance personnel reviewed the job in the field but had not taken note of the hot piping in the room as an indication that the evaporator was not drained. Also, radiation levels of the presumed drained system were the same as those of the undrained system measured two days earlier; this may not have been expected.

Radiological Consequences and Radiation Protection Response

The licensee estimated that about 150-200 gallons of water and sludge were released during the event. All three workers were sprayed with the liquid to various extents. All workers wore protective clothing and respiratory protection equipment which helped mitigate the severity of the injuries and contamination. (The respirator worn by the more seriously injured worker was coated with sludge.) Low-level skin contamination was identified with isolated hot spots up to 4000 dpm and was removed with saline wash by the licensee and/or the local hospital; licensee calculated skin doses were less than 5 mrad. Dosimetry worn by the three workers and those responding to the event, including offsite personnel, showed no significant dose (< 70 mrem). Bioassays consisting of whole body counts and urine or fecal sampling showed no internal deposition in two of the workers and minor (<1% maximum permissible body burden) for another worker. Although no significant intake is suspected, fecal samples from the more seriously injured man are undergoing further analyses by a vendor; additional invivo or invitro measurements may be made for this worker.

Cubicle smearable contamination levels measured shortly after the event were 40,000-60,000 dpm/100cm^2. Post-incident (one hour) air samples showed concentrations less than one MPC. All liquid and sludge released was contained in the cubicle or diverted through floor drains to the radwaste system. Gaseous and particulate effluent that may have been released presumably was collected by the cubicle's exhaust system and eventually released to the plant stack after filtration and significant dilution. The station HVAC exhaust monitoring system showed no abnormal releases. Currently, the affected cubicle has been decontaminated to clean status except for a small area immediately surrounding the evaporator. The evaporator pressure boundary has been restored and both evaporators are operable.

The response by the radiation protection staff and offsite medical facilities was generally good although the licensee identified some communication/coordination weaknesses.

No violations or significant weaknesses in the radiation protection area were identified by the inspectors.

Corrective Actions

The licensee identified several areas in need of improvement, the most significant being to establish a mechanism to ensure safety tagouts are verified in the field by the personnel performing the work and that the equipment is safe to work on. The safety tagout verification has been implemented on an interim basis even though the final administrative mechanism is not yet in place.

Other corrective actions planned by the licensee include the following:

- Conduct training with plant staff supervision and plant maintenance and contractor personnel regarding the incident.

- Conduct training and establish a continuous training program on work practices to be followed prior to and during work to ensure safety.

- Develop policies covering responsibilities and communications/ coordination with offsite medical personnel.

- Conduct training with the radiation protection staff regarding decontamination kit availability and related coordination with hospital personnel.

In addition, the radiation protection department plans to provide special instructions (night orders) to their staff to confirm that the component/system and location listed on an RWP correspond and are accurate. The implementation of the corrective actions related to the radiation protection program will be reviewed during a future inspection (Open Item 461/88017-02).

b. Spill in the Low Pressure Core Spray (LPCS) Pump Room

At about 5:00 p.m. on April 12, 1988, approximately 1000 gallons of radioactive water was unexpectedly and rapidly drained from an RHR system valve being repaired. The valve is located in the LPCS pump room cubicle. Fortunately, no one was present in the cubicle at the time of the release. The accidental spill was apparently caused by two poor practices: incomplete valve/component tagout and the attempt to do two jobs simultaneously on the same component. (The second job was local leak rate testing [LLRT].)

Radiological control of the event was immediately established by radiation protection. Relatively minor personal clothing and hand contamination occurred when two operators initially investigated the event. The water straightway subsequently drained to the plant radwaste system. Smears of the rust-like residual contamination on the floor yielded results as high as one rad/hr; predominant isotopes were identified as Cr-51, Mn-54, Fe-59, Co-60, and Co-58. The initial air sample taken inside the cubicle showed concentrations of 1.3E-9 µCi/ml with an effective half-life of 120 minutes. Properly controlled decontamination efforts ensued for several weeks. Cubicle contamination levels have been generally reduced to less than 3000 dpm/100cm^2.

A licensee representative stated that the high level of radioactivity in the water most likely resulted from crud in the [illegible] system piping.

Corrective actions include training to increase operator awareness of this type of hazard and administrative (procedural) controls to preclude two jobs simultaneously on the same component. These matters are further described in Inspection Report No. 461/88014(DRP).

8. Post Accident Sampling System (PASS) Capability

The inspectors reviewed PASS capabilities during potential loss of offsite and certain backup power supplies. Supplement 5 of the SER states that there are alternate power supplies for the PASS should offsite power be lost. A licensee representative stated that if offsite power is unavailable, all three divisional diesel generators are required for PASS sampling. Division I powers the PASS panel and the inboard containment isolation valves; Division II is needed to supply power to the outboard isolation valves; and Division III to power the Division III Shutdown Service Water, which is a backup source of cooling water to the PASS panel. The apparent necessity of having all three divisional diesel generators available to utilize PASS was discussed in a telecon with the licensee on July 28, 1988, and is considered an open item pending further NRC review of the adequacy of the system for conformance to NUREG 0737 criteria (Open Item 461/88017-03).

No violations or deviations were identified.

9. Allegation Followup

Discussed below are two sets of allegations relating to the radiation protection program at the Clinton Station which were evaluated during this inspection. The evaluation consisted of record and procedure review and interviews with licensee personnel. The latter allegation evaluation also included review of an investigative report prepared by a private investigator hired by the licensee and included contacts with the alleger.

a. The NRC Region III office received information which expressed a concern regarding Clinton security badges and dosimetry. The security badge/dosimetry concern and inspectors' findings are discussed below. The individual's other concerns, which pertain to security matters, were discussed in Inspection Report No. 461/88019 (Allegation No. RIII-88-A-0023).

Allegation: Station procedures require that a dot be placed on security keycards for dosimetry purposes. Radiation protection has not done this for months.

Discussion: The alleger's concern apparently refers to a color coding (colored dot) system for security keycards to indicate the dosimetry requirements for a particular person.

Several years ago, the licensee implemented a trial program for color coding security badges (keycards) to indicate general plant area access and the necessity for dosimetry. Specifically, a colored dot was placed on security badges to indicate that an individual was authorized access into radiologically controlled areas and a different colored dot was used to indicate that an individual was RWP-work qualified. In the latter case, security personnel would be alerted that dosimetry should be attached to the security badge. This trial program was not finalized and ceased roughly one year ago.

Finding: The allegation was not substantiated. The color coding (dot) system was never a plant procedure or regulatory requirement and was instituted only on a trial basis. The program was terminated by the licensee because it was not deemed beneficial.

b. The Clinton Plant Manager received a letter from a former contract radiation protection technician (RPT) which expressed concerns regarding, among others, certain aspects of the radiation protection program. Certain of these matters were previously addressed in Inspection Report No. 461/88005. The licensee retained the services of a private investigator to investigate these concerns. The investigation report prepared by the investigator and associated transcripts were reviewed further by the inspectors during this inspection, specifically regarding the individual's concerns relative to the RWP program and to a revised job coverage report. The review of these matters included discussions with the alleger. The alleger's specific RWP and report revision concerns and the inspectors' findings are discussed below (Allegation No. RIII-88-A-0051).

Allegation: Radiation work permits (RWPs) do not reflect the actual radiological conditions of the work area. To support his claims, the alleger provided Illinois Power Company with two specific examples.

Discussion: The alleger stated that job specific RWPs (SRWPs) lacked necessary radiological information because they did not reflect radiological conditions of various areas and components in the general vicinity of the work and only reflected conditions specific to the work area. One example provided by the alleger concerned a SRWP which did not reflect all the radiological conditions shown on the general area survey maps. The survey maps indicated higher contamination levels in one isolated area remote to the specific work area for a blade guide removal job. (This particular job was the subject of a similar allegation concerning the adequacy of the RWP. See Inspection Report No. 461/87009 for details of that allegation (Allegation No. RIII-86-A-0200)).

Radiation survey information is incorporated into the RWP system to specify pertinent radiological conditions and to determine protective measures for workers on the RWP. Radiation survey results written on the Specific Radiation Work Permit (SRWP) typically reflect the results of a survey performed specifically for the SRWP; in some cases they reflect the radiological conditions shown on the routine area survey map. In the examples cited by the alleger, the more highly contaminated area (which was not indicated on the RWP) was not in or even immediately adjacent to the SRWP work area, nor would the SRWP workers be required to travel near it going to or from the SRWP work area. The licensee's policy is to not specify general (unrelated) area radiological conditions on SRWPs unless the information is necessary so workers can avoid the area because there is a possibility they may traverse through or

near it. The inspectors do not find fault with this policy. The RWPs used for the blade guide removal job appear to have adequately specified the radiological conditions and protective measures to protect workers from radiation and contamination.

The alleger's second RWP example concerned repair of hydraulic leaks from the main steam stop valves. In this example, the licensee discovered that the SRWP for the job did initially specify the incorrect radiological conditions because the RWP survey information was based on a weekly survey and there had been a change in plant conditions (increase in reactor power) since then. However, the licensee discovered the problem prior to commencement of any work under the SRWP and revised (lined-out) the incorrect survey data to reflect the actual conditions. No workers received any significant exposure as a result of the error.

Finding: The allegation regarding the RWP program was not generally substantiated. The licensee's policy to exclude remote area radiological conditions on SRWPs which are not necessary for the safe performance of the specific job is acceptable and standard practice. It appears that appropriate RWPs were written and adequate protective measures were taken for the blade guide removal job.

While the alleger's assertions regarding the main steam stop valve job were true, no significant licensee inadequacies were identified. Although the RWP written for this job reflected the incorrect radiological conditions initially, the problem was identified by the licensee during a routine review of RWPs and the RWP was revised to reflect the accurate information prior to the performance of work under this SRWP.

Allegation: The alleger was directed by radiation protection supervision to revise his report concerning the circumstances surrounding a worker's refusal to perform a blade guide removal job in October 1986. The individual was allegedly instructed to "defuse the report" because "it would make radiation protection look bad" and to delete radiological information concerning higher contamination levels not reflected on the RWP. (This RWP was one of the examples referenced in the preceding allegation.)

Discussion: About one month after the blade guide removal job, the RPT was instructed by radiation protection supervision to prepare a report describing the circumstances surrounding the maintenance worker's refusal to perform the work. According to the alleger, his completed report was provided to his supervisor and subsequently returned with instructions to "defuse the report" because "it would make radiation protection look bad." A (new) second report was subsequently authored by the alleger.

During this inspection, the inspectors interviewed those radiation protection supervisors who allegedly instructed the RPT to revise his original report. The supervisors indicated the RPT was only instructed to revise the report to delete non-relevant remarks and personal opinions regarding certain individuals and not to change the substance of the report. The radiation protection supervisors involved denied the alleger's claim that pertinent radiological survey information which indicated higher contamination levels than those reflected on the RWP was deleted from the report. The alleger was contacted in an attempt to procure the original report, but he was unable to produce it.

Finding: The veracity of the alleger's assertions regarding his revised report could not be ascertained. The alleger was instructed by radiation protection supervision to revise his report; however, the exact scope of the revisions cannot be proven without the initial (unrevised) report. However, irrespective of the exact report revisions, no significant radiological shortcomings were identified for the blade guide removal job. As previously stated, appropriate RWPs were written and adequate radiological protective measures were taken for the blade guide removal job.

Additional Alleger Concern:

In addition to the above allegations, the alleger was concerned that he may have withheld information from the NRC because, allegedly in response to instructions from his supervisor, he did not inform an NRC inspector who was reviewing an allegation related to the blade guide removal work (Allegation No. RIII-86-A-0200) of the existence of his initial report of that work or of the alleged incorrect RWP.

The inspectors reviewed the investigative report prepared by the private investigator hired by the licensee and questioned the radiation protection supervisor who allegedly instructed the RPT not to offer certain information to NRC inspectors during interviews concerning the blade guide removal job. The supervisor indicated that employees are typically advised to be honest and open and to answer questions truthfully, and denied the alleger's assertion that he instructed him to withhold certain information or implied that such information should not be offered. Similar findings were documented in the private investigator's report. According to radiation protection management, it is not their policy to instruct (coach) employees regarding the type or scope of information that should be provided to NRC representatives. According to radiation protection management personnel, this matter will be discussed with radiation protection supervisors and the policy that employees not withhold any pertinent information concerning licensed activities and to offer any information deemed relevant will be reiterated.

No violations or deviations were identified.

10. Radiation Control Access, Tours and Independent Measurements

During tours of the containment, fuel, auxiliary, and turbine buildings, radioactive material controls, access controls, postings, and housekeeping appeared good. Inspector observations of ingress and egress activities at main control points and other SOP areas indicated that workers were adhering to dress and frisking requirements.

The inspectors performed direct radiation surveys of equipment and selected areas in the containment and turbine buildings; survey results were consistent with postings. Smear surveys were performed in the same areas; no detectable contamination was found.

No violations or deviations were identified.

11. NRC Information Notices

The inspectors reviewed licensee actions in response to the following Information Notice (IN). For this IN, the inspectors noted that the licensee reviewed the IN for applicability, distributed the IN to appropriate personnel, and had made adequate response (See also Section 3 Item 461/87037-04).

No. 86-44: Failure to Follow Procedures When Working in High Radiation Areas.

12. Exit Meeting (IP 30703)

The inspectors met with licensee representatives (denoted in Section 1) at the conclusion of the inspection on July 15, 1988. The inspectors discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. Although the licensee identified the private investigator's report, and associated transcripts, discussed in Section 9(b) as proprietary and not for public disclosure, they did not object to inclusion of summary information from the investigation report in the inspectors' report. The inspectors specifically discussed the following matters.

a. The improvements noted in the staffing and stability of the radiation protection department (Section 4).

b. The weaknesses identified by the licensee as a result of the radwaste evaporator/injured worker event (Section 7(a)).

c. That the inspectors' followup of the private investigator's review of a former employee's concerns consisted primarily of a review of the employee's RWP/report revision concerns, and that the investigator's report would be made available to other NRC inspection program areas (Section 9(b)).