



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION IV  
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February 7, 2003

Harold B. Ray, Executive Vice President  
Southern California Edison Co.  
San Onofre Nuclear Generating Station  
P.O. Box 128  
San Clemente, California 92674-0128

SUBJECT: NRC INSPECTION REPORT 050-00206/2003-06

Dear Mr. Ray:

An NRC inspection was conducted on January 5-9, 2003, at your San Onofre Nuclear Generating Station, Unit 1 facility. This inspection was an examination of activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspection included an examination of selected procedures and representative records, observations of activities, and interviews with personnel. The enclosed report presents the results of that inspection. Overall, the inspection determined that you are conducting decommissioning activities in compliance with regulatory and license requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

If you have any questions concerning this inspection, please contact D. Blair Spitzberg, Ph.D., Chief, Fuel Cycle & Decommissioning Branch, at (817) 860-8191 or Mr. Robert J. Evans, Senior Health Physicist, at (817) 860-8234.

Sincerely,

***/RA DBSpitzberg acting for/***

Ken E. Brockman, Director  
Division of Nuclear Materials Safety

Docket No.: 50-206  
License No.: DPR-13

Enclosure:  
NRC Inspection Report  
050-00206/2003-06

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**ENCLOSURE**

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Docket No: 50-206

License No: DPR-13

Report No: 050-00206/2003-06

Licensee: Southern California Edison Co.  
P.O. Box 128  
San Clemente, California 92674

Facility: San Onofre Nuclear Generating Station, Unit 1

Location: San Clemente, California

Dates: January 5-9, 2003

Inspector: Robert J. Evans, PE, CHP, Senior Health Physicist  
Fuel Cycle & Decommissioning Branch

Approved By: D. Blair Spitzberg, Ph.D., Chief  
Fuel Cycle & Decommissioning Branch

Attachment: Supplemental Inspection Information

ADAMS Entry: IR05000206-03-06 on 01/05/2003 - 01/09/2003; Southern  
California Edison Co., San Onofre Nuclear Generating Station;  
Unit 1. Decommissioning Report. No Violations.

## **EXECUTIVE SUMMARY**

### San Onofre Nuclear Generating Station, Unit 1 NRC Inspection Report 050-00206/2003-06

This inspection was a routine, announced inspection of decommissioning activities being conducted at San Onofre Nuclear Generating Station, Unit 1. The inspection included organization, management, and cost controls; decommissioning performance and status review; and solid radioactive waste management and transportation of radioactive materials. Overall, the licensee was conducting decommissioning in accordance with regulatory and procedural requirements.

#### **Organization, Management and Cost Controls at Permanently Shutdown Reactors**

- The licensee had an organization in place that was sufficient to conduct decommissioning activities. The licensee recently implemented a change to the organizational structure, and amendments to the Defueled Safety Analysis Report and Permanently Defueled Technical Specifications were necessary because of this change (Section 1).
- Despite a reduced Unit 1 workforce because of an operating unit outage, the operations shift crew composition met or exceeded Permanently Defueled Technical Specifications requirements (Section 1).
- The licensee implemented an employee safety concerns program that allowed interested parties to submit concerns for review. The licensee was receiving concerns and was investigating them in a timely manner (Section 1).

#### **Decommissioning Performance and Status Review at Permanently Shutdown Reactors**

- The licensee experienced a loss of power incident at Unit 1 during December 2002, but took appropriate contingency actions in response to the incident. The licensee continues to upgrade the electrical equipment that provides power to Unit 1 in an attempt to increase equipment availability and reliability (Section 2.a).
- The licensee experienced a decommissioning incident that resulted in a work stand-down. Although the licensee has experienced several personnel safety incidents during decommissioning, licensee management continued to demonstrate a strong commitment to personnel safety (Section 2.b).
- The licensee continued to have an effective As Low As Reasonably Achievable program to help minimize occupational exposures (Section 2.c).
- The licensee continued to maintain the spent fuel pool within Permanently Defueled Technical Specifications and procedural requirements (Section 2.d).

- An annual valve verification was required by the Defueled Safety Analysis Report, but the licensee deleted that requirement from the applicable procedure because it was determined that the requirement was no longer necessary. The licensee issued an action request to ascertain why a procedure change deleted the annual inspection from the procedure without a corresponding change to the Defueled Safety Analysis Report (Section 2.e).
- Site tours confirmed that radiation protection controls were in place to support decommissioning activities. Housekeeping in the radiologically restricted areas had improved since the previous inspection (Section 2.f).

#### Solid Radioactive Waste Management and Transportation of Radioactive Materials

- The licensee shipped radioactive waste for offsite disposal during 2002. Documentation indicated that the licensee had shipped the material in accordance with NRC and U.S. Department of Transportation requirements (Section 3).
- The inspector discussed a transportation incident with the licensee involving the mechanical breakdown of a truck used to ship radioactive waste from the site. The incident was not reportable to the NRC, and the load was subsequently delivered to a commercial low-level waste disposal facility without further incident (Section 3).

## Report Details

### Summary of Plant Status

San Onofre Nuclear Generating Station, Unit 1, was permanently shut down during November 1992 and was permanently defueled by March 1993. The unit remained in SAFSTOR until June 1999, when decommissioning was initiated. At the time of this inspection, the licensee was conducting decommissioning activities under the DECON option as stated in its Post Shutdown Decommissioning Activities Report dated December 15, 1998.

Work completed since the previous inspection included removal of the large components from the containment sphere, including reactor pressure vessel (RPV), three steam generators, pressurizer, and RPV head. All components, with the exception of the RPV, were shipped to a waste disposal site located in Utah during October-November 2002. The RPV was scheduled to be shipped to a disposal site in South Carolina during mid-March 2003. Other work completed included disassembly and removal of the Lampson heavy lift crane, installation of covers over the containment sphere openings (locations where the large components were removed from containment), and removal of four reheaters from the former turbine building.

Few decommissioning activities were in progress during the inspection because most personnel had been reassigned to assist with the Unit 3 refueling outage. Decommissioning activities would recommence following completion of the outage. Work planned for the near future included removal of the containment spray piping, pressurizer surge line, miscellaneous piping inside of containment, and the hydrogen recombiners.

## **1 Organization, Management, and Cost Controls (36801)**

### **1.1 Inspection Scope**

The inspector reviewed the licensee's organizational structure to ascertain whether there was sufficient staffing to support decommissioning activities. Also reviewed was the licensee's nuclear safety concern program to ascertain whether it was functioning in accordance with management directive requirements.

### **1.2 Observations and Findings**

#### **a. Organizational Structure**

The licensee's organizational structure is described in both the Defueled Safety Analysis Report (DSAR) and the Permanently Defueled Technical Specifications (PDTs). Since the previous inspection, the licensee implemented a change in the structure. Effective November 30, 2002, the former Nuclear Oversight & Regulatory Affairs Division was split into two groups, Nuclear Oversight & Assessment and Nuclear Regulatory Affairs. This reorganization impacted the Unit 1 licensing and oversight groups, but not the plant operations, health physics, and maintenance groups. As a result of the reorganization, the organizational charts provided in the DSAR were out-of-date. The licensee planned to revise the DSAR during the next routine biennial update, currently scheduled for

August 2004. The inspector concluded that supervisory and managerial level positions continued to be filled with qualified individuals dedicated to the decommissioning of Unit 1.

The inspector noted that the organizational structure was not in complete agreement with PPTS requirements. Specifically, Section 6.2.1, "Offsite and Onsite Organization," specifies that the vice president-business and financial services shall have corporate responsibility for decommissioning activities. At the time of the inspection, the vice president-engineering and technical services had that responsibility. The licensee previously issued Proposed Change Number 270 to update PPTS. The proposed change, which requires NRC approval, will bring the PPTS into agreement with the licensee's current organizational structure. Immediately after the onsite inspection, the licensee issued Action Request 030200598 to investigate why an organizational change was implemented prior to updating the PPTS. The inspector concluded that the licensee's failure to update the PPTS in a timely manner was not safety significant and was administrative in nature.

During the inspection, few decommissioning activities were in progress in Unit 1 because many workers had been temporarily reassigned to support an operating unit outage. These workers were expected to return to their duties at Unit 1 at some point in the near future. The inspector made unannounced visits to the Unit 1 control room. The number of operators on duty always met the requirements specified in PPTS Table D6.2-1, "Minimum Shift Crew Composition."

b. Employee/Safety Concerns Program Review

The nuclear safety concerns program was reviewed to determine if the program allowed employees and other individuals to voice concerns related to Unit 1 activities. The program requirements were described in the licensee's Nuclear Organization Directive D-008. The nuclear safety concerns program was a stand-alone department that reported to the vice president, engineering & technical services. The nuclear safety concerns program manager was authorized to take concerns directly to the executive vice president-generation or the executive vice president-general counsel if the issue involved other vice presidents.

Employees could submit concerns via internal mail, U.S. Postal Service mail, telephone, electronic mail, in person, or drop boxes located throughout the plant. To ensure employee awareness, the nuclear safety program issued annual "reminder" memorandums to plant personnel as well as handouts to incoming and outgoing personnel. Concerns submitted to the nuclear safety concerns group during calendar year 2002 for Unit 1 were reviewed. These concerns had been investigated by the licensee in a timely manner and corrective actions were taken, as appropriate.

1.3 Conclusions

The licensee had an organization in place that was sufficient to conduct decommissioning activities. The licensee recently implemented a change to the organizational structure, and amendments to the DSAR and PPTS were necessary

because of this change. Despite a reduced Unit 1 workforce because of an operating unit outage, the operations shift crew composition met or exceeded PDTS requirements. The licensee implemented an employee safety concerns program that allowed interested parties to submit concerns for review. The licensee was receiving concerns and was investigating them in a timely manner.

## **2 Decommissioning Performance and Status Review at Permanently Shutdown Reactors (71801)**

### **2.1 Inspection Scope**

The inspector evaluated whether the licensee and its contracted workforce were conducting decommissioning activities in accordance with license and regulatory requirements.

### **2.2 Observations and Findings**

#### **a. Loss of Electrical Power Incident**

Since the previous inspection, the licensee experienced a loss of power incident that impacted Unit 1 operations. On December 26, 2002, Unit 1 experienced a loss of power to five 480-volt load centers. Power was lost to equipment in the spent fuel pool (SFP) cooling, component cooling water, saltwater cooling, and primary plant makeup systems. Power was also lost to the SFP area radiation monitor and selected effluent radiation monitors. Unit 1 operations implemented contingency actions in accordance with its abnormal operating instructions. Power was restored to the load centers about 3.5 hours later. The loss of power event had no impact on the SFP level, and the licensee still had the capability to provide makeup water to the pool in an emergency situation through alternate means.

Power outages were also experienced by Unit 1 during July-August 2002. Previously, the power outages were attributed to faulting of two underground 12-kilovolt power lines that supplied power to Unit 1. The age of the cable (greater than 20 years old) and cable environment (underground) resulted in moisture intrusion and insulation failures. The most recent power outage was caused by a ground fault signal at a substation. The fault was detected in the substation's load side power circuitry, equipment controlled by another utility, and not the supply side 12-kilovolt cables.

The licensee previously implemented an equipment replacement program to exchange older transformers, distribution switches, and underground cables. During 2002, the licensee replaced selected sections of the underground 12-kilovolt transmission lines and installed a new disconnect switch between the two 12-kilovolt power supply lines. During 2003, the licensee plans to replace an additional 1000 feet of underground cable in each of the two 12-kilovolt lines. The licensee's goal is to improve the reliability of the electrical grid that supplies power to Unit 1.

b. Incident Resulting in a Work Stoppage

The licensee recently experienced an incident that resulted in a work stand-down. On November 22, 2002, demolition activities were in progress in the auxiliary feedwater pump area. The work consisted of torch cutting of small bore piping in a "cut and drop" process. During cutting operations involving a 4-foot section of 3-inch piping, the pipe unanticipatedly fell about 6 feet, bounced, and rolled into the oxygen-acetylene cutting torch hose. The pipe punctured the hose and ignited the gas, resulting in an 18-inch flame coming from the cut hose. Workers immediately shut off the gas supply which extinguished the flame.

The licensee stopped the work and conducted discussions with the workers. Normally, a rope was used to help maintain control of the dropped pipe, but because of unusual circumstances, the workers elected not to use a rope in this situation. Also, the cutting torch hose was subsequently determined to be too close to the work area. Management expectations of work performance, based on the skill of the craft, inferred that the area would be properly prepared for pipe cutting operations by removing items in the area.

During the work stand-down, licensee management reminded workers of its expectations for conduct of work. Although there were no injuries because of this incident, the potential for an injury existed. The inspector concluded that the incident was not indicative of normal work practices, and that the licensee took appropriate actions following the event to prevent recurrence.

c. Review of As Low As Reasonably Achievable Program

The inspector reviewed the As Low As Reasonably Achievable (ALARA) program and its effectiveness. Performance indicators were tracked and evaluated by the licensee, including ALARA exposure goals. Collectively, personnel exposures were consistently under the exposure goals in recent years. The exposure goal for 2002 was 64 person-rems, but total exposure was actually 61.8 person-rems. The work activity for calendar year (CY) 2002 that had the highest collective exposure was the large component removal project. This work activity had a collective dose of 35.8 person-rems, followed by health physics support functions at 11.5 person-rems.

The exposure goal for CY2003 was 36 person-rems with a contingency of 5.4 person-rems for unanticipated work. The work activities planned for CY2003 that had the greatest potential for exposure, in order, were the decommissioning of the remaining containment systems, health physics support, and spent fuel transfer activities. Total exposures continue to decrease over time as the decommissioning work is completed and as sources of radiation are removed from the site.

The licensee held quarterly ALARA meetings during CY2002, and a quorum of individuals was always present. The licensee discussed issues related to Unit 1 activities at each meeting. The committee also issued awards to individuals who provided ALARA suggestions that successfully resulted in a reduction of personnel exposures. Overall, the licensee had a strong ALARA program in place at Unit 1.

d. Spent Fuel Pool Safety

The PDTs provides the safety limits, limiting conditions of operation, and surveillance requirements for the SFP. Plant tours, record reviews, and interviews with plant operators were conducted to verify if the SFP was being maintained in accordance with PDTs and procedural requirements.

Safety Limit D2.1 specifies that the water level in the SFP shall be maintained above plant elevation 16 feet whenever fuel assemblies are stored in the SFP. Further, a minimum water level limit of 40-foot, 3-inches was specified in plant procedures. During the onsite inspection, the pool level was noted to be above the 40-foot, 8-inch elevation. The inspector reviewed the operational logs for October 2002 through January 6, 2003, and noted that the lowest level during that time frame was 40-feet, 5.5-inches.

Table D3.1.3-1 of PDTs requires that both chloride and fluoride be maintained less than or equal to 0.15 parts per million. The pool was sampled monthly by the licensee. The sample results for October-December 2002 were reviewed. The sample results document that chloride concentration was less than or equal to 0.0064 parts per million and fluoride concentration was less than or equal to 0.0012 parts per million during this time frame.

The procedural limit for SFP temperature was 150 degrees Fahrenheit with a high temperature alarm setpoint of 125 degrees. The pool temperature varied between 66 and 72 degrees during October-December 2002. Pool temperature remained well below the procedural limit during this time frame.

Since the previous inspection, the licensee converted the Unit 1 auxiliary feedwater storage tank into a Unit 2/3 demineralized water storage tank. The licensee planned to reuse the seismically-qualified tank for storage of fire water. The auxiliary feedwater storage tank had been one of several backup sources of water for the Unit 1 spent fuel pool. During the inspection, the inspector observed that all piping connections from the auxiliary feedwater storage tank had been severed. Selected outlet connections were fitted with firewater hose connections, connections that are typically incompatible with standard pipe fittings.

The normal source of SFP makeup water was the primary plant makeup tank because it contained high purity, demineralized water. Other sources of makeup water (in order of preference) included demineralized water from the Units 2/3 demineralized makeup water system, domestic (potable) water, fire water, water transported by a fire truck, and the service water reservoir. The refueling water storage tank, typically a backup source of water, had been drained and was unavailable. Amendment 160 to the facility operating license deleted the auxiliary feedwater storage tank from the PDTs, in part, because alternate sources of makeup water were available.

The inspector noted that operating procedure SO1-4-18, "Spent Fuel Pool System Operation," Revision 15 (in use in the Unit 1 control room) was out-of-date. The procedure still considered the auxiliary feedwater storage tank in service as a source of SFP makeup water. If a loss of SFP inventory were to occur, the licensee could not

transfer the auxiliary feedwater storage tank inventory to the SFP as written in the system operating procedure. The inspector questioned operations staff personnel, and the operators were aware that the tank was unavailable and that the procedure was out-of-date. Other sources of SFP makeup water were still available.

Although the auxiliary feedwater storage tank was no longer safety related or required for normal operations, the inspector discussed with the operations superintendent the licensee's policy for updating procedures. The operations superintendent stated that the procedures would be updated when the former auxiliary feedwater storage tank was available as a water source. He also indicated that a pipe connection was planning to be procured that could be used to connect a 2-inch hose to the tank's 4-inch fire water hose connection. As an interim measure, the operations superintendent stated he would issue a night letter (standing orders) to include the interim status of the auxiliary feedwater storage tank in lieu of a temporary procedure change.

e. Annual Boundary Valve Verification

Section 5.2.7 of the DSAR discusses the potential for contamination leakage to the environment. To minimize this potential, the DSAR states that operators will annually verify that the boundary valves are closed. This commitment was previously included in Unit 1 Operating Instruction SO1-3-1, Attachment 4, "Monitoring SAFSTOR Containment Equipment and Boundaries," Revision 2. Changes in plant conditions prompted the licensee to revise the procedure. Revision 5 (dated October 25, 2000) to the procedure significantly reduced the number of boundary valves that required an annual verification. The boundary valve verification was last conducted during April 2001.

During November 2001, the attachment was deleted from the procedure, in part, because the licensee concluded that there were no boundary valves to inspect. However, during December 2002, the licensee elected to revise the procedure to annually monitor abandoned equipment for leakage. Because of the timing of the procedure revisions, a boundary valve/abandoned equipment verification was not conducted during CY2002.

Following the inspector's inquiry, the licensee issued an action request to investigate why a DSAR requirement was deleted from the operating procedures without a corresponding change to the DSAR. The inspector concluded that the failure to conduct an annual valve verification during CY2002 was not safety significant because there were no non-operating system boundary valves to inspect. Operating system valves were still being controlled by their respective system operating procedures. The Unit 1 operations superintendent stated that the next annual abandoned equipment inspection would be conducted during February 2003.

f. Site Tours/Control of Radioactive Material

The inspector conducted tours of the Unit 1 facility to observe decommissioning work in progress. The inspector observed radiological area postings, boundaries, and housekeeping. Access to the restricted and contaminated areas was controlled by

radiation caution signs, barricades, boundary lines, locked doors and gates. Radiological boundaries were well defined and posted in all areas.

The inspector noted that housekeeping had improved since the previous inspection, especially in the radiologically restricted areas. In particular, the containment sphere had been cleaned of loose tools, trash, and debris.

The inspector conducted radiological ambient gamma radiation surveys of the Unit 1 restricted areas using a Ludlum Model 2401-EC2 survey meter (NRC No. 077380), in part, to confirm the accuracy of the restricted area postings. The radiation areas and high radiation areas were properly posted with warning signs and barriers as appropriate.

On August 3, 2002, the containment area radiation monitor failed its channel functional test. The containment area monitor was mounted in containment and was designed to alarm on high radiation. Licensee personnel began taking contingency actions consisting of routine radiation exposure measurements in containment using portable equipment. On November 1, 2002, the Unit 1 decommissioning review committee approved the permanent removal of the containment radiation monitor, in part, because of problems with repairing the monitor and because the monitor would have to be moved in the near future to support upcoming decommissioning activities. The licensee determined that the monitor was not necessary because portable equipment could be used in place of the fixed monitor. An engineering change package was developed to permanently remove the monitor from service. At the end of the inspection period, the monitor was still installed but out-of-service pending implementation of the engineering change package.

### 2.3 Conclusions

The licensee experienced a loss of power incident at Unit 1 during December 2002, but took appropriate contingency actions in response to the incident. The licensee continues to upgrade the electrical equipment that provides power to Unit 1 in an attempt to increase equipment availability and reliability. The licensee experienced a decommissioning incident that resulted in a work stand-down. Although the licensee has experienced several personnel safety incidents during decommissioning, licensee management continued to demonstrate a strong commitment to personnel safety. The licensee continued to have an effective ALARA program to help minimize occupational exposures. The licensee continued to maintain the SFP within PDTs and procedural requirements.

An annual valve verification was required by the DSAR, but the licensee deleted that requirement from the applicable procedure because it was determined that the requirement was no longer necessary. The licensee issued an action request to ascertain why a procedure change deleted the annual inspection from the procedure without a corresponding change to the DSAR. Site tours confirmed that radiation protection controls were in place to support decommissioning activities. Housekeeping in radiologically restricted areas had improved since the previous inspection.

In summary, decommissioning activities were being conducted in accordance with license and regulatory requirements.

### **3 Solid Radioactive Waste Management and Transportation of Radioactive Materials (86750)**

#### **3.1 Inspection Scope**

The purpose of this portion of the inspection effort was to determine whether transportation and disposal activities were being conducted in compliance with applicable NRC and U.S. Department of Transportation regulations.

#### **3.2 Observations and Findings**

The inspector reviewed the licensee's documentation for waste material disposed during CY2002. During the year, the licensee disposed of both Class A and Class C wastes. The Class A wastes included the RPV head, three steam generators, pressurizer, as well as 45 shipments (36,442 cubic feet) of general Class A wastes created through the decommissioning process. The Class A wastes were disposed at a commercial low-level waste facility in Utah. The Class C wastes included two high integrity containers of garnet material, residual material from the reactor vessel internals segmentation project, and two boxes containing miscellaneous waste filters, valves, piping, and reactor core detectors. The Class C wastes were disposed at a commercial facility in South Carolina. All shipping records appeared to comply with applicable NRC and U.S. Department of Transportation requirements.

The inspector discussed an incident with the licensee involving the shipment of the RPV head. On November 4, 2002, the truck that was transporting the RPV head to the low-level waste disposal site in Utah broke down in Nevada. The truck became disabled when a driveline component failed. The truck remained on the side of the road for about 2 days until repairs were completed on the driveline.

The shipment of the RPV head was being conducted by a contractor for the licensee. The truck driver had two sets of emergency response instructions, one provided by the licensee and a second provided by the contractor. Step 6.1 of the contractor's emergency response plan stated that in any emergency or incident (i.e., accident, bad weather, tie-down failure, mechanical breakdown) the driver will notify the licensee. The driver notified the load dispatcher of the truck failure, but not the licensee. The licensee became aware of the incident the day after the truck broke down. Unit 1 operations personnel issued an action request to document the missed notification.

The inspector reviewed whether the incident was reportable. Since package integrity was never compromised and since the load remained under law enforcement or driver control at all times, the inspector concluded that the incident was not reportable to the NRC. The inspector noted confusion by site personnel as to whether the incident was reportable to the licensee. The confusion involved whether "mechanical breakdown" meant the breakdown of the package or the truck. Further, the inspector noted that the

licensee's emergency response instructions had no similar reporting requirement. The incident was not safety significant because package integrity was not compromised as a result of the mechanical failure of the truck. The package was subsequently delivered to the waste disposal site on November 6, 2002.

### 3.3 Conclusions

The licensee shipped radioactive waste for offsite disposal during CY2002. Documentation indicated that the licensee had shipped the material in accordance with NRC and U.S. Department of Transportation requirements. The inspector discussed a transportation incident with the licensee involving the mechanical breakdown of a truck used to ship radioactive waste from the site. The incident was not reportable to the NRC, and the load was subsequently delivered to a commercial low-level waste disposal facility without further incident.

## 4 **Exit Meeting Summary**

The inspector presented the inspection results to members of licensee management at the exit meeting on January 9, 2003. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspector.

## ATTACHMENT 1

### **PARTIAL LIST OF PERSONS CONTACTED**

#### Licensee

J. Custer, Superintendent, Unit 1 Operations  
J. Fee, Manager, Maintenance  
M. McBrearty, Engineer, Nuclear Regulatory Affairs  
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### **INSPECTION PROCEDURES (IP) USED**

IP 36801	Organization, Management, and Cost Controls at Permanently Shutdown Reactors
IP 71801	Decommissioning Performance and Status Review at Permanently Shutdown Reactors
IP 86750	Solid Radioactive Waste Management and Transportation of Radioactive Materials

### **ITEMS OPENED AND CLOSED**

#### Opened

None

#### Closed

None

#### Discussed

None

### **LIST OF ACRONYMS USED**

ALARA	As Low As Reasonably Achievable
CY	calendar year
DSAR	Defueled Safety Analysis Report
IP	NRC Inspection Procedure
RPV	reactor pressure vessel
SFP	spent fuel pool
PDTS	Permanently Defueled Technical Specifications