ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-285
License No.:	DPR-40
Report No.:	50-285/98-24
Licensee:	Omaha Public Power District
Facility:	Fort Calhoun Station
Location:	Fort Calhoun Station FC-2-4 Adm., P.O. Box 399, Hwy. 75 - North of Fort Calhoun Fort Calhoun, Nebraska
Dates:	November 2-6, 1998
Inspector(s):	Michael P. Shannon, Senior Radiation Specialist
Approved By:	Blaine Murray, Chief, Plant Support Branch

ATTACHMENT: Supplemental Information

EXECUTIVE SUMMARY

Fort Calhoun Station
NRC Inspection Report 50-285/98-24

Plant Support

- In general, a good external exposure controls program was implemented. All Technical Specification high radiation areas were properly controlled; however, a number of potential vulnerabilities were identified with the inventory and storage of very high radiation area and restricted high radiation area keys (Section R1.1).

- Radiological surveys posted outside areas/rooms in the radiological controlled area accurately reflected radiological conditions. Proper thermoluminescent dosimeters were used for establishing personnel neutron doses. Radiation work permits were clearly written (Section R1.1).

- A violation of Technical Specification 5.8.1.a. was identified involving an example of the failure to tag temporary lead shielding, and three examples involving the failure to post airborne radioactivity areas. No response to this violation is required (Sections R1.1 and R1.3).

- Housekeeping throughout the radiological controlled area was good. Areas were free of debris, and tools and equipment staged for work in-progress were properly stored (Section R1.1).

- An effective internal exposure program was in place. Respiratory equipment was properly issued to qualified personnel. Whole-body counters were properly calibrated. Internal dose assessment methodologies were proper to determine internal dose (Section R1.2).

- All personnel observed exiting the radiological controlled area used the personnel contamination monitors properly. Radiation workers used good health physics practices while exiting contaminated areas. Radioactive material, laundry, and trash containers were properly labeled, posted, and controlled. Good radioactive source inventory and leak test programs were in place (Section R1.3).

- In general, radiation protection program procedures were well written. However, one minor violation was identified involving a procedure not written consistent with the requirements of 10 CFR Part 20. The licensee took immediate action to revise the procedure in question (Section R3.1).

- The acting radiation protection manager satisfied the requirements of Technical Specification 5.3.1. (Section R5.1).

- Radiological condition reports provided management with a good overview of radiological program areas and were effective to resolve the original problem (SectionR7.1).

REPORT DETAILS

Summary of Plant Status

The plant operated at 100 percent power during the inspection.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 External Exposure Controls

a. Inspection Scope (83750)

Selected radiation workers and radiation protection personnel involved in the external exposure control program were interviewed. A number of tours of the radiological controlled area were performed. The following items were reviewed:

- Radiological controlled area access controls
- Control of high radiation areas and high radiation area keys
- Personnel dosimetry
- Radiation work permits
- Job coverage by radiation protection personnel
- Housekeeping in the radiological controlled area

b. Observations and Findings

During tours of the radiological controlled area, the inspector observed that high radiation areas were properly controlled and posted. All Technical Specification required high radiation area doors (known at the station as restricted high radiation areas) were locked.

During the review of the control of restricted high radiation areas the inspector reviewed the process for issuing restricted high radiation area keys. Additionally, the inspector performed an inventory of both the very high radiation area and restricted high radiation area keys. No problems were identified with the key issue process and all keys were accounted for; however, potential vulnerabilities with the key control program were noted.

(1) In the operations control room the very high radiation area key locker contained 8 keys, 4 keys for each of the 2 very high radiation areas located in the containment building (containment sump area and reactor cavity stairs). None of the keys were labeled with the area they opened, and the locker did not contain a list that described which set of keys opened which area. When the inspector asked the operations shift manager which key he would issue to open the containment sump area, he did not know.

(2) Each operations shift manager had a key to the general key locker, which contained the key for the very high radiation key locker. The inspector concluded that this created the potential for someone other than the on-duty shift manager issuing the very high radiation area keys.

(3) The auxiliary building operator's 3 restricted high radiation area keys were on a key ring with 11 additional keys. The inspector noted that this key ring was stored in a locker located in the hallway on elevation 989 foot of the auxiliary building. The inspector also noted that the locker was locked with a "IC35" series key which was a common key used by the operation department. The inspector concluded that this created the potential for someone other than the on-duty auxiliary building operator opening a restricted high radiation area. The inspector noted that the auxiliary building operator's restricted high radiation area keys were not accounted for at shift turnover.

(4) The radiation protection operations supervisor had a set of 3 restricted high radiation area keys locked in a file cabinet in his office. During discussions with the radiation protection staff, the inspector was informed that the radiation protection operations supervisor would sign a restricted high radiation area key out from the shift radiation protection technician's key locker located at the radiological controlled area access point. The inspector concluded that having an additional set of restricted high radiation area keys created the potential for the keys being mis-used or mis-place.

(5) Although the 3 restricted high radiation key rings located in the shift radiation protection technician's key locker were inventoried at shift turnover, the individual keys on each ring were not accounted for. The inspector noted that one of the three restricted high radiation area key rings located in this locker had two restricted high radiation area keys on it. When the shift radiation protection technician was asked by the inspector if he would notice if one of the two restricted high radiation area keys on the ring would be missing during the shift inventory, he stated that he likely would not because he only accounts for the three rings of keys and not the amount of keys on each ring.

Radiation protection management acknowledged the inspector's observations, and stated that they would review the very high radiation area and restricted high radiation area key inventory and storage programs for possible improvements.

The inspector noted that radiological survey maps posted outside each room reflected general radiological conditions within the room. All radiological postings were clearly and consistently posted. Field interviews with radiation workers revealed that workers were knowledgeable of the general radiological conditions in their work area and the proper response to electronic dosimeter alarms.

In 1991, the licensee, with the assistance of a vendor, conducted a spectral analysis to determine the neutron energies inside the reactor containment building during reactor operations. The analysis determined that the neutron energies ranged from

approximately 50 to 500 kilo-electron volts (keV). The licensee used a vendor who was certified by the National Voluntary Laboratory Accreditation Program for all categories to process its thermoluminescent dosimeters. Neutron doses were based on the use of correction factors which were developed using a tissue equivalent proportional counter to determine the neutron fluence and energy spectra encountered in the reactor containment building during reactor operations. From a review of data supplied by the licensee, the inspector determined that personnel entries into the reactor containment building during reactor operations had remained relatively constant during the past 4 years, ranging from as high as 25 in 1994 to as low as 9 in 1996, with the average being 17 entries per year. The inspector noted that the highest individual neutron dose assigned during 1998 was 75 millirem.

The inspector reviewed randomly selected radiation work permits and noted that the permits were written in a clear, consistent manner. The inspector noted that the licensee divided the radiation work permits into sections, such as, Radiological Conditions, Dosimetry Requirements, Protective Clothing Requirements, and Worker Instructions. The inspector noted that this made the permits easy to read and more user friendly. The inspector reviewed selected radiation work permit packages for repeat work and noted that the radiation protection ALARA staff incorporated both industry and site lessons learned to improve ALARA job performance.

On November 3, 1998, the inspector attended the pre-job ALARA briefing for the transfer of spent resin from the spent resin storage tank located in the auxiliary building to a high integrity container located in the radwaste building. Additionally, the inspector observed the majority of the transfer activities. The inspector noted that experienced personnel were used for the task. Lessons learned from previous resin transfers were discussed, and point of contact personnel were named for each area to minimize mis-communication. However, the inspector noted that although the radiological conditions were discussed, one radiological survey map for each of the 2 areas involved in the transfer was being passed around to the 10 people involved in the task while the ALARA technician discussed the radiological conditions. Additionally, the radiation work permit was explained but not distributed to the workers. The inspector commented that not having the radiological information and radiation work permit in front of the workers could lead to confusion or become a distraction during the briefing. The inspector also commented that some licensee's used an overhead projector to project the radiation work permit and survey maps when briefing more than a few people. The licensee acknowledged the inspector's comment. Additionally, the inspector noted that although workers were asked if they had any questions, no one was specifically questioned about the radiation work permit or radiological conditions to ensure that the information was correctly communicated to the workers involved in the task.

No problems were noted with the job coverage and radiological controls provided for the resin transfer task. Radiation protection technicians properly monitored both personnel dose and radiological conditions. However, during the walk down of the resin transfer areas on November 3, 1998, the inspector observed that temporary lead shielding was placed on top of the roof of room 506 in the radwaste building to reduce the exposure rate on top of the radwaste building roof. The licensee informed the inspector that the

shielding was installed on the morning of November 2, 1998. The inspector observed that the shielding did not have temporary shielding request tags attached to it as required by station Procedure RP-307, "Use and Control of Temporary Lead Shielding," Revision 6. Such tags state, "CAUTION removal or repositioning of this shielding could result in excessive radiation levels in the immediate vicinity and possible over exposure, CONTACT RP BEFORE REPOSITIONING OR REMOVING THIS SHIELDING." Prior to the start of the resin transfer, the inspector discussed this observation with a radiation protection supervisor involved with the resin transfer task.

On November 4, 1998, at the inspector's request, a radiation protection technician accompanied the inspector to the top of the roof of room 506 and verified that the temporary shielding request tags had not been attached. The radiation protection technician properly tagged the temporary lead shielding at that time. Technical Specification 5.8.1.a requires, in part, that written procedures be established, implemented, and maintained that meet or exceed the minimum requirements of Appendix A of USNRC Regulatory Guide 1.33. Regulatory Guide 1.33 Appendix A, Section 7.e.9. requires procedures for the ALARA program. Section 7.4.4.B. of station Procedure RP-307, states, a TSR (temporary shielding request) tag is received from the ALARA (section) and attached to the shielding in a visible location by workers during or soon after (the) shielding installation. The failure to tag the above temporary shielding was identified as an example of a Violation of Technical Specification 5.8.1.a. (50-285/9824-01). Of particular concern was the fact that the lack of a tag on the temporary lead shielding was brought to the attention of a radiation protection supervisor approximately 24 hours before the shielding was tagged. Additionally, during the resin transfer a radiation protection technician performed a radiation survey on top of the roof of room 506 and did not notice the shielding was not tagged.

On November 5, 1998, the licensee wrote condition report 98-1978 documenting the failure to tag the temporary shielding. Corrective actions included: (1) communicate to radiation protection personnel, the procedural requirements and expectations regarding the maintenance and implementation of the temporary shielding program. (This action is scheduled to be completed by November 30, 1998); and, (2) conduct training for radiation protection personnel concerning the deficiencies identified by this condition report and the resulting corrective actions. This training is to include the NRC radiological inspection reports for inspections performed during the months of November and December 1998. (This action is scheduled to be completed by April 30, 1999). The inspector reviewed the licensee's immediate and proposed long-term corrective actions pertaining to this event and determined that they were appropriate, and if implemented, will likely prevent a similar occurrence.

Additionally, on November 3, 1998, at approximately 12:30 p.m. the radiation protection staff identified that the results of an air sample taken in room 506 in the radwaste building during the spent resin transfer was 3.66 derived air concentration (DAC). Section 3.16.2 of station Procedure RP-204, "Radiological Area Controls," Revision 25,

states, "airborne radioactivity areas are posted at 0.3 DAC." At 3:45 p.m., the radiation protection staff obtained the results of a back-up air sample in room 506, which showed that the air sample results were less than 0.3 DAC. From interviews with radiation protection supervision it was determined that room 506 was not posted as an airborne radioactivity area in accordance with the above procedure.

The licensee informed the inspector that during the time in question room 506 was posted and controlled as a restricted high radiation area. The inspector commented that controlling an area as a restricted high radiation area did not relieve the licensee of the procedural requirement to properly post the area. The licensee acknowledged the inspector's comment.

Technical Specification 5.8.1.a requires, in part, that written procedures be established, implemented, and maintained that meet or exceed the minimum requirements of Appendix A of USNRC Regulatory Guide 1.33. Regulatory Guide 1.33 Appendix A, Section 7.e.3. requires procedures for airborne radioactivity monitoring. The failure to post room 506 in the radwaste building as an airborne radioactivity area was identified as a first example of a Violation of Technical Specification 5.8.1.a. involving the failure to post an airborne radioactivity area (50-285/9824-01).

Housekeeping throughout the radiological controlled area was good. The inspector noted that areas were free of debris, and tools and equipment staged for work in-progress were properly stored.

c. Conclusions

In general, a good external exposure controls program was implemented. All Technical Specification high radiation areas were properly controlled; however, a number of potential vulnerabilities were identified with the inventory and storage of very and restricted high radiation area keys. Radiological surveys posted outside areas/rooms in the radiological controlled area accurately reflected radiological conditions. Proper thermoluminescent dosimeters were used for establishing personnel neutron doses. Radiation work permits were clearly written, and historical data was used to incorporate lessons learned from both the site and industry. A violation was identified for the failure to tag temporary lead shielding. A first example of a violation involving the failure to post an airborne radioactivity area was identified. Housekeeping throughout the radiological controlled area was good, areas were free of debris, and tools and equipment staged for work in-progress were properly stored.

R1.2 Internal Exposure Controls

a. Inspection Scope (83750)

Selected radiation protection personnel involved with the internal exposure control program were interviewed. The following items were reviewed:

- Respiratory protection program

- Whole body counting program, including the calibration of the counter
- The internal dose assessment program

b. Observations and Findings

There were 55 full-faced, negative-pressure respirators issued for radiological work since January 1, 1998. From a review of the respirator issue log, the inspector selected 6 individuals at random and determined that respirators were properly issued to qualified individuals. The inspector determined from a review of the total effective dose equivalent/as low as is reasonably achievable (TEDE/ALARA) evaluations completed to justify respiratory use for these individuals, that the evaluations were proper. During the review of the respirator issue log, the inspector noted that respirators issued for asbestos related work was not consistently documented. Sometimes the radiation work permit number was used, while other times the asbestos work permit number was used making the respiratory issue verification process difficult. Radiation protection management informed the inspector that they would review the respiratory issue documentation process for program improvements. On November 5, 1998, the licensee documented this issue in condition report 98-1986.

Whole-body counters were verified to be calibrated using standards traceable to the National Institute of Standards and Technology. The inspector noted that an acceptable phantom was used along with radiation sources that covered energy ranges between approximately 88 -1836 keV. The inspector concluded that a proper whole-body calibration program was in place.

Internal dose assessments were reviewed. The inspector noted that the highest internal dose assigned, in 1998 was 23 millirem. No problems were noted by the inspector during the review of the methodologies used to determine internal dose.

c. Conclusions

An effective internal exposure program was in place. Respiratory equipment was properly issued to qualified personnel. Whole-body counters were properly calibrated using National Institute of Standards and Technology standards. Internal dose assessment methodologies were proper to determine internal dose.

R1.3 Control of Radioactive Materials and Contamination; Surveying and Monitoring

a. Inspection Scope (83750)

Areas reviewed included:

- Contamination monitor use and response to alarms
- Control of radioactive material
- Source inventory and control programs
- Portable instrumentation calibration and performance checking programs
- Adequacy of the surveys necessary to assess personnel exposure

b. Observations and Findings

All personnel observed exiting the radiological controlled area used the personnel contamination monitors properly. Radiation protection personnel stationed at the egress point provided appropriate and timely guidance to workers who alarmed the monitors.

During tours of the radiological controlled area, the inspector noted that all radioactive material containers were properly labeled, posted, and controlled. Contamination boundaries were clearly identified and properly posted, step-off pads were placed at the entrances/exits to contaminated areas. Trash and laundry barrels were properly maintained to prevent the spread of radioactive contamination. The inspector observed radiation worker activities, while exiting contaminated areas and noted use of good health physics practices.

The inspector randomly selected six radioactive sources from an inventory list provided by the licensee. Five of the six sources were found in their designated location and properly labeled. The sixth was properly shipped to the University of Michigan. From a review of the last two inventory lists, the inspector noted that the inventory and source leak testing programs were performed in accordance with station procedures. No problems were identified with the source control and inventory programs.

All portable radiation detection instrumentation observed in use in the radiological controlled area was properly calibrated and source response checked in accordance with station procedures. The licensee used a vendor to calibrate the portable neutron instrumentation. Calibration certificates documented that the neutron survey meters were calibrated using a plutonium-beryllium (PuBe) source, which was traceable to National Institute of Standards and Technology. Prior to use, portable neutron instrumentation was source response checked using a plutonium-beryllium source.

Independent radiological measurements performed by the inspector confirmed that area radiological postings reflected general radiological conditions within the room. All radiological postings were conspicuously and clearly posted.

During the review of the licensee's 1998 air sample log, the inspector randomly selected 10 areas in which air sample results exceeded the licensee's posting limit of 0.3 derived air concentration (DAC). The inspector determined, from a review of survey documentation and discussions with radiation protection supervision, that 2 of these 10 areas were not posted as an airborne radioactivity activity area in accordance with station procedures. These areas were, in addition to, the area described in Section R1.1 of this report.

The first area was room 13 on elevation 989 foot of the auxiliary building. On April 23, 1998, at approximately 4:45 a.m. radiation protection personnel identified that the results of an air sample taken in the above room was 0.35 DAC. At approximately 11:45 a.m., the same day radiation protection personnel obtained the results of a second air sample in room 13 which showed that the air sample result was 0.38 DAC. The area was properly posted as an airborne radioactivity area after the results of the

second sample was obtained. The failure to post the above area as an airborne radioactivity area when the first sample was obtained was identified as a second example of a violation of Technical Specification 5.8.1.a. involving the failure to post an airborne radioactivity area (50-285/9824-01).

The next area was on elevation 1045 foot in the reactor containment building. On May 6, 1998, at approximately 6:50 p.m., radiation protection personnel obtained the results of an air sample taken during work on Spray Control Valve "RC 374" . The results indicated an air concentration of 3.21 DAC. A back-up air sample taken about one hour later revealed the area no longer met the posting requirements of an airborne radioactivity area. The failure to post the above area as an airborne radioactivity area was identified as a third example of a Violation of Technical Specification 5.8.1.a. involving the failure to post an airborne radioactivity area (50-285/9824-01).

On November 5, 1998, the licensee wrote condition report 98-01979, documenting the three examples of the failure to post airborne radioactivity areas. Corrective actions included: (1) communicate to radiation protection personnel, the procedural requirements and expectations related to the prompt posting of airborne radioactivity areas. (This action is scheduled to be completed by November 30, 1998); (2) communicate management's expectations as to the proper documentation method for annotating the posting of an airborne radioactivity area. (This action is scheduled to be completed by November 30, 1998); and (3) conduct training for radiation protection personnel concerning the deficiencies identified by this condition report and the resulting corrective actions. This training is to include the NRC radiological inspection reports for inspections performed during the months of November and December 1998. (This action is scheduled to be completed by April 30, 1999).

The inspector reviewed the licensee's immediate and proposed long-term corrective actions pertaining to the failure to post the three airborne radioactivity areas and determined that they were appropriate, and if implemented, will likely prevent a similar occurrence.

c. Conclusions

All personnel observed exiting the radiological controlled area used the personnel contamination monitors properly. Radiation workers used good health physics practices while exiting contaminated areas. Radioactive material, laundry, and trash containers were properly labeled, posted, and controlled. Good radioactive source inventory and leak test programs were in place. Portable radiation survey instrumentation was properly calibrated and source response checked. Two additional examples of a violation of Technical Specification 5.8.1.a. involving the failure to post airborne radioactivity areas were identified.

R3 Radiological Protection and Chemistry Procedures and Documentation

R3.1 Radiation Protection Procedure Review

a. Inspection Scope (83750)

Selected radiation protection procedures related to the areas of inspection were reviewed for adequacy.

b. Observations and Findings

In general, radiation protection program procedures were well written. However, during the review of radiation protection program procedures, the inspector noted one minor violation of a procedure that was not written consistent with the requirements of 10 CFR Part 20. Technical Specification 5.11. requires, that, radiation protection procedures be written consistent with the requirements of 10 CFR Part 20. 10 CFR Part 20.1601 requires high radiation areas to be locked. Section 1601 (c) of 10 CFR Part 20, states that a licensee may apply to the Commission for approval of alternative methods for controlling access to high radiation areas. Technical Specification 5.11.1 implements an alternative method for the control of high radiation areas. Technical Specification 5.11.1 states, that, each high radiation area in which the intensity of radiation is 1000 mrem/hr or less shall be barricaded.

Section 7.4.1 of Procedure RP-204, "Radiological Area Controls," Revision 25, states "When a major portion of a room (or area) is a High Radiation Area, the room (or area) should be either physically barricaded or access controlled with a lockable door or gate.

Procedure FCSG-8, "Fort Calhoun Station Writer's Guide," Revision 2, discusses words used to depict requirement levels. Attachment 7.2 states that the word "shall" means a mandatory requirement. The word "should" means a recommended, but not an enforceable requirement. Therefore, the use of the word "should" in Procedure RP 204, conveys the meaning to workers that the barricading or locking of a high radiation area is a recommended action rather than a mandatory requirement.

The failure to write procedures consistent with the requirements of 10 CFR Part 20 is identified as a Violation of Technical Specification 5.11. However, during tours of the radiological controlled area, the inspector did not identify any high radiation areas that were not controlled in accordance with Technical Specification requirements. Therefore, the failure to maintain procedures consistent with the requirements of 10 CFR Part 20 constitutes a violation of minor significance and is not subject to formal enforcement action. On November 4, 1998, the licensee documented this item in condition report 98-1982. Corrective actions documented included changing Procedure RP-204 to reflect the Technical Specification requirement that high radiation areas shall be barricaded.

c. Conclusions

In general, radiation protection program procedures were well written. However, one minor violation was noted involving a procedure, which was not written consistent with the requirements of 10 CFR Part 20. The licensee took immediate action to revise the procedure.

R5 Staff Training and Qualification in Radiological Protection and Chemistry

R5.1 Radiation Protection Staff Qualifications

a. Inspection Scope (83750)

The inspector reviewed the qualifications of the acting radiation protection manager.

b. Observations and Findings

Due to a recent organizational change, an individual was designated as the acting radiation protection manager. Technical Specification 5.3.1 requires that the individual filling the position of radiation protection manager (RPM) meet or exceed the qualifications of USNRC Regulatory Guide 1.8, September 1975. From a review of the acting radiation protection manager's resume, the inspector determined that this individual satisfied the requirements of USNRC Regulatory Guide 1.8, September 1975.

c. Conclusions

The acting radiation protection manager satisfied the requirements of Technical Specification 5.3.1.

R7 Quality Assurance in Radiological Protection and Chemistry Activities

R7.1 Quality Assurance Audits and Surveillances, and Radiation Department Self-Assessments and Radiological Occurrence Reports

a. Inspection Scope (83750)

Radiological condition reports written since July 1, 1997, were reviewed.

b. Observations and Findings

The inspector reviewed selected radiological condition reports written since July 1, 1997, and noted that the station identified items at the proper threshold to provide management with a good overview of radiological program areas. Corrective actions to prevent a re-occurrence appeared to be effective to resolve the original problem, and, in general, condition reports were closed in a timely manner. No negative trends were identified during this review.

c. Conclusions

Radiological condition reports provided management with a good overview of radiological program areas and were effective to resolve the original problem.

R8 Miscellaneous Radiological Protection and Chemistry Issues

(Closed) Violation 50-285/9806-05: Failure to control entries into a restricted high radiation areas

The inspector verified that the corrective actions described in the licensee's response letter dated May 29, 1998, were implemented. No similar problems were identified.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at an exit meeting on November 6, 1998. The licensee acknowledged the findings presented. No proprietary information was identified.

ATTACHMENT

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Dryden, Engineer, Station Licensing
M. Frans, Manager, Nuclear Licensing
S. Gambhir, Division Manager, Nuclear Operations
B. Hansher, Supervisor, Station Licensing
R. Hodgson, Supervisor, Radiation Protection
T. Jamieson, Supervisor, Radiation Protection
J. Mattice, Supervisor, Radiation Protection
R. Phelps, Division Manager, Engineering
M. Puckett, Acting Manager, Radiation Protection
L. Schwesoer, Engineer, Quality Assurance
J. Solymossy, Plant Manager
J. Tills, Assistant Plant Manager
M. Welch, Corporate Health Physics

NRC

W. Walker, Senior Resident Inspector

INSPECTION PROCEDURE USED

83750 Occupational Radiation Exposure

LIST OF ITEMS OPENED AND CLOSED

Opened

50-285/9824-01	VIO	Failure to tag temporary lead shielding and post three airborne radioactivity areas.

Closed

50-285/9806-05	VIO	Failure to control entries into a restricted high radiation area.

LIST OF DOCUMENTS REVIEWED

A summary of radiological condition reports written from July 1, 1997, to November 1, 1998

Radiation Protection Procedure RP-201, "Radiation Work Permits," Revision 15

Radiation Protection Procedure RP-202, "Radiological Surveys," Revision 13

Radiation Protection Procedure RP-204, "Radiological Area Controls," Revision 25

Radiation Protection Procedure RP-307, "Use and Control of Temporary Lead Shielding," Revision 6

Radiation Protection Procedure RP-405, "Radiation Source Inventory Control," Revision 4

Radiation Protection Instruction RPI-6, "Alternate Access Control of Radiological Controlled Area," Revision 2

Station Standing Order SO-O-26, "Plant Keys," Revision 29