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

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Report Nos.: 50-413/89-02 and 50-414/89-02

Licensee: Duke Power Company
422 South Church Street
Charlotte, NC 28242

Docket Nos.: 50-413 and 50-414 License Nos.: NPF-35 and NPF-52

Facility Name: Catawba 1 and 2

Inspection Conducted: January 30 - February 3, 1989

Inspector: for F. N. Wright 3/3/89 Date Signed

Approved by: J. E. Potter, Chief 3/3/89 Date Signed
Facilities Radiation Protection Section
Emergency Preparedness and Radiolgical Protection Branch
Division of Radiation Safety and Safeguards

SUMMARY

Scope

This routine, unannounced inspection was conducted in the areas of pre-outage planning, preparations, and management support for implementing the licensee's radiation protection program. The review included: licensee organization and management controls; maintaining occupational exposures as low as reasonably achievable (ALARA); training and qualifications; outage preparations and provisions; and licensee action on previously identified inspection findings.

Results

Two violations of NRC requirements were identified:

1. Failure to take adequate timely corrective action on NRC identified violations.

2. Failure to provide licensee workers adequate training on the significance of yellow flashing lights, and failure to post the associated high radiation area. This was similar to a violation concerning training cited in a Notice of Violation issued September 16, 1988.

The input from section supervisors on methods to further reduce occupational radiation exposure was found to be minimal, although the

person-rem totals per unit were low for a facility having two partial refueling outages during the year.

The outage radiological controls were generally effective even though there had been a reduction in radiation protection technician support when compared to previous outages.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*V. Barbour, Quality Assurance, Director of Operations
W. Bradley, Manager, Quality Assurance Verification
*W. Deal, Station Health Physicist
A. Duckworth, Director, Technical Services Training
*R. Glover, Compliance Engineer
*V. King, Compliance Engineer
*P. LeRoy, Regulatory Compliance
T. Owens, Station Manager
R. Rivard, ALARA Planning Supervisor

Other licensee employees contacted during this inspection included technicians and office personnel.

Nuclear Regulatory Commission

*M. Lesser, Resident Inspector
*W. Orders, Senior Resident Inspector

*Attended exit interview

2. Organization and Management Controls

Through interviews with the licensee's staff, the inspector reviewed the licensee's health physics (HP) outage organization plans, staffing levels, lines of authority and degree of interaction with other plant work groups.

a. Health Physics Organization

The licensee had a HP staff which was highly specialized, in that, the staff was divided into small units having specific areas of responsibility. During refueling outages the licensee's four surveillance and control (SC) groups were deployed to provide continuous HP outage support in the auxiliary and containment buildings.

The licensee used contract HP supervisors for steam generator and auxiliary building work. The licensee contracted with approximately ten supervisors and one hundred ANSI qualified HP technicians to provide for outage surveillance and control activities. In areas where the licensee did not have utility employee supervisors, the licensee tries to place experienced ANSI qualified licensee HP technicians to control work. The licensee also used contract technicians and clerical help in the HP support units.

Through interviews with licensee representatives, the inspector determined that the licensee had used approximately 180 contract HP support personnel during previous outages. During the Unit 1 Cycle 3 outage, the licensee had reduced the number of contract support personnel by 10 percent and was planning to have 15 fewer contract support personnel during the Unit 2 Cycle 2 refueling outage. These reductions were being made in the licensee's radiation protection staffing levels in an effort to reduce utility expenses. Licensee representatives, in the HP section, reported that the reductions in outage staffing levels had not adversely affected the licensee's ability to implement the radiation protection program. Except as noted in Paragraph 2.c. and 4 of this report, the inspector found that appropriate radiological controls were being implemented with this reduced staffing level.

No violations or deviations were identified.

b. Licensee Audits

Technical Specification (TS) 6.11 requires that procedures for personnel radiation protection be prepared consistent with the requirement of 10 CFR 20 and be approved, maintained, and adhered to for all operations involving personnel radiation exposure.

Catawba Nuclear Station (CNS) Directive 3.8.3, Contamination Prevention, Control and Decontamination Responsibilities, Revision 24, dated November 29, 1988, requires in Section 4.6.2.2 that personnel perform a survey for contamination when leaving a radiation control area (RCA). If frisking just the hands and feet, a minimum frisk of 40 seconds is required.

CNS Directive 3.8.6 (TS), Radiation Exposure Control, Revision 17, dated November 21, 1988, requires in Section 2.7 that all individuals complete a Daily Exposure Time Record Card (DETRC) for each entry into the RCA/radiation control zone (RCZ) and each change of radiation work permit (RWP).

The inspector reviewed licensee Quality Assurance (QA) Surveillance Audit CN-88-34 which was conducted December 5-9, 1988. The surveillance reported the following radiological control findings on January 27, 1989.

(1) Employees were exiting an RCA from areas that are not normal exit points (i.e., back door of Auxiliary Building, elevation 594' and Unit 1 Control Room location).

(2) Hand held items were not being frisked.

(3) Dose cards were not being completed for each entry/exit of RCA (mostly at Unit 2 entry/exit point).

(4) A HP Technician (Vendor) was reaching into the RCZ and performing work without being dressed in accordance with the RWP.

As a result of the findings, the licensee terminated the vendor HP technician that had violated the RWP requirements. The Station Health Physicist also issued a letter to station management concerning the audit. The letter, Intrastation Letter to Group Superindendents and Section Heads, issued December 29, 1988, addressed radiation protection practices relative to the QA Surveillance Audit CN-88-34. The letter, in part, discussed the following conditions:

- Employees were observed exiting the RCA at points other than the Single Point Access (SPA). The exit points observed did not meet procedural requirements for emergency conditions or escorting of material. One observed exit at the Material Control Point did not include the required hand and foot frisk. Several exits were discovered to be into and out of the Control Room using the Unit 1 side access, as well as the access door to the ventilation equipment room. Both doors were clearly marked as not being an exit and, in addition, did not have any frisking equipment.

- A similar situation was discovered by HP when personnel were detected exiting at the 560' elevation below the SPA. This exit also had no frisking equipment available. This door was clearly marked as not being an RCA exit. These persons were challenged and given proper instruction.

- Frisks of hand held items were observed to be inadequate (not frisked at all or frisked too fast). Many of these observations were made at the Unit 2 Control Room entrance/exit.

- Dose cards were not completed for each entry/exit from the RCA. Most of these observations also occurred at the Unit 2 Control Room extrance/exit. For these observations, the individual was identified by the auditor, and dose card records were audited the next day and no dose record was available.

- A contract HP technician was observed reaching into an RCZ and performing work without meeting dress requirements. HP action was to terminate the individual immediately.

In addition, the licensee issued a CNS Radiological Protection Practices Training Package as an attachment to the letter. The training package was prepared for section supervisors for use in crew tailgate meetings. The report findings of hand held items not being frisked and dose cards not being completed for each exit of the RCA in accordance with the above requirements were recurring examples of

the earlier violation issued in Inspection Report (IR) No. 50-413, 414/87-31.

c. Management Controls and Corrective Action

10 CFR 50, Appendix B, Criterion XVI states that measures shall be established to assure that conditions adverse to quality, such as deviations and nonconformances, are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

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

CNS Directive 3.8.3, Contamination Prevention, Control and Decontamination Responsibilities, Revision 24, dated November 29, 1988, requires in Section 4.6.2.2 that personnel perform a survey for contamination when leaving the RCA. If frisking just the hands and feet, a minimum frisk of 40 seconds is required.

CNS Directive 3.8.6 (TS), Radiation Exposure Control, Revision 17, dated November 21, 1988, requires in Section 2.7 that all individuals complete a DETRC for each entry into the RCA/RCZ and each change of the RWP.

IR No. 50-413, 414/87-31 documented the results of an inspection made September 14-18, 1987. A Severity Level IV violation (50-413, 414/87-31-02) was issued for failure to adhere to radiological control procedures in that:

(1) From September 14 to September 17, 1987, ten of twelve individuals observed frisking at the RCA access/exit point located at the top of the spiral stairway on the 609' elevation, frisked for only 20-25 seconds and;

(2) Two individuals who worked inside an RCA/RCZ on the removal, repair, or replacement of a detector in the Unit 1 Reactor Building on August 24, 1987, did not complete a daily dose card as required.

On November 17, 1987, the licensee responded to the violation issued in IR No. 50-413, 414/87-31 for violation 87-31-02. The NRC reviewed the licensee's proposed corrective action and determined that the proposed corrective action was not sufficient to prevent recurrence, and a supplemental response was received dated December 11, 1987, and with clarification, it was accepted in an NRC letter dated January 15, 1988.

On December 10, 1987, the NRC issued IR No. 50-413, 414/87-40. In Paragraph 7 of the report, the inspector reported numerous examples of personnel failing to perform personnel monitoring in accordance with licensee procedures. The Notice of Violation described a failure to properly store contaminated tools and post a copy of a previous Notice of Violation.

On April 7, 1988, the NRC issued IR No. 50-413,414/88-12 for an inspection made on February 22-26, 1988. In Paragraph 4.f of the report, the inspector reported on discussions held with licensee representatives concerning the uses and limitations of the personnel Single Point Access (SPA). Licensee representatives indicated that they were still evaluating the adequacy of the SPA in minimizing the potential of low level contamination leaving the RCA. The inspector noted that the HP technician nearest to the area was located one level above and could only be reached by telephone. The tools/equipment frisking station was also located one elevation above the exit. Some individuals were confused about whether items frisked at the tools/equipment frisking station must be frisked again at the SPA. Licensee representatives acknowledged the inspector's comments and agreed to evaluate equipment release practices.

The inspector noted that the signs regarding personnel monitoring in the men's change room, next to friskers indicated that the friskers were there for "convenience". Licensee representatives had indicated that personnel contamination surveys were "required" in the change rooms when personnel had been working in contaminated areas. Licensee representatives indicated that they would reevaluate the adequacy of the signs.

On September 16, 1988, the NRC issued IR No. 50-413, 414/88-27, documenting a violation involving the failure of operations personnel to follow radiological control procedures on two occasions during responses to stop leaks in radioactive systems. The report also documented the licensee's failure to take full corrective action for violation 50-413, 414/87-31-02.

The licensee's response to these violations indicated that an immediate program of HP SPA routine observations would be implemented to improve compliance with the frisking and dose card requirements and they would be in full compliance on March 1, 1988. However, as of July 19-22, 1988, the program of routine observations had not been implemented. The inspector noted that this was the second time in as many inspections that the licensee had failed to meet all aspects of their commitments to the NRC by the date established by the licensee.

The cover letter for the September 16, 1988 NRC report discussed the licensee's failure to take full corrective actions on the violation 50-413, 414/87-31-02, and for another violation 50-413, 414/87-40-03, The cover letter stated that the NRC views failure to take full corrective action on these radiological safety as a serious matter.

On October 28, 1988, the licensee issued their response to the Severity Level IV violation issued in IR No. 50-413, 414/88-27 which included, management audit of several new records at Catawba such as:

- HP Problem Reports
- Dose Card Error Reports
- Single Point Access Logbook
- Radiological Incident Investigations

The licensee also discussed continuing management involvement in ALARA training and pre-outage meetings and that hand and foot monitors had been purchased and placed in service throughout the plant. The licensee reported that whole body friskers had been purchased and would be delivered in late 1988.

The licensee addressed the corrective action associated with the hot tool room procedure violation discussed in IR No. 50-413, 414/87-40.

The licensee listed these corrective actions for the root cause of the problems:

> Organizational changes were made which allowed the technical and work execution aspects of the maintenance group to be separated. A new position was created that would separate the technical and executional aspects of a job. The licensee stated that "with better job planning packages available, the execution crews can now devote full attention to procedures, training, and improving performance."

The inspector attempted to verify completion of corrective action for violation 50-413, 414/87-31-02. However, during the inspection, as detailed in Paragraph 2.b, the inspector noted a QA Surveillance made in December 1988, which documented additional examples of failure to perform contamination frisks in accordance with licensee procedures and failure to complete daily dose cards in accordance with licensee procedures.

These findings by the licensee are additional examples of failure to follow procedures and indicate a failure to take adequate and timely corrective action sufficient to preclude recurrence of a similar violation cited on September 16, 1988. Failure to take adequate and timely corrective action is therefore, a violation of 10 CFR 50, Appendix B, Criterion XVI (50-413/89-02-01).

One violation was identified.

3. Outage Planning and ALARA Activities

10 CFR 20.1.c states that persons engaged in activities under licenses issued by the NRC should make every reasonable effort to maintain radiation exposures ALARA. The recommended elements of an ALARA program

radiation exposures ALARA. The recommended elements of an ALARA program are contained in Regulatory Guide 8.8, Information Relevant to Ensuring That Occupational Radiation Exposure at Nuclear Power Stations will be ALARA, and Regulatory Guide 8.10, Operating Philosophy for Maintaining Occupation Radiation Exposures ALARA.

a. ALARA

The inspector reviewed the licensee's program for maintaining occupational exposures ALARA, including the station's ALARA goals and objectives, the effectiveness in setting and meeting ALARA goals, participation by different station groups in the ALARA program, and the functions of the onsite ALARA group.

The licensee's ALARA goal for 1988 was 552 person-rem. The goal was based on the licensee's task schedule for the year and the licensee's person-rem exposure history for the planned work. The integration scheduling staff provided the ALARA group with a list of planned tasks. The ALARA group reviewed the job history files and established an ALARA package for jobs which are expected to exceed one person-rem exposure. The ALARA packages included detailed job dose reduction recommendations, copies of RWPs, surveys, and other information obtained in previous work experience for the job. The inspector reviewed selected ALARA planning packages and determined that dose exposure reductions were being made through in depth planning and application of basic ALARA techniques.

Through interviews with licensee representatives, the inspector determined that the ALARA group had solicited comments and dose reduction recommendations from section supervisors on the 1988 exposure estimates and that only one supervisor had commented on his section's estimated exposure for the year. The remaining supervisors reported that the person-rem estimate determined by the ALARA group appeared appropriate. In general, the ALARA group set the annual goal based on their estimates and there was very little input from the plant staff supervisors to further reduce exposures.

The licensee exceeded its 1988 person-rem goal by approximately four person-rem. The licensee's 1988 ALARA goal of 552 person-rem was the 1988 person-rem estimate. While the licensee demonstrated an ability to accurately project work and implement ALARA techniques to maintain personnel exposures ALARA, the input from section supervisors on methods to further reduce exposures was minimal. However, the 278 person-rem totals per unit were low for a facility having portions of two refueling outages during the year.

The inspector attended an outage planning meeting which included key licensee staff personnel, representatives from Turkey Point, and corporate staff personnel. The meeting agenda included an open discussion on lessons learned during the Unit 1 refueling outage and plans for the upcoming refueling outage. Discussion topics included

improving worker efficiency, use of mockup training equipment, preparation of equipment, improved communications, shielding, limitations on overtime, training, and exposure reduction activities. The inspector observed a free exchange of information in a spirit of cooperation to improve work objectives.

The inspector reviewed the following licensee procedures.

ALARA Manual, Revision 3

Maintenance Management Procedure 1.9, CNS ALARA Planning, dated July 21, 1988

CNS Directive 3.8.1 (TS) ALARA Program, dated August 21, 1988

No violations or deviations were identified.

b. Provisions

Through interviews with licensee representatives the inspector determined that the licensee had established resources to support the outage. such as protective clothing, respirators, radiation warning signs, etc. and had the ability to borrow supplies or equipment from the utility's other nuclear facilities.

No violations or deviations were identified.

c. Training and Qualifications of Vendor Health Physics Technicians

TS 6.3 requires that each member of the facility staff meet or exceed the minimum qualifications of ANSI N18.1-1977 for comparable positions, except for the Radiation Protection Manager, who shall meet or exceed the qualifications in Regulatory Guide 1.8, September 1975.

TS 6.4.1 states that a retraining and replacement training program for the facility staff shall be in accordance with ANSI N18.1-1971. Paragraph 5.5 of ANSI N18.1 states that a training program shall be established which maintains the proficiency of the operating organization through periodic training exercises, instruction periods, and reviews.

The inspector reviewed plant procedure HP/O/B/1000/19, Vendor Health Physics Technician Training/Qualification, Revision 0. The inspector determined that the procedure provides specific guidance for evaluating the previous work experience of vendor HP technicians in order to comply with the ANSI N18.1-1971 requirements. The procedure also specifies the training requirements necessary to meet the requirements of TS 6.4.1.

No violations or deviations were identified.

4. High Radiation Area Control Event

10 CFR 19.12 requires a licensee to provide certain specified information and instructions to individuals who work in or frequent any portion of a restricted area.

10 CFR 20.203(c)(1) requires a licensee to post each high radiation area with a conspicuous sign or signs bearing the radiation caution symbol and the words: CAUTION HIGH RADIATION AREA. A "high radiation area" is defined in 10 CFR 20.202(b)(3), as any area, accessible to personnel, in which there exists radiation, originating in whole or in part within licensed material, at such levels that a major portion of the body could receive in any one hour a dose in excess of 100 millirems.

TS 6.12 requires that, for individual high radiation areas accessible to personnel with radiation levels of greater than 100 mR/hr that are located within large areas, such as pressurized water reactor (PWR) containment, where no enclosure exists for purposes of locking, and where no enclosure can be reasonably constructed around the individual areas, that individual area shall be barricaded, conspicuously posted, and a flashing light shall be activated as a warning device.

NRC Information Notice (IN) No. 88-79: Misuse of Flashing Lights for High Radiation Area Controls, was issued on October 7, 1988. The Notice was issued to all holders of operating licenses for nuclear power reactors. The purpose of the Notice was to alert addressees to problems involving misuse of flashing lights for high radiation controls. The Notice discussed five events involving improper access control of high radiation areas. As discussed in the Notice, inappropriate use of such access controls could lead to potentially significant, inadvertent, radiation exposures. Additionally, the Notice stated that it was apparent that plant workers and supervisors did not fully understand the TS requirements for high radiation access control.

During the inspection the inspector determined that on December 16, 1988, two employees apparently entered a high radiation area unknowingly. One of the two employees was assigned to the Catawba mechanical maintenance staff and the other was a construction maintenance department (CMD) employee based at the Oconee facility on site to support the Unit 1 outage.

The inspector reviewed the HP Investigation Data sheet which described the event and the written statement of the event prepared by the Catawba worker. According to the worker, the employees entered lower containment after reviewing RWP No. 88-919 and after discussing their work with a HP representative. The two employees were going to perform preventive maintenance (PM) on several limitorque operators.

According to the worker's statement, he asked the HP technician if a respirator would be required for entry and was told that respirators would not be required for the planned work. The workers checked in with the HP

rover for permission to enter lower containment and were told to proceed. The employees climbed down a ladder into lower containment to work on their first valve. After completing work on the first valve the workers crossed over an airduct and up some scaffolding to the second limitorque operator. As the men began their paperwork, they were interrupted by HP personnel monitoring the B and C steam generator platform and told that they were in a respirator required area and a high radiation area. The HP technician told the men to exit the platform area which had a flashing yellow light. The workers exited containment, were surveyed, and found to be free of external contamination. One worker received only 10 mrem whole body exposure while the second worker received 30 mrem whole body exposure for the entry. An air sample taken on the platform did not indicate any airborne radioactive material on the steam generator platform.

The Catawba worker reported in his write-up of the event that they had not crossed any identified rope or signs in getting to the platform from above. The worker also stated that he was unaware of the significance of a flashing yellow light. The HP Investigation Data sheet also documented that the licensee workers had entered the platform area from above and that the workers did not know the significance of the flashing yellow light.

The immediate steps taken to prevent recurrence of this type of event was to post the access taken by the workers as a high radiation area. The long-term steps taken to prevent recurrence was to proceduralize the posting of the area. The inspector determined that the dose rate on the platform was 500 mrem per hour (mr/hr) beta and 500 mr/hr gamma at the cold leg side of the generator. The dose rate was approximately 35 mr/hr four feet from the manway. The gamma dose rate twelve inches from the manway was 300 mr/hr gamma.

Through interviews with the General Employee Training (GET) supervisor, the inspector determined that the Catawba worker had taken bypass training for the last four years and that the use and meaning of yellow flashing warning lights was not included in the bypass training. The inspector contacted the resident inspector at Oconee and determined that, for the CMD employee based at Oconee, the bypass training there also did not include training on the use and significance of flashing yellow lights.

Failure of the licensee to provide adequate training for employees concerning the significance of flashing yellow lights and failure of the licensee to post accessible areas of a high radiation area in accordance with the requirements of 10 CFR 20.203(c)(1) are examples of a violation of NRC requirements of 10 CFR 19.12 requiring the licensee to provide information and instructions to workers (50-413, 414/89-02-02). This violation is similar to a violation concerning training cited in a Notice of Violation issued September 16, 1988, and could reasonably be expected to have been prevented by previous corrective action.

One violation was identified.

5. Licensee Action on Previous Enforcement Matters (92702)

(Open) Violation 87-31-02: Failure to adhere to radiological control procedures for personnel contamination monitoring and completion of daily dose cards. The item will remain open since previous implementation of licensee corrective actions had not been adequate. This was exemplified by a licensee audit conducted in December 1988, which reported findings concerning persons exiting the RCA from areas that were not normal exit points, hand held items not properly surveyed, dose cards not being completed for each entry and exit portal, and a contract HP technician reaching in a RCZ and performing work without being dressed in accordance with the RWP.

6. Exit Interview

a. Inspector Comments

The inspection included a review of selected QA Surveillances, Outage Planning and the ALARA program for control of radiation exposures. Through review of representative records and discussions with licensee representatives the inspector reviewed the licensee's planning, preparations, and management support for implementing the radiation protection program during outages.

- The inspector discussed staffing levels for the outage and determined that due to budget restraints the licensee had completed the Unit 1 outage with fewer HP vendor technicians than previously utilized. Licensee representatives reported that adequate radiation protection controls were maintained even with the reduced staff during the outage.

- The inspector reviewed licensee's utilization of special training including use of mockup training.

- The inspector discussed the licensee's methods for ensuring adequate supplies were available to support outage activities.

- The inspector reviewed selected ALARA work packages and determined that the licensee was taking steps to reduce exposures by clearly defining job sequences and taking measures to improve worker efficiency and lowering personnel exposures.

- The inspector reviewed selected documented which demonstrated that numerous ALARA pre-job planning and post job meetings were taking place to ensure that persons were adequately prepared for upcoming work and methods for improving the tasks were being evaluated.

- The inspector discussed management support for the radiation protection program including the purchase of additional personnel monitors (hand and foot) which were installed and in

use. Whole Body Friskers had been purchased and the licensee had initiated the installation of whole body friskers during the inspection which should enhance personnel monitoring capabilities.

- The inspector reviewed the licensee's GET program and determined that the instructors were adequately qualified and that lesson plans were well documented. The inspector determined that the licensee could provide the general employee training during the peak periods prior to outage start dates.

The inspector determined that the licensee had an adequate training program for vendor HP technicians.

b. Inspection Findings

The inspector discussed violation 50-413, 414/87-31-02 issued October 19, 1987, for failure to adhere to radiological control procedures for personnel contamination monitoring and completion of daily dose cards. The item will remain open since previous implementation of licensee corrective actions had not been sufficient.

The inspector stated that procedure violations in personnel monitoring had been documented in the recent radiation protection inspections. The previously identified violations and those documented in the licensee's audit report will be reviewed by Region II management for the need to consider additional enforcement actions. The item was left as an unresolved item (URI)*.

Upon review by Region II staff, the licensee's failure to take timely corrective actions of radiological protection violations to preclude recurrence was identified as a violation of 10 CFR 50, Appendix B, Criterion XVI 50-413, 414/89-02-01 (Paragraph 2.c).

During the inspection, the inspector determined that on December 16, 1988, two licensee employees had unknowingly entered a respirator and high radiation area established for steam generator work. The area was monitored by a video system and HP personnel took action to remove the employees from the area. The inspector reviewed the radiological investigation sheet and the written account of the event. According to one of the employees they had not crossed any high radiation or respirator required boundaries until approached by HP personnel. The employees had noticed a flashing yellow light but claimed that they did not know the significance of the light. The inspector determined that the employees did not receive any internal contamination, external contamination, or significant external exposure. The inspector stated that there appeared to be a violation

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

for inadequate GET since neither employee claimed to know the significance of flashing yellow lights and/or failure of the licensee to adequately post a high radiation area. The inspector stated that the event would be discussed with Region II staff following the inspection.

The NRC has determined that there were two violations; one for failure to adequately post a high radiation area in accordance with the requirements of 10 CFR 2.203(c)(1) and one for failure to provide adequate training for individuals who work in or frequent a restricted area. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspector during this inspection. The inspector expressed his appreciation for the staff cooperation during the conduct of the inspection.