

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *G. Creighton, Senior Regulatory Specialist
- *O. Fraser, Quality Assurance Site Manager
- *L. Gucwa, Manager, Nuclear Engineering and Licensing, Corporate
- *W. Kirkley, Acting Manager, Health Physics and Chemistry
- *H. Nix, General Manager
- *R. Ott, Supervisor, Health Physics/Chemistry Training
- *D. Smith, Superintendent, Health Physics
- *L. Summer, Plant Manager
- *R. Zavadoski, Manager, Health Physics and Chemistry

Other licensee employees contacted during this inspection included craftsmen, engineers, operators, and office personnel.

Nuclear Regulatory Commission

- *J. Menning, Senior Resident Inspector
- *R. Musser, Resident Inspector

*Attended exit interview

2. Management Controls

a. Organization and Staffing

The present HP staffing levels utilized to provide coverage during outage activities were discussed with licensee representatives. Currently the licensee has approximately 64 permanent HP technicians, that is, 22 senior and 32 Level II ANSI qualified technicians, and 5 Level II and 5 Level I non-ANSI qualified technicians. Two HP supervisors, supporting the Operations HP group functions, report directly to the HP Superintendent. Approximately 11 persons are assigned to HP support functions. In addition to the site's permanent HP personnel, the licensee has added approximately 110 temporary contract personnel including 70 senior and 19 junior level technicians, and 21 computer terminal operators for support during the current outage.

The contract HP technician orientation and training program was reviewed and discussed with cognizant licensee representatives. Facility building locations, plant systems, high radiation/contamination areas, instrumentation, and selected facility procedures and policies are reviewed during the three day training program. A written examination of the presented material is

administered with grades of 80 percent (%) and 70% required by ANSI qualified Senior and Junior technicians, respectively, to demonstrate satisfactory understanding of the material. Review of test records for the current outage indicated that 91 of 94 personnel, including the HP technicians, who completed training successfully passed the test.

The HP training program for the permanent technicians also was reviewed during the inspection. The program consisted of a five week classroom session of math and science followed by a written test, an applied session concerning job coverage and procedures, and on-the-job experience in plant programs such as radwaste, respiratory protection, and dosimetry. Trainees are permitted two opportunities to demonstrate knowledge of classroom material, score 80% or greater on a written examination, while the applied and on-the-job training performance are observed and evaluated by knowledgeable facility personnel. An ALARA training program currently is being developed and is scheduled for completion by January 1, 1989. The inspector informed licensee representatives that this program will be reviewed during subsequent inspections.

During the inspection, the ability of the HP staff to support job coverage was discussed with licensee management and contract workers. Licensee representatives stated that staffing was adequate to provide coverage for all outage activities. For selected high dose rate jobs, coverage was provided on an individual basis. Other work was provided HP coverage by HP personnel assigned to a specific area. From discussions with selected workers, including temporary craftsmen, and direct observations of work in progress, the inspector noted that HP coverage of work activities appeared adequate. Workers indicated that HP technicians were readily available and assisted in reading personnel monitoring devices and providing surveys for selected outage activities. At the time of the inspection, technicians were working six, twelve hour shifts to provide coverage for major drywell activities. Following completion of the major outage job activities, scheduling was expected to return to a five day, twelve hour shift rotation.

No violations or deviations were identified.

b. Management Controls

The inspector reviewed and discussed the use of deficiency cards and quality assurance (QA) audits to identify radiation protection issues during outage activities. Procedural controls for appropriate review and management involvement in radiation protection issues identified by deficiency card and QA audit findings detailed in Inspection Report (IR) Nos. 50-321, 366/87-27 remained in effect during the current inspection.

Deficiency card reports issued from September 1, 1988, the start of Unit 1 outage activities, through November 1, 1988, regarding HP concerns were reviewed. Approximately 2,100 deficiency reports were issued, 1,600 for Unit 1 and 500 for Unit 2. Of the total deficiency cards submitted during the period reviewed, approximately 40 (2%), related to radiological issues. The majority of personnel radiation protection issues identified included failure to follow HP procedures during entry into high radiation areas, failure to wear thermoluminescent dosimeters (TLDs) in the drywell, improper dressout and the improper transfer and monitoring of equipment removed from contaminated areas. The inspector verified that management review and subsequent corrective actions were in progress or completed in accordance with plant procedures for the issues having potential radiological safety and/or regulatory significance. Pursuant to 10 CFR 2, Appendix C.V.A., these issues were considered licensee identified violations (LIVs) and a Notice of Violation (NOV) was not issued due to the violations being (1) licensee identified, (2) severity level IV or V, (3) not reportable, (4) corrected, and (5) not expected to be preventable by corrective action for a previous violation (50-321/88-35-01).

The use of deficiency cards to identify trends regarding poor radiation protection practices was discussed with cognizant licensee representatives. The inspector noted and discussed the following issues for the current outage: many of the doses expended per job or radiation work permit (RWP) exceeded the projected man-rem estimates for job completion; licensee management granted numerous administrative dose extensions for contractor personnel; workers personally had approached the inspector about high doses received while performing selected job activities; and the number of personnel contamination events remained elevated relative to previous identification of the problem (IR 50-321, 366/88-18). However, no remarks reflecting ALARA concerns, for example, excess dose rates and/or time in areas, training concerns, and only one personnel internal contamination event, were noted in the deficiency reports reviewed. Licensee representatives stated that doses expended, issues regarding excess rework being conducted for selected job activities, and personnel contamination reports were reviewed by management. Licensee management stated that, the need to improve performance in these areas was being stressed to workers through various instructions and meetings, although the actions and responses were not tracked as would be required by the deficiency reporting system.

QA audits of personnel radiation protection, radwaste control, and transportation activities associated with the outage activities were discussed. Licensee representatives stated that audit activities increasingly were directed to observation of work in progress rather than document review. The inspector reviewed a previous audit of Unit 2 HP outage activities, QA Audit of the Health Physics Program, dated March 11, 1988. Identified weaknesses included, an inadequate

radiological survey, air sampling representativeness, and contaminated materials found outside of the radiologically controlled area (RCA). Although not reviewed by the inspector, licensee representatives stated that all corrective actions had been completed. The inspector noted that reviews of the site's ALARA programs during the outage had not been included in the audit.

At the time of the inspection, no audit of the current Unit 1 outage HP activities had been conducted, however, licensee representatives stated that an audit of radiation protection activities was scheduled to begin November 7, 1988, and would include outage work. Scheduled review topics included ALARA, dosimetry, respiratory protection, contamination control, radiation surveillances, RWPs, and data analysis. Following discussion between NRC and licensee representatives regarding the unanticipated elevated person-rem expended during the reactor water cleanup (RWCU) pipe replacement during this outage and associated radiation protection issues identified during the current NRC inspection, the licensee stated that increased emphasis regarding ALARA issues and concepts at the facility would be reviewed during the audit. The inspector informed licensee representatives that this audit would be reviewed during subsequent inspections and would be tracked as an inspector followup item (IFI) 50-321/88-35-02.

3. Training and Qualifications (83723)

10 CFR 19.12 requires the licensee to instruct all individuals working in or frequenting any portion of the restricted area in the health protection aspects associated with exposure to radioactive material or radiation, in precautions or procedures to minimize exposures, and in the purpose and function of protective devices employed, applicable provisions of Commission regulations, individual responsibilities and the availability of radiation exposure data.

10 CFR 20.103(c)(2) requires that the licensee maintain and implement a respiratory protection program that includes determination by a physician prior to initial use of respirators that the individual user is physically able to use respiratory equipment.

General employee training (GET) received by contractor craftsmen conducting RWCU pipe replacement was reviewed and discussed with the craftsmen and cognizant licensee representatives. The use of videotapes to provide dressout information has been increased and appeared to have improved worker awareness and improved dressout techniques during the current outage. All craftsmen interviewed stated that the provided GET was adequate concerning radiation protection issues. The inspector verified through record review and discussion with selected craftsmen that GET training, respiratory fit testing, and medical qualifications were complete for individuals entering the drywell to conduct various tasks.

A recent NRC inspection (IR 50-321, 366/88-31) identified deficiencies concerning the performance of craftsmen in completing welds on RWCU pipe in the drywell. From discussion with cognizant licensee HP representatives, the inspector determined that HP staff input was minimal in conducting "hands on" training prior to the craftsmen performing welds for the actual job conditions. The inspector reviewed mockup training conducted for welders involved in the RWCU pipe replacement task. Training was conducted in an unconfined space and the participants were not required to utilize the full complement of protective equipment necessary, that is, only gloves and a face shield and respirator (lacking a cartridge) were worn. The inspector noted that for adequate training, conditions should be as representative, as much as practicable, of the field situation. The inspector noted that the significant differences between the training and field situation may have contributed to the poor quality of welds resulting in excess rework and the initially unexpected expenditure of time in high dose rate areas. Licensee representatives stated that the adequacy of the training programs would be reviewed in detail in regard to ALARA considerations. The inspector informed licensee representatives that the training program requirements to prepare craftsmen for actual field conditions would be reviewed during a subsequent inspection and would be tracked as IFI 50-321/88-35-03.

No violations or deviations were identified.

4. External Exposure (83723)

10 CFR 20.101 requires that no licensee shall possess, use, or transfer licensed material in such a manner as to cause any individual in a restricted area to receive in any period of one calendar quarter a total occupational dose in excess of 18.75 rems to the hands, forearms, feet, and ankles.

In October 1987, the licensee initiated the use of wrist mounted TLDs to monitor extremity exposure when requested for personnel conducting specific activities at the facility. Prior to October 1987, all extremity exposures were conducted using finger ring TLDs. Licensee representatives informed the inspector that the rationale for the change was to decrease the frequency of losing the finger ring dosimetry when removing protective clothing while still using dosimetry acceptable to provide accurate extremity dose measurements. When the change was initiated, the licensee had not conducted any studies to verify the adequacy of the wrist mounted dosimeters to monitor extremity exposure. Beginning April 1988, the licensee reinitiated the use of finger ring TLDs and began a comparative study of extremity exposure measured by finger ring and wrist mounted TLDs for selected jobs at the facility.

The inspector reviewed the July 1, through September 30, 1988, tabulated data for the comparison study. In general, the ratio of measured extremity dose, that is, finger ring to wrist mounted dosimetry results, ranged from two or three to one. No definite trends in the ratios were identified for the selected tasks reviewed. The most significant

differences in dose measurements involved refueling activity, RWCU pump inspection, control rod drive maintenance, and fuel pool diving activities. The licensee stated that the comparative study was continuing. The inspector noted that this issue was identified previously as IFI 50-321/88-16-01 and would remain open subject to the licensee's final decision regarding use of the wrist dosimetry.

10 CFR 20.101(b) requires that during any calendar quarter the total occupation dose to the whole body shall not exceed three rems and the licensee shall determine each individual's accumulated occupational dose to the whole body on Form NRC 4.

The inspector discussed doses received by personnel involved in the RWCU pipe replacement task and the number of personnel being granted dose extensions above the site's administrative limit of 1.25 rem per quarter. The inspector reviewed the daily printout of site personnel dose as measured by self-reading dosimeters (SRDs) and reviewed NRC Form 4's for selected personnel. No individuals exceeded the regulatory limits and all appropriate NRC Form 4's were complete and filed. The inspector noted that from October 1 through 30, 1988, more than 350 persons were granted whole body dose extensions, twelve of which were above two rem for the quarter. In addition, the majority of extensions greater than two rem whole body were granted to personnel performing or supporting activities on the RWCU pipe replacement. At the time of the inspection, cognizant licensee personnel had not determined if the numbers and degree of extensions were comparable to those granted during outages having similar job scope.

No violations or deviations were identified.

5. Internal Exposure Control and Assessment

10 CFR 20.103(a)(1) requires that no licensee shall possess, use, or transfer licensed material in such a manner as to permit any individual in a restricted area to inhale a quantity of radioactive material in one calendar quarter greater than the quantity which would result from inhalation for 40 hours per week for 13 weeks at uniform concentrations of radioactive material in air specified in Appendix B, Table I, Column 1.

10 CFR 20.103(b)(1) requires that the licensee use process or other engineering controls to the extent practicable to limit concentrations of radioactive materials in the air to levels below those which delimit an airborne radioactivity area as defined in 10 CFR 20.203(d)(1)(ii).

The inspector discussed with licensee representatives and reviewed internal personnel contamination event records associated with the outage. Licensee representatives stated that only one incident had potential for internal contamination of workers. A licensee personnel contamination report indicated that on October 7, 1988, an employee while cleaning stud bolts on the inside of the Unit 1B Main Steam Isolation Valve (MSIV) outboard valve became contaminated. The contamination initially was

detected when the worker exited the drywell and performed a routine whole body frisk at the Unit 1 dressout trailer on October 8, 1988, at approximately 1:30 a.m. Contamination was measured by an HP-210 probe, indicated approximately 2,000 disintegrations per minute per probe area (dpm/area) and 10,000 dpm/area, on the torso and face, respectively. A HP technician assisted the employee in decon activity, completed a Personnel Contamination Report (PCR), and escorted the worker to the Dosimetry Office for a whole body count. A whole body count was conducted as required by procedure due to the level of facial contamination. From approximately 2:30 a.m. until 6:00 a.m. on October 8, 1988, the employee showered several times and was subjected to whole body analyses after each shower. Whole body counts continued on October 9, 1988, and were stopped subsequent to determination of no positive results on October 10, 1988.

The inspector reviewed and discussed the worker's estimated exposure and licensee's incident evaluation based on the maximum body burden measured by whole body analyses. Using International Congress of Radiation Protection (ICRP) II methodology, the licensee estimated an exposure of 12 maximum permissible concentration-hours (MPC-hrs) for the exposed worker. In addition, licensee representatives determined a total dose to the gastro-intestinal (GI) tract for the isotopes identified, that is, Cobalt-60, Zinc-65, and Zirconium/Neobium-95, of approximately 47 millirem (mrem) to the GI tract and 2 mrem to the lung. The inspector noted that the licensee's calculation appeared adequate and that no regulatory limits were exceeded. Although the licensee's evaluation of the event was not complete at the time of the inspection, the preliminary cause of the contamination was stated to be the worker's failure to follow the applicable RWP for the scope of the job attempted. The contaminated worker and an assistant had signed-on RWP 188-0911, which required a full-face respirator only when breaking into a contaminated system rather than RWP 188-0951, which required a full face respirator throughout the job. The inspector noted that the assistant was not contaminated during the incident. Licensee corrective actions included a critique with the involved workers and their supervisor, a requirement for HP technicians to observe RWP requirements and job initiation, a review of training provided and the reemphasis of worker responsibility to follow appropriate RWPs. Licensee representatives stated that the final incident report was due on November 11, 1988. The inspector informed licensee representatives that this issue would be considered a LIV and a NOV would not be issued at this time (50-321/88-35-04).

6. Control of Radioactive Materials and Contamination, Surveys and Monitoring (83726)

a. Survey Instrument Performance Checks

The inspector verified that the daily performance checks for RM-14 instrumentation were performed as detailed in HP Instrumentation Procedure, 62HI-OCB-016-OS, Radiation Monitor RM-14 Operation and Calibration, Rev. 2, dated May 9, 1988. In addition, the licensee stated that data were still being collected as detailed in Special

Purpose Procedure 62-SP-040788-YL-101N, dated April 26, 1988, to provide a data base regarding the necessary frequency for radioactive source checks of the monitoring instrumentation, excluding the RM-14 instrumentation. Licensee representatives stated that a decision would be made in a timely manner regarding the frequency of instrument performance checks. During tours of the facility, the inspector verified that daily performance checks were being conducted for all contamination survey instrumentation as required.

No violations or deviations were identified.

b. Personnel Contamination Reports

During a previous inspection of radiation protection activities, the licensee outlined temporary changes to assess potential personnel contamination events identified at the facility. The inspector noted that procedure 62RP-RAD-004-OS, Personnel Decontamination, Rev. 4, dated June 1, 1988, detailed a flow chart and noble gas decay curve for use to logically evaluate potential contamination events. An assessment of a potentially contaminated individual included verification of monitor alarms, review of areas visited, location of the contamination of the person, and determination if changes in contamination levels follow the expected noble gas decay rate half-life of approximately 30 minutes, through time. In addition, the procedure required the completion of a PCR for all contamination events exceeding 100 cpm/probe area.

The inspector reviewed and discussed with cognizant licensee representatives the PCRs generated from January 1, through November 11, 1988. More than 1100 PCRs were generated with skin and clothing contamination representing, 30% and 70%, respectively, of the cases reported. Licensee representatives stated that recently an additional HP technician was assigned to statistically analyze and evaluate the PCR data in an effort to provide trends to be used to identify the root causes of the high rate of personnel contamination at the facility. The inspector noted the following issues during review of the licensee's personnel contamination data.

- ° Personnel contamination appeared to be widespread among personnel at the site, that is, the number of PCRs issued were similar for personnel whether wearing or not wearing protective clothing (PC).
- ° For personnel wearing PCs, contamination soaking through the cloth material onto the skin appeared as a major cause of skin contamination.
- ° For personnel not wearing PCs, the major cause of contamination was entering an unknown/unposted contaminated area.
- ° The majority of PCRs generated indicated contamination on shoes.

The inspector discussed the PCR data and suspected root causes with cognizant licensee representatives. The licensee indicated that corrective actions including the use of modesty garments beneath PCs, increased worker awareness, and increased frequency of mopping general floor areas in the RCA were being undertaken. Following the discussions, the licensee indicated that root causes and subsequent corrective actions, for example, increased cleaning to reduce contamination spread into noncontaminated areas from overhead spaces and/or adjacent areas in the RCA, were continuing to be investigated. The inspector stated that the licensee's review of this issue and the performance in reducing personnel contamination events at the facility would be reviewed during subsequent inspections.

No violations or deviations were identified.

c. Facility Tours

10 CFR 20.201(b) requires each licensee to make or cause to be made such surveys as (1) may be necessary for the licensee to comply with the regulations in this part and (2) are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present.

TS 6.8.1 requires written procedures to be established, implemented and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A, 1978, recommends written procedures for radiation surveys.

Plant Procedure, 60AC-HPX-004-OS, Radiation and Contamination Control, Rev. 5, dated August 12, 1988, requires HP to perform nonroutine radiation and contamination surveys, as required, to support operation and maintenance.

During a tour of the Hot Machine Shop (HMS) on October 31, 1988, the inspector independently measured an unmarked "Hot Spot," approximately 40 milliRem per hour (mR/hr) in a walkway located next to the southwest side of the Kelly Building. The inspector questioned why this area was not marked nor identified on the currently posted survey record when all other similar dose rate areas in the HMS were identified. Discussions with an HP technician indicated that contaminated tools and/or equipment, with dose rates of approximately 100 mR/hr, had been moved from the east to the west section of the Kelly building. The material originally was transferred to reduce the dose rates to individuals working in the east area of the HMS. The inspector noted that in addition to the contaminated tools, the west section of the Kelly building contained contaminated control rod drive filters, having dose rates greater than one rem per hour (R/hr). The inspector discussed with cognizant licensee representatives, the requirements for conducting an immediate

radiological survey to evaluate radiological hazards resulting from the changed radiological conditions. Licensee representatives stated that the timeliness of surveys was not indicated in the applicable procedure, however, HP technicians were trained to conduct surveys immediately after changing radiological conditions. Failure to perform a radiological survey subsequent to changing radiological conditions was identified as an apparent violation of 10 CFR 20.201(b) (50-321, 366/88-35-05).

7. Program for Maintain Exposures As Low As as Reasonable Achievable (ALARA)

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 exposure ALARA.

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

Administrative Control Procedure, 60AC-HPX-009-OS, ALARA Program, Rev. 1, dated April 23, 1987, established the requirements and responsibilities to ensure that occupational radiation exposure is maintained ALARA.

The inspector discussed the licensee's ALARA program in regard to the RWCU pipe replacement work during the current outage. The licensee assigned a member of the HP organization to coordinate the planning and preparation for HP activities associated with outage activities. This individual's responsibilities involved review of the task with other engineers and supervisory personnel to determine requirements for each selected task. The inspector noted that the RWCU task was reviewed and discussed in regard to ALARA concerns approximately two months prior to the start of the outage. Planning included review of HP requirements for similar jobs at the site and/or at similar boiling water reactor (BWR) facilities. Based on the hours expected to complete the RWCU pipe replacement and the expected dose rates in the general work areas, the licensee budgeted approximately 15 man-rem to the RWCU task. As of November 1, 1988, approximately 42 man-rem, had been expended as measured by SRDs.

Further discussions between licensee and NRC representatives reviewed the following details which pertain to the unanticipated man-rem expended relative to the estimated dose to be expended for the RWCU pipe replacement.

- ° The pre-outage planning was inaccurate, the hours required to complete the task was underestimated.
- ° The actual general area dose rates were similar to those expected. However, draining of a RHR pipe resulted in dose rates approximately four times higher than expected for some selected work areas. During pre-outage planning, the RHR pipe was not expected to be drained.

- ° The licensee determined that for optimum timeliness in performance of the pipe replacement and minimal dose expended, the cost-to-benefit ratio indicated shielding of the pipe was not beneficial. However, this initial determination was conducted prior to experiencing problems with the RWCU pipe welds.
- ° Time to complete the task was not reviewed and adjusted when workers performance did not meet expectations. As a result of poor and/or marginal welds, excess rework was being conducted by craftsmen.
- ° Training for the craftsmen was not conducted for simulated conditions in the drywell nor was all required HP protective clothing and equipment used during practice work on mockups (Paragraph 2).

The inspector discussed management's review and actions regarding ALARA with this job. Licensee management stated that they were aware of the unanticipated manrem expended and stopped work on approximately October 30, 1988, approximately 27 days into the job, to review options regarding the task. The inspector noted that the expended dose reached 100% of the expected value on day 18 of the job, and questioned the licensee as to what percent of measured versus expected man-rem indicated that a more formal evaluation of an on-going task should be conducted. Licensee representatives agreed that without proceduralized action levels based on comparisons of the measured to expected man-rem for each task, any actions taken could be judged as arbitrary. Licensee representatives agreed that even though doses were below regulatory limits for all workers, the timeliness and definitiveness of management actions regarding resolution of ALARA concerns regarding the RWCU pipe replacement needed improvement.

In addition, the inspector reviewed and discussed the site ALARA person-rem goal for 1988. Licensee representatives indicated that a goal of 1,060 person-rem for the year was established. As of November 3, 1988, approximately 1,200 person-rem had been expended with several high dose-intensive jobs remaining for the Unit 1 outage. Review of licensee data concerning dose expended per RWP, that is, those budgeted for 5 person-rem or more, indicated that more than 20 RWPs exceeded their estimated person-rem, ranging from 110% to approximately 3500% of the budgeted allowance. The inspector noted that the actual total person-rem expended relative to the estimated dose would be reviewed during subsequent inspections and would be tracked as IFI 50-321/88-35-06.

8. Exit Interview

The inspection scope and findings were summarized on November 3, 1988, with those persons indicated in Paragraph 1. The inspector described the areas inspected and reviewed concerns regarding the licensee's ALARA program as it related to work performed on the RWCU system. ALARA concerns included deficiencies in training craftsmen for not using simulated work conditions; timeliness of management actions regarding person-rem goals, and the high number of personnel contamination events

reported. One apparent violation concerning the failure to conduct a radiation survey in the Unit 2 Hot Machine Shop was discussed. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspector during this inspection. During a teleconference between NRC and licensee representatives on December 12, 1988, additional items concerning LIVs and two IFIs regarding training and person-rem expenditure were discussed. Dissenting comments were not received from the licensee.

<u>Item Number</u>	<u>Description and Reference</u>
50-321/88-35-01	LIVs - Miscellaneous issues identified and corrected by site deficiency card reporting system: failure to wear TLD as required; improper high radiation area entry; improper dressout; and improper transfer of material between contaminated and non-contaminated areas.
50-321/88-35-02	IFI - Review licensee audit of ALARA concerns associate with October 1988 Unit 1 outage.
50-321/88-35-03	IFI - Review adequacy of craftsmen training to simulate actual field conditions.
50-321/88-35-04	LIV - Worker failure to follow applicable RWP resulting in internal personal contamination event.
50-321, 366/88-35-05	VIO - Failure to conduct an adequate radiological survey of the Hot Machine Shop following movement of contaminated equipment.
50-321/88-35-06	IFI - Review Unit outage person-rem expended versus original estimate for outage activities.