

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-237/87003(DRSS); 50-249/87003(DRSS)

Docket Nos. 50-237; 50-249

Licenses No. DPR-19; DPR-25

Licensee: Commonwealth Edison Company
P. O. Box 767
Chicago, IL 60690

Facility Name: Dresden Nuclear Power Station, Units 2 and 3

Inspection At: Dresden Site, Morris, Illinois

Inspection Conducted: December 8-18, 1986, and January 6-13, and
February 6, 1987

D. E. Miller
Inspectors: D. E. Miller

2/13/87

Date

W B Grant
W. B. Grant

2/13/87

Date

L. R. Greger
Approved By: L. R. Greger, Chief
Facilities Radiation Protection
Section

2/17/87

Date

Inspection Summary

Inspection on December 8-18, 1986 and January 6-13, and February 6, 1987
(Reports No. 50-237/87003(DRSS); No. 50-249/87003(DRSS))

Areas Inspected: Routine, unannounced inspection of the radiation protection and radwaste management programs for operational and refueling/maintenance outage activities. Also reviewed were past open items, radiation protection program improvements, a liquid effluent release event, and a solid radwaste transportation event.

Results: Two violations were identified (failure of two employees to perform procedural requirements - Section 8; liquid release without operable monitor or action statement compliance - Section 8).

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DETAILS

1. Persons Contacted

- *D. Adam, Regulatory Assurance Supervisor
- D. Ambler, Radiological Engineer
- *J. Brunner, Assistant Superintendent, Technical Services
- *E. Eenigenburg, Station Manager
- *R. Flessner, Superintendent, Services
- *P. Hamby, Health Physicist, Nuclear Services
- *E. O'Connor, Rad/Chem Supervisor
- *R. Jeisy, Station Quality Assurance (QA) Supervisor
- W. Johnson, Lead Chemist
- *J. Kotowski, Assistant Superintendent, Operations
- D. Sharper, Waste Systems Engineer
- *D. Soccomando, Lead Health Physicist
- *J. Wujciga, Superintendent, Production

- *L. McGregor, NRC Senior Resident Inspector
- *P. Kaufman, NRC Resident Inspector

The inspectors also contacted several other licensee and contractor personnel.

*Denotes those present at the exit meeting.

2. General

This inspection, which began at 8:30 a.m. on December 8, 1986, was conducted to examine the radiation protection and radwaste management programs for operational and refueling/maintenance activities. Also reviewed were past open items, radiation protection program improvements, a liquid effluent release event, and a solid radwaste transportation event.

3. Licensee Action on Previous Inspection Findings

(Open) Open Items (237/86008-01; 249/86010-01): Cleanup program for outdoor areas. The general cleanup of unwanted materials continues; most areas have been cleared of such materials. As discussed in Inspection Reports No. 50-237/86023; No. 50-249/86028, there were more than 100 sea vans onsite that contained contaminated waste materials, contaminated tools, and other contaminated materials and equipment. Since then, the licensee selected a bidder to take ownership of the vans and all contaminated material. The bidder was to have transported the vans and contents offsite, decontaminate the recoverable materials, and properly dispose of the remainder. The contract stated that the bidder was to

take possession of the materials at Dresden Station before transport. It was subsequently discovered, however, that the successful bidder legally could not take possession of the materials at the Station because such possession was not permitted by the bidder's Agreement State radioactive material license. Dresden Station then became the shipper. The licensee and contractor checked the contents of each van to assure adequate packing of items and quantification of radioactive contents, and to add internal bracing of the van's contents to prevent load shifting during transport. Consequently, the licensee's target date of mid-December for completion of removal of the vans from the site was not met. A total of 20 vans were transported offsite as of January 6, 1987.

(Open) Open Items (50-237/85026-01; 50-249/85021-01): Disposition of contaminated soil. The licensee planned to submit a 10 CFR 20.302 request to the NRC by December 31, 1986, for permission to bury contaminated soil on owner controlled property. On January 5, 1987, Dresden Station received guidance from the CECO corporate office concerning their recommended method of onsite radioanalysis of the previously collected contaminated soil samples; the licensee began performance of the analyses on January 6, 1987. No new target date had been established for submittal of the 10 CFR 20.302 request.

(Open) Open Items (50-237/85041-02; 50-249/85035-02): Contamination reclamation program. This matter is discussed in Section 4.

4. Control of Radioactive Materials and Contamination

The inspectors reviewed the licensee's program for control of radioactive materials and contamination, including: changes in instrumentation, equipment and procedures; effectiveness of survey methods, practices, equipment and procedures; adequacy of review and dissemination of survey data; and effectiveness of methods of control of radioactive and contaminated materials.

The licensee's contamination reduction program continues. An overall reduction in the extent of contaminated areas and the concentration of contamination in contaminated areas is being realized. Methods being used to reduce contamination spread events are discussed in Section 6. The extent of contaminated areas and the concentration of contamination in contaminated areas is being trended. Progress of the program will be reviewed during future inspections (50-237/85041-02; 50-249/85035-02).

During the current refueling outage, the drywell was pressure washed to reduce contamination levels, and the torus internals are being cleaned and repainted. The licensee is planning a modification of torus basement sumps to decrease the probability of flooding and recontamination.

The licensee began radiological sorting of potentially clean waste that is removed from controlled areas. The sorting is being performed in a low background area (interim radwaste storage facility) using friskers. No problems were noted during the inspector's review of the sorting program.

No violations or deviations were identified.

5. Internal Exposure Control

The inspectors reviewed the licensee's internal exposure control and assessment programs, including changes to procedures affecting internal exposure control and personal exposure assessment; determination whether engineering controls, respiratory equipment, and assessment of individual intakes meet regulatory requirements; planning and preparation for maintenance and refueling tasks including ALARA considerations; and required records, reports, and notifications.

The licensee's program for controlling internal exposures includes the use of protective clothing, respirators, and equipment, and control of surface and airborne radioactivity. A selected review of air sample and survey results was made; no significant problems were noted.

Whole body count (WBC) data was reviewed for counts performed during the fourth calendar quarter 1986 on company and contractor personnel. Several followup counts were performed on persons who showed elevated initial counts. Followup counting was adequate to verify that the 40 MPC-hour control measure was not exceeded.

The licensee has initiated a program for trending WBC data greater than one percent of Maximum Permissible Body Burden (MPBB). The trending is in two categories; WBCs that initially were greater than one percent of MPBB and reduced to near zero on recounting, and WBCs greater than one percent MPBB.

The inspectors reviewed the licensee's trending data; no problems were noted.

No violations or deviations were identified.

6. Personal Contamination Events

Tracking of personal contamination events began during the Unit 3 recirculating piping replacement (RPR) program and is discussed in Inspection Reports No. 50-237/86008, No. 50-249/86010, No. 50-237/86023, and No. 50-249/86028. The number of personal contamination events was trending downward, even though the number appeared large, until December 1986 when 264 events were reported. Sixty-five percent of the

264 events were clothing contamination; 70 percent of the clothing contaminations were shoe contamination events. The 264 events are an increase of 105 percent from the previous month.

The licensee attributes the elevated number of personal contamination events to the Unit 2 refueling/maintenance outage, installation of fire protection piping which involved extensive work in building overhead areas which had accumulated small quantities of contamination over the years, work being performed in the Unit 2/3 radwaste building in preparation for major revamping work, and work performed in the Unit 2 and 3 torus basements to prepare for modification of sumps and sump pumps.

The licensee maintains records showing inplant areas in which individual personal contamination events occurred and the person involved; causes of these events are investigated. In addition, the following actions have been taken to reduce personal contamination events:

- Institution of routine cleaning of the plant, including assignment of designated stationman to each floor to conduct daily mopping; to see that leaks are contained; to keep all pipes, walls, and equipment uncontaminated; and to remove trash and used RWP clothing.
- Assignment of an RCT to the decon room to follow events.
- Use of INPO criteria to trend events.
- Computer tracking of events.
- Requirement that contaminated individual takes his personal contamination report (PCR) to his supervisor.
- PCRs are given to department heads for trending.

Personal contamination events appear to be trending downward again during January, with 44 events reported through January 13, 1987.

No violations or deviations were identified.

7. Radiation Protection Programmatic Improvement Initiatives

In response to findings from onsite, corporate, and industry quality assurance audits, the licensee has or will implement the following:

- Establish remote Radiation Work Permit (RWP) review stations to relieve congestion at the RWP issue area. This has been accomplished.
- Remodel the RWP office and evaluate the RWP remote stations for adequacy and necessity. Planning is in progress.

- Modify radiation protection foreman tasks so that unit foremen can provide more direct supervision of RCTs and oversight of radiological work. This has been accomplished.
- Establish goals for personal contamination and radiological occurrence reports by department. Implementation in progress.
- Establish a file and audit program for performance evaluations of each rad/chem department employee. This program has been initiated.
- Establish a program where health physicists and station first line supervisors tour the station on designated days to review ongoing radiation protection practices. This program has been initiated.
- Program for evaluation of trending of whole body counting results that are greater than one percent of an organ burden. A health physicist now signs off on the vendor reports. Corporate has a trending program and report. This is considered implemented by the licensee.
- Program for review and evaluation of vendor calibration of whole body counter (annual). This program has been developed.
- Evaluate the frequency of source checking of two high radiation range survey instruments. The instruments have been marked for emergency use; a sticker was affixed indicating need for source check on high range before use. The licensee considers this item complete.
- Ensure the effectiveness of trending program for personal contamination events. The licensee has expanded the trending program to better identify root cause of events. The licensee considered this item complete.
- Ensure that the health physics staff spot checks selected RWPs for adequacy. The licensee considered this item completed and implemented.
- Ensure that RCTs question workers to determine their understanding of RWPs. The licensee considers this item completed and implemented through additional RCT training and foreman spot checking.
- Develop action plan and implementing procedures for additional posting and access controls for "very high radiation" areas. The action plan and implementing procedures are being developed. The licensee plans implementation by March 1, 1987.

- Ensure that health physicists spot check RWPs to evaluate adequacy of prescribed air sampling. These spot checks have been implemented; the licensee considers this item closed.
- Serialize respirators with metal tags to aid in control and assure ability to locate wearer if needed. Serialization is complete.
- Ensure that significant contamination events are being investigated by representatives of the affected department and corrective actions address the cause. A procedure change was initiated to address and implement this initiative.
- Ensure that plant tours by health physicists include radioactive materials storage areas and that prompt action is taken to correct any deficiencies. Checklists have been developed to aid implementation. The licensee has implemented this program.

No violations or deviations were identified.

8. Liquid Effluent Release Event

a. Event

At 1845 hours on January 5, 1987, a planned liquid radwaste release of "C" waste sample tank was started. At 2350 hours, the oncoming midnight shift radwaste foreman attempted to collect a routine sample of the ongoing release at the liquid radwaste monitor (this sample is analyzed for compliance with State of Illinois requirements). The foreman found that there was no flow through the monitor. The foreman investigated and found that three valves located between the liquid radwaste discharge line and the monitor were mispositioned, and that, consequently, the discharge to the river was proceeding without an operable radwaste monitor. The foreman terminated the release, which was nearly completed, and wrote a Deviation Report describing the "as found" condition.

b. Monitor Requirements

When making planned liquid radwaste releases to the river, the licensee routinely performs the technical specification action statement requirements (Technical Specification No. 3.2 and Table No. 3.2.4) that would apply if the effluent monitor were inoperable. The action statement requires that prior to initiating a release at least two independent samples be analyzed and at least two members of the facility staff independently verify the release calculations and discharge valving. These requirements appear in licensee Procedure No. DOP 2000-28, "Radioactive Waste Discharge to River," which implement Section 8.2.3 of the station's Offsite Dose Calculation Manual (ODCM).

c. Investigation Summary

At about 0830 hours on January 6, 1987, the licensee informed onsite NRC representatives that there had been a problem with a liquid radwaste release the previous day, and that the licensee had started an investigation into the event.

At about 0830 hours on January 7, 1987, the licensee informed onsite NRC representatives of the licensee's preliminary findings. The NRC Senior Radiation Specialist, who was onsite, performed an independent investigation of the event.

Based on NRC and licensee investigation of the event, the following was determined. The investigation details are discussed in Section 8.e. below. The following matters were also discussed during the enforcement conference. (Section 12)

- The relatively inexperienced B-operator who performed the initial valve lineup failed to assure the proper positioning of two valves (designated on a DOP 2000-28 checklist), failed to read and comply with a temporary procedure change (which was attached to the release paperwork) concerning the proper positioning of a third valve, and failed to perform a DOP 2000-28 procedural step which requires that sample flow be verified 15 minutes after initiating the radwaste liquid release. The B-operator also stated that he had performed a procedural requirement to check the liquid monitor readout after he initiated the release, but failed to recognize that the monitor readout was abnormal. The operator's failings appear attributable to poor performance on his part, weaknesses in the method of informing operators of procedural changes, and weaknesses in radwaste operator training.

Technical Specification 6.2 requires that detailed written procedures including applicable checkoff lists be prepared, approved, and adhered to, to implement Offsite Dose Calculation Manual (ODCM) requirements. Procedure DOP 2000-28 contains the ODCM implementation requirements.

Failure of the B-operator to perform certain procedural requirements of DOP 2000-28 is considered noncompliance with Technical Specification 6.2 requirements (237/87003-01; 249/87003-01).

- The radwaste foreman on duty during performance of the valving checklist knowingly failed to perform the required independent valve position verification, while signing the checklist indicating that he had performed the verification. The foreman stated that he did not perform the independent verification

because he was busy, was not feeling well, and because he trusted the radwaste operator to properly perform the lineup. He stated that he had never previously failed to verify a valve lineup when he was supposed to do so, nor was he aware of anyone else having done so. (He did indicate, however, that he had previously, on occasion, performed the valve lineup without anyone performing an independent verification.) The foreman had provided little or no guidance to the relatively inexperienced B-operator for the January 5, 1987 release.

Failure of the radwaste foreman to perform the required independent valve position verification, while signing the checklist indicating that he had done so, is considered willful noncompliance with Technical Specification 6.2 requirements (237/87003-01; 249/87003-01).

- The planned liquid radwaste release on January 5, 1987, was made with the liquid radwaste monitoring instrumentation inoperable and the limiting condition for operation action statement (Action B of Table 3.2.4) not complied with. Technical Specification 3.2.F.1 requires that the liquid radwaste effluent gross activity monitor be operable or that Action B of Table 3.2.4 be complied with. The liquid radwaste release made on January 5, 1987, was in noncompliance with Technical Specification 3.2.F.1 requirements (237/87003-02; 249/87003-02).
- The B-operator was aware that the radwaste foreman had falsely signed the valving checklist verification but informed no one.
- The liquid radwaste released to the river did not exceed regulatory limits.

d. Immediate Licensee Corrective Actions

On January 7, 1987, the licensee informed onsite NRC representatives that the radwaste foreman was suspended from duties on the previous day pending determination of formal disciplinary actions. On January 8, 1987, the licensee provided to the inspector a copy of the licensee's Potentially Significant Event preliminary report which summarized the licensee's investigation, findings, and proposed corrective actions. On January 13, 1987, the licensee verbally updated the inspector concerning the following corrective actions taken and proposed.

- The involved radwaste foreman was given ten working days off without pay and was demoted to an engineering assistant position.
- The B-operator was given one day off without pay.
- All station employees were being informed of this incident, its ramifications, and the importance of strict procedural compliance.

- Two of the valves that were mispositioned were permanently locked in their proper position. Modifications are planned which will simplify the valve positioning checklists and reduce possibility of valving error.
- Additional training of radwaste foreman and B-operators is planned.

e. Investigation Findings Details

- The radwaste foreman on duty, during initiation of the liquid radwaste release, assembled the paperwork for release of "C" Waste Sample Tank river discharge. The paperwork consisted of two temporary procedure change sheets for Procedure DOP 2000-28 "Radioactive Waste Discharge to River;" three checklists on which discharge times, activities, tank levels, etc, are recorded; a checklist for valve lineup for "C" Waste Sample Tank; and a checklist for lineup of the Off-Stream Liquid Effluent Monitor. The radwaste foreman, who has a desk in the shift supervisor's office, had another operator hand carry the paperwork to the radwaste control room where a relatively inexperienced B-operator was given the paperwork. The only instruction provided the B-operator was for him to call the foreman when the release was ready to be started. When the B-operator called the foreman and told him the release was ready to start, the foreman told the B-operator to start the discharge and he would be down later to sign off the valve verifications on the checklists. The radwaste foreman later went to the radwaste control room and signed the valve verifications without checking the valves or otherwise verifying proper discharge or monitor sample flows. There was little conversation between the radwaste foreman and the B-operator. When asked why he did not perform the valve lineup verifications, the radwaste foreman stated that he was busy, was not feeling well, and because he trusted the radwaste operator to properly perform the lineups.

During interviews with other radwaste foremen and radwaste operators, there was no indication that other radwaste foremen have failed to provide adequate guidance to and supervision of operators or that they have failed to perform the required valve lineup verifications.

As stated above, radwaste foremen have a desk in the shift supervisor's office. This is to provide easy interface between the radwaste foremen and shift supervisors, particularly at the start of a shift. According to those interviewed, radwaste foreman generally spend a majority of their on duty time in the

field providing supervision of operators and oversight of radwaste operations. Due to the physical separation between the shift supervisor's office and the D2/3 radwaste control room and radwaste areas, it appears that better awareness of radwaste conditions and supervision of radwaste operators may be achieved by locating the radwaste foremen's desk in these areas. This matter was discussed during the enforcement conference (Section 12).

- The relatively inexperienced B-operator involved in this event stated that he had performed but one previous liquid radwaste release. He stated that for the previous release a radwaste foreman had walked through the checklists with him but did not train him concerning temporary procedure changes that may be attached to the discharge paperwork. The B-operator stated that when the discharge paperwork for discharge of "C" Waste Storage Tank was brought to him on January 5, 1987, he reviewed Procedure DOP 2000-28 before starting the checklists. He stated that he did not notice the temporary procedure change concerning positioning of a valve attached to the release paperwork; nor did he remember being taught to look for and properly perform temporary procedure changes, and therefore did not properly position a valve in the liquid effluent monitor sample line. During performance of the liquid effluent monitor sample line checklist, the B-operator was to open two valves; the operator stated that he checked the valves by hand, thought they were already open, and went to the next checklist step; the two valves were later found to be closed. The operator said that he had been taught the proper method of valve position verification, but did not use the techniques in this instance. Improper positioning of the valves prevented sample flow through the radwaste liquid effluent radiation monitor. The B-operator completed the remainder of the checklists and called the foreman. The foreman told the B-operator to start the release. The release was started. The B-operator stated that he was aware that the radwaste foreman was required to perform a valving verification, but he informed no one that it had not been performed prior to or during the release.

A DOP 2000-28 procedural step requires that sample flow through the monitor be verified 15 minutes after initiating the liquid radwaste release. The B-operator stated that he failed to remember to perform this procedural requirement. Therefore, the release continued without sample flow through the monitor. An additional problem with sample flow alarm indication is described in a following subsection. The B-operator stated that he had performed a procedural requirement to check the liquid monitor readout after the release was started, but failed to recognize that the monitor reading was abnormal.

Radwaste operators received generic radwaste systems training at CECO's Braidwood Training Center; the training is INPO accredited. However, the training is systems oriented. No formal or on-the-job training or qualification program is routinely provided to radwaste operators for specific operational radwaste procedures. The B-operator stated that he had received generic training concerning the proper methods of assuring proper valve positioning, but had failed to properly apply the methods on two of the valves later found to be mispositioned. Also, had the B-operator been more familiar with the valve lineup checklists, he should have realized that the two valves were required to be closed on a post-discharge checklist and his supposedly finding the valves open would indicate that the previously performed checklist would not have been properly performed.

The B-operator's actions in performance of the radwaste liquid release was poor; additional training appears needed. Supervision of the B-operator provided by the radwaste foreman was essentially nonexistent.

- The liquid radwaste effluent monitor low sample flow alarm is actuated by a flowrater. According to licensee representatives, during flushing of the monitor and associated piping after termination of a liquid release the flowrater plumette occasionally "hangs-up" in the full scale flow position thereby defeating the low flow alarm. The radwaste foreman, who identified that there was no flow through the monitor, indicated in the deviation report that the low flow area was not lit; he later stated that the plumette may have stuck during the flush cycle performed after the previous liquid release.

During interview, the B-operator stated that when he performed a checklist item calling for "After flow is verified, reset the 2/3 Radwaste Discharge Loss of Sample Flow Alarm," he found that the alarm light was not lit. He stated that he mentally questioned why the alarm light was not lit, but did not inform the radwaste foreman or investigate further.

It appears that the sample flowrater should be repaired or replaced, or an additional procedural step developed to assure proper actuation of the low sample flow alarm.

- Revised radwaste procedures and temporary procedure changes are routed to radwaste foremen for filing and implementation. For the temporary procedure changes for this event, the change sheets were copied by the radwaste foreman and attached to the release paperwork. The release paperwork does not include the entire DOP 2000-28 procedure, only the applicable valving

checklists for the specific liquid radwaste tank to be released to the river and temporary procedure changes. There is no program for distribution of appropriate procedures and changes to radwaste operators for their review, nor is there a formal program for assuring that operators are informed of applicable changes. The licensee depends on an informal system whereby radwaste foreman inform appropriate radwaste operators of changes. In this case, the informal program failed.

- The release was in progress for several hours before it was recognized that there was no sample flow through the monitor. Even though the valving errors were made and valve positioning was not verified, there were several indicators that should have caused earlier detection of lack of sample flow through the monitor. They include:
 - a. The B-operator failed to question why the monitor low flow alarm target was not lit when he performed a checklist item to reset the alarm target.
 - b. Proper performance of a procedural requirement to verify sample flow through the monitor 15 minutes after the release was started was not accomplished.
 - c. The B-operator did not recognize that the monitor count-rate strip chart indication was abnormal. The radwaste foreman apparently also did not notice the abnormal strip chart indication.
 - d. Had an attempt been made to collect the routine grab sample from the monitor shortly after the release was started, instead of near completion of the release, the loss of flow would have been detected earlier. According to other radwaste foremen, the sample, or a portion of it, is normally collected early in the release period. In this case, the oncoming radwaste foreman recognized that no sample had been collected and that the release was nearly completed; he attempted to collect the sample immediately.

Two violations were identified.

9. Solid Radwaste Transportation Incident

On December 8, 1986, the licensee was notified by the Barnwell, S.C. burial site of a problem with a solid radwaste shipment that left Dresden Station on December 4, 1986. The shipment was concentrated waste solidified in a liner and transported in a shielding cask. The burial

site informed the licensee that smearable contamination levels up to 177,000 dpm/100 cm² were found in the inside bottom of the shielding cask; condition 60 of the State of South Carolina Radioactive Material License No. 097 (burial site's license) permits up to 20,000 dpm/100 cm².

Two CECo employees went to the burial site on December 9, 1986, to inspect the shipping cask. Dresden station radwaste department employees reviewed onsite operations and equipment to seek the source of the radioactive materials. It was found that a process shield, in which the liner was processed and stored onsite until transfer to the truck mounted shielding cask for transport, also had radioactive materials on the inside bottom; the physical quantity of material was "a couple of cupfulls." No other onsite process shield was found to contain radioactive materials. The licensee considers the process shield to be the source of the material found in the shipping cask; the process shield was decontaminated.

On December 22, 1986, Dresden Station received a letter from the State of South Carolina Bureau of Radiological Health stating that no violations or civil penalty would be imposed in this case. Dresden Station was requested to submit written corrective actions. The written corrective actions were submitted as requested; they included additional proceduralized routine quality assurance inspections of onsite process shields.

No violations of NRC or DOT requirements were identified.

10. Plant Tours

Several tours of radiologically significant areas were made to review posting, access controls, contamination controls, and housekeeping. During these tours it was noted that many improvements have been made or are in progress of being made to strengthen the health physics program during routine operation and refueling outages. The improvements include:

- Increased numbers of shielded frisker stations throughout the plant with more comprehensive instructions concerning actions to follow when personal contamination is detected.
- Increased use of whole body friskers throughout the plant.
- A new personnel decontamination facility located in the access control building, and relocation of the shoe decontamination facility.
- Increased surveillance of plant activities by health physicists and RCT foremen.

- Increased number of plant areas that have been decontaminated and repainted.
- Good housekeeping throughout the plant.

No instance of persons not adhering to procedures was noted during these tours.

No violations or deviations were identified.

11. Exit Meeting

The inspector met with licensee representatives (denoted in Section 1) at the conclusion of the inspection on January 13, 1987. The inspector summarized the scope and findings of the inspection. The inspector also discussed the likely information content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee identified no such documents/processes as proprietary. In response to certain items discussed by the inspector, the licensee:

- a. Stated that the improvements being made in outside housekeeping and radioactive materials storage areas would continue (Section 3).
- b. Acknowledged the violations (Section 8).
- c. Stated that the contamination reclamation program would continue (Section 3).

12. Enforcement Conference

An enforcement conference was held February 6, 1987, to discuss the January 5, 1987, liquid radwaste release event, Region III staff concerns about the errors made during the release, and the associated apparent violations of requirements, including willfulness. The principal attendees at the meeting held at the NRC Region III office are listed below.

Region III employees indicated their concern about the actions of the B-operator and radwaste foreman, and possible training, equipment, and procedural shortcomings. The licensee presented corrective actions that have been taken and are proposed.

Principal Licensee Attendees

- D. Galle, Assistant Vice President and General Manager
- B. Stevenson, Manager, Nuclear Safety
- D. Farrar, Director, Nuclear Licensing

- N. Kalivianakis, Vice President, Nuclear Operations
- J. Eenigenburg, Station Manager (Dresden)
- L. Gerner, Superintendent, Compliance

Principal Region III Attendees

- A. Davis, Administrator
- J. Hind, Director, Division of Radiation Safety and Safeguard
- C. Paperiello, Director, Division of Reactor Safety
- W. Shafer, Chief, Emergency Preparedness and Radiological Protection Branch
- L. Greger, Chief, Facilities Radiation Protection Section
- B. Stapleton, Enforcement Specialist