

Canadian Nuclear
Safety Commission



Commission canadienne
de sûreté nucléaire

Minutes of the Canadian Nuclear Safety
Commission (CNSC) Meeting held
on June 19, 2014

Minutes of the Canadian Nuclear Safety Commission (CNSC) Meeting held Thursday, June 19, 2014 beginning at 10:42 am at the Public Hearing Room, 14th floor, 280 Slater Street, Ottawa, Ontario.

Present:

M. Binder, President
A. Harvey
D.D. Tolgyesi
R. Velshi
S. McEwan

M. Leblanc, Secretary
L. Thiele, General Counsel
D. Carrière and M. Hornof, Recording Secretaries

CNSC staff advisors were: A. McAllister, M. Rickard, J. Burtt, R. Jammal, T. Jamieson, G. Rzentkowski, P. Elder, P. Thompson, M. Rinker, R. Lane, B. Prieur, B. Torrie, C. Moses, K. Heppell-Masys, C. Françoise, K. Murthy, T. Manning, B. Poulet, L. Sigouin and G. Frappier

Other contributors were:

- Ontario Power Generation: C. Spence, P. King, L. McWilliams, R. McCalla, A. Webster, J. Peters and C. Lorencez
- Bruce Power: F. Saunders
- Pacific Northwest National Laboratories: K. Branch
- Cameco Corporation: D. Ingalls
- University of California: L. Zablotska
- Health Canada (FNEP – Federal Nuclear Emergency Plan): B. Ahier
- Ontario Office of the Fire Marshall and Emergency Management: D. Nodwell
- Hydro-Québec: M. Désilets

Constitution

1. With the notice of meeting, CMD 14-M29, having been properly given and a quorum of Commission Members being present, the meeting was declared to be properly constituted.
2. Since the meeting of the Commission held May 7 and 8, 2014, Commission Member Documents CMD 14-M29 to CMD 14-M36 were distributed to Members. These documents are further detailed in Annex A of these minutes.

Adoption of the Agenda

3. The revised agenda, CMD 14-M31.B, was adopted as presented.

Chair and Secretary

4. The President chaired the meeting of the Commission, assisted by M. Leblanc, Secretary and D. Carrière/M. Hornof, Recording Secretaries.

Minutes of the CNSC Meeting Held May 7 and 8, 2014

5. The Commission Members approved the minutes of the May 7 and 8, 2014 Commission Meeting as presented in CMD 14-M32.

STATUS REPORTSStatus Report on Power Reactors

6. With reference to CMD 14-M33, which includes the Status Report on Power Reactors, CNSC staff presented updates on the following:
 - On June 18, 2014, Bruce A Nuclear Generating Station (NGS) Unit 1 was in an unplanned outage. As of June 19, 2014 it had returned to 9% of full power and was expected to synchronize to the grid on June 20, 2014;
 - Darlington NGS Unit 1 was at 80% of full power as of June 19, 2014 and was expected to return to full power on June 20, 2014.
7. The Commission requested further information regarding the manual shutdown of Bruce A NGS Unit 1. A Bruce Power representative provided a description of the events that led to the shutdown, including the discovery of moisture in the generator. The Commission asked Bruce Power why they would initiate a manual shutdown rather than relying on system sensors. The Bruce Power representative explained that an organized, manual shutdown is better for the system than when a set-point is tripped. The Commission sought confirmation that the cause of the event will be fully investigated. The Bruce Power representative advised the Commission that they are conducting a full investigation. CNSC staff will provide the Commission with further information regarding this event.
8. With respect to the lightning strike near the Bruce B NGS on June 17, 2014, the Commission enquired about what special precautions are taken by Bruce Power when severe weather is expected. The Bruce Power representative responded that lightning strikes on Lake Huron are a common occurrence in the spring and summer. The Bruce Power representative further stated that nuclear power plants are designed and built for severe weather and explained related design specifications. The Bruce Power representative also stated that they have multiple systems in place to detect severe weather and that they have management plans for such events.

ACTION
due
August,
2014

9. The Commission requested more detail on the synthetic oil leak at the Darlington NGS. OPG representatives explained the event and the corrective actions taken. They also informed the Commission that the Ontario Ministry of the Environment (MOE) was notified of the incident. The Commission enquired about the root cause of the event. OPG representatives responded that a heat exchanger failed, causing the leak. This failure could not be observed through visual inspection, which is the standard inspection process. CNSC staff provided more information regarding these inspection practices. The Commission expressed concerns that the root cause for the event was not yet discovered, and still considers this file open. CNSC staff will provide the Commission with further information regarding the heat exchanger failure and subsequent oil leak at Darlington NGS.
10. The Commission requested additional details on the refrigerant leak at the Darlington NGS Tritium Removal Facility. OPG provided a description of the event. The cause was found to be a solenoid valve failure, the first known issue with that type of valve. OPG representatives explained the corrective actions taken and told the Commission that the Ontario MOE had been notified of the event. The Commission further enquired about what happens to the refrigerant when there is a leak. OPG representatives responded that it is released into the air.

ACTION
due
August,
2014

Event Notification - Gentilly-2 Nuclear Generating Station

11. In CMD 14-M33, CNSC staff presented information regarding cracks in the concrete ring surrounding the reactor enclosure at the Gentilly-2 NGS which were found on May 23, 2014. A visual inspection by Hydro-Québec found that some pieces of concrete had detached from the concrete ring. These affected pieces were removed.
12. The Commission enquired whether CNSC staff physically inspected the cracks in the concrete. CNSC staff responded that they did not have access to the area as it is at a height of 200 feet. CNSC staff noted having discussed the situation with Hydro-Québec and having reviewed their reports.
13. The Commission asked Hydro-Québec for more details on planned follow-up. The Hydro-Québec representative stated that an inspection of the concrete ring by a specialist is planned for the near future and that the results should be available in the fall of 2014. The Hydro-Québec representative further explained the purpose and functionality of the ring and noted that the cracks have no effect on the structure of the reactor enclosure.

14. The Commission enquired why part of the concrete ring that did not appear to be affected was now missing. The Hydro-Québec representative responded that an additional piece of concrete was removed when the visual inspection revealed that water had leaked into the cracks in that area. The Commission noted that leaking water often affects other structures. The Hydro-Québec representative responded that they did not see anything of concern during the visual inspection.
15. The Commission expressed concern that concrete falling from the top of the reactor enclosure could pose a serious health and safety hazard. The Hydro-Québec representative acknowledged that it is a concern, which is why they did a visual inspection of the whole ring immediately after seeing the cracks. The inspection confirmed that there were no other loose pieces of concrete.
16. Since Gentilly-2 NGS is presently in a defueled safe storage state, the Commission enquired whether the integrity of the reactor enclosure was now as important to the safety of the NGS as when the NGS was operational. The Hydro-Québec representative confirmed that it is not and stated reasons why this was the case, noting that the risk of overpressure is non-existent. CNSC staff concurred with the Hydro-Québec representative. This matter is considered closed.

Event Initial Report (EIR) – Information Regarding an Incident at Cameco’s Port Hope Conversion Facility

17. With reference to CMD 14-M36 and CMD 14-M36.A, CNSC staff presented a status update of the Cameco Corporation (Cameco) Port Hope Conversion Facility ‘Near-Miss Event’ of January 28, 2014. CNSC staff stated that, although there were no explosions or releases during the event, the situation could have been more serious. CNSC staff explained the causes of the event and stated that the incident resulted in regulatory action from the CNSC and corrective actions by Cameco. Cameco was also required to perform a root cause analysis. Cameco representatives reiterated to the Commission that the safety of their employees, the public and the environment is very important to them.
18. The Commission asked CNSC staff and Cameco for more details on how the event occurred and what caused the plant shutdown. The Commission was also concerned that programmable logic controller (PLC) software upgrades were being performed while the plant was fully operational. Cameco representatives detailed the event which occurred while a software update to the plant’s control system was being performed by a third-party contractor. Another problem arose after the shutdown when Cameco technicians were troubleshooting the shutdown and incorrectly assessed the state of

- the facility after the emergency stop was activated. Additional awareness training for technicians has since been provided. Cameco representatives stated that minor software upgrades are routinely performed while the plant is running and there have been no previous issues. CNSC staff confirmed that issues began when software was introduced that sent data back into the PLC and while manual intervention was needed to restore the PLC which contributed to putting the plant into an unsafe condition.
19. The Commission asked CNSC staff to outline how serious this event could have been and what were the potential consequences of the event. CNSC staff stated that this was a near-miss event and that the consequences of an unmitigated circumstance could be severe. CNSC staff added that experienced workers acted appropriately to prevent serious consequences. CNSC staff also stated that the plant is designed in such a way that while a localized issue could exist, the various parts of the plant are isolated to prevent problems from propagating through the plant. Cameco representatives detailed the defence in depth approach, as well as the barriers that are in place to protect workers and the public.
 20. The Commission enquired what other deficiencies in the plant were identified and what corrective measures have been taken to resolve them. CNSC staff stated that Cameco has competent staff in the plant. However, during this event, procedural adherence and compliance, as well as some training, were lacking. Cameco representatives stated that although the contractor was competent, contractor management procedures were not followed. CNSC staff concurred with Cameco. Cameco technicians have undergone further training since the event. CNSC staff stated that corrective measures also include identifying risks prior to making changes in the plant and ensuring that there is appropriate management oversight of contractors. CNSC staff also stated that they have increased their regulatory oversight of the plant.
 21. The Commission expressed concern that many deficiencies at the plant were identified and that many corrective actions had to be taken. CNSC staff stated that proper programs and procedures are in place, but that improvements are needed. CNSC staff added that the event was a wake-up call and that there is a strong emphasis on lessons learned.
 22. The Commission enquired about the availability of the root cause analysis report for the event. Cameco stated that a comprehensive report was done and was shared with CNSC staff but that it contains proprietary information. The Commission stated that the root cause analysis report should be part of Cameco's proactive disclosure program. CNSC staff explained that a root cause analysis report is a technical report and is, in general, not viewed as

being very informative for the public. Cameco representatives responded that they have posted information about the event on their website. They also held a Public Community Forum in Port Hope, ON, in May 2014 that explained the event. When asked by the Commission whether they plan on sharing the meaningful information from their root cause analysis with the public, Cameco representatives stated that they would have to take the question back to the company for consideration. CNSC staff stated that while they felt a presentation was sufficient for this event, a short written submission (CMD) for any events of this type should be presented to the Commission in the future.

INFORMATION ITEMS

Presentation by CNSC Staff on the Study of Consequences of a Hypothetical Severe Nuclear Accident and Effectiveness of Mitigation Measures

23. With reference to CMD 14-M30 and 14-M30.A, CNSC staff presented the *Study of Consequences of a Hypothetical Severe Nuclear Accident and Effectiveness of Mitigation Measures*. This presentation is in response to a follow-up request from the Commission during the hearing for the environmental assessment regarding the proposal to refurbish and continued operation of the Ontario Power Generation (OPG) Darlington Nuclear Generating Station (DNGS) in December 2012. The draft study was released for public review on June 4, 2014.
24. CNSC staff presented information on the study approach, a discussion of the study results and insights, and the relation and applicability of the study to other initiatives and other nuclear power reactor sites. CNSC staff also proposed future work on this topic.
25. The Commission expressed its satisfaction with CNSC staff's study and the comprehensiveness of the report. The Commission requested that grey information boxes within the document be appropriately referenced to assure the credibility of the information contained within. The Commission also suggested that the document clearly state which areas were not assessed in the study.
26. The Commission expressed concern that some of the language used in the report may lead to misinterpretation or confusion. CNSC staff stated that it intends to write a longer executive summary to convey the information contained in the document to the general public in lay language. CNSC staff stated that it is open to suggestions for improving the document, and will conduct another review of the report to remove any discrepancies.

27. The Commission enquired about the population weighted dose approach used in the study. CNSC staff explained the population weighted dose approach that was used.
28. The Commission enquired about the evacuation time estimates studies completed by OPG and used in CNSC staff's study. CNSC staff explained that the time estimates, which were compiled specifically for the Darlington New Build Environmental Assessment and the Pickering Refurbishment Environmental Assessment, were peer-reviewed by consultants hired by CNSC staff and were found to be accurate. A representative from the Office of the Fire Marshall and Emergency Management (OFMEM) explained that it relies on and is supportive of the time estimate data. The OFMEM representative also explained that the Ontario Ministry of Transportation is developing traffic modelling software to help further verify and validate the evacuation time estimates.
29. The Commission asked if other events that have led to the evacuation of large populations were taken into consideration in the calculation of OPG's evacuation time estimates. CNSC staff reported that the evacuation of 200,000 people in the 20 km radius surrounding the Fukushima-Daiichi nuclear reactor was performed over four days. An OPG representative explained how evacuation time estimates are calculated and stated that the modelling completed to arrive at these estimates took into consideration experience from the multiple events that have occurred worldwide. The OPG representative stated that it continues to update the time estimates as new information arises.
30. The Commission enquired about baseline cancer rates. The Radiation Epidemiologist from the University of California explained how baseline cancer rates were used in modelling and predicting excess cancers from the hypothetical releases assessed in the study. The Commission enquired about the margin of error surrounding the baseline cancer rates used in the study. The Radiation Epidemiologist from the University of California responded that the modelling performed in CNSC staff's study captures the 90 percent lower and upper bounds because cancer rates fluctuate yearly in different age groups. This information is not currently presented in the report, but will be added to the final report. CNSC staff stated that, taking into consideration variability of cancer rates per region, the increase in the total risk may not be detectable.
31. The Commission enquired about the excess future risk data presented in the document. CNSC staff explained that the number of individuals that will get cancer cannot be calculated from this data; this data purely represents an individual's future risk in

- getting cancer. The Commission noted that the language used may lead the public to falsely correlate the information to increased cancers within a population instead of individual future risk.
32. The Commission asked if studies conducted following the Chernobyl accident showed an increased incidence of adult thyroid cancers. The Radiation Epidemiologist from the University of California responded that there are no studies that show increased incidences of thyroid cancer in the general adult population. One study showing an increased risk of thyroid cancer in adult clean-up workers is not widely accepted due to the methodologies used to arrive at its conclusion.
33. The Commission asked how the predicted cancer rates from the Chernobyl accident compare to the actual recorded cancer rates 27 years after the accident. The Radiation Epidemiologist from the University of California responded that the initial prediction study was conducted by the International Agency for Research on Cancer in 1994, but that this agency has not followed-up on its predictions to compare with actual cancer rates. Data from individual countries show increased risk of thyroid cancer, but it cannot be determined if this is due to radiation doses from the event or to other changes in the environment, increased screening or increased detection. The Commission discussed the higher incidence rates of thyroid cancer globally, and noted that this may be due to better and more frequent screening and detection. CNSC staff noted that a fact sheet presenting a comprehensive picture of the Chernobyl health data is being prepared for publication on the CNSC website.
- ACTION
due
October,
2014
34. The Commission enquired about the Fukushima-Daiichi accident cancer predictions. The Radiation Epidemiologist from the University of California responded that the Fukushima accident cancer rate predictions used data from atomic bombing events in Japan as well as data from the Chernobyl nuclear accident.
35. The Commission enquired about the basis for using a hypothetical radioactive release of Cesium-137 greater than 1×10^{14} becquerel (Bq) in the study. CNSC staff explained that this release is the safety goal for the design of new nuclear power plants and would prevent permanent relocation and permanent social disruption. CNSC staff noted that assessments completed to date have not found a series of events that would lead to this type of generic release from Canadian nuclear reactors.
36. The Commission asked for views on whether potassium iodide (KI) pills should be distributed to residents occupying the area surrounding the plant. The OFMEM representative responded that, using insights from CNSC staff's report, it will review existing policies pertaining to KI pill distribution to determine if revisions

are required. The OFMEM representative discussed its current efforts on providing emergency planning information to the public. The Health Canada representative stated that it is in the process of revising its Health Canada Intervention Guidelines which includes recommendation for KI usage in an emergency.

37. With regard to radiological doses, the Commission enquired about matters relating to the regulatory limit and the health effects. CNSC staff explained that the regulatory limit is one millisievert for members of the public, a value used for determining when a population can return to areas affected by radiation to avoid health effects. CNSC staff hopes that lessons learned from the Fukushima-Daiichi accident will help in preventing confusion on this matter in the future. CNSC staff stated that it will be posting a factsheet on its website to address the Commission's question.
- ACTION
due
October,
2014
38. With regards to psychosocial effects, the Commission enquired about the circumstances where an evacuation would be more harmful than sheltering and where psychosocial effects would trump preventative measures. The representative from the Pacific Northwest National Laboratories responded that there is currently no clear information to make this type of determination since evacuations are not entirely under the control of the people giving instructions; therefore, it is unknown if and when psychosocial effects would trump preventative measures. Information being gathered from the Fukushima-Daiichi nuclear accident will provide better insight into the consequences of evacuations in terms of psychosocial and economic effects.
39. The Commission enquired about the sensitivity of the results presented in the report. CNSC staff explained that staff made assumptions in order to carry out the study; however, staff did assess the excess risk for a range of doses not presented in the report. CNSC staff found that, in most cases, the conclusions are not vastly different from what is documented in the report. The Commission stated that it would be useful to have this information as part of the report. CNSC staff responded that it will add information pertaining to the sensitivity analysis in the report.
40. The Commission enquired about the process that will be followed to finalize and publish the document following the public consultation period. CNSC staff responded that the public review period closes at the end of August. CNSC staff stated that it would discuss the approach with the Secretary of the Commission. The Commission requested that CNSC staff present its disposition of public comments before the report is published.
- ACTION
due
November,
2014

41. The Commission asked how CNSC staff intends to proceed with this study. CNSC staff responded that it has met with the OFMEM and Health Canada and that both indicated that they would be providing more detailed comments on the report during the public review period. CNSC staff stated that it has been following all of the work that has been done post-Chernobyl and post-Fukushima. CNSC staff stated that it will use other activities to update regulatory guidance and provide advice to others as needed. The Commission suggested that CNSC staff clearly indicate their intent with regards to future work stemming from the findings of this report when they present this report to the public. The Commission requested that CNSC staff clearly indicate in the conclusion of the report that mitigation measures already in place are likely to prevent this rare event, or indicate that it is unlikely that the event will occur.

DECISION ITEMS

Regulations Amending Certain Regulations Made under the Nuclear Safety and Control Act (Miscellaneous Program)

Note: the following item was held in closed session.

42. With reference to, CMD 14-M35, CNSC staff sought the approval of the Commission to proceed with the draft *Regulations Amending Certain Regulations Made under the Nuclear Safety and Control Act (Miscellaneous Program)*. This proceeding was held *in camera* as draft regulations qualify as a Cabinet confidence.¹²
43. After considering the recommendations submitted by CNSC staff, the Commission approves the *Regulations Amending Certain Regulations Made under the Nuclear Safety and Control Act (Miscellaneous Program)*.

DECISION

Regulatory Document REGDOC-2.2.2, *Personnel Training*

44. With reference to CMD 14-M34 and 14-M34.A, staff presented REGDOC-2.2.2 "*Personnel Training*" for final approval by the Commission. This document sets out requirements of the CNSC for the development of training systems at nuclear facilities in Canada and provides guidance on how these requirements should be met, including the Systematic Approach to Training (SAT) methodology. REGDOC-2.2.2 underwent a rigorous public consultation process and represents a significant improvement in clarifying regulatory expectations for training systems at nuclear

¹ *Access to Information Act*, R.S.C., 1985, c. A-1, sec. 69

² *Privacy Act*, R.S.C., 1985, c. P-21, sec. 70

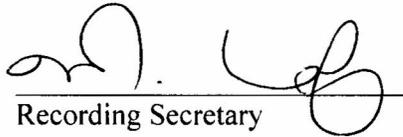
- facilities in Canada. CNSC staff noted that some stakeholders who participated in the consultation process commended the CNSC's approach as good practice.
45. Based on comments obtained during the consultation process, the Commission enquired whether REGDOC-2.2.2 applies to hospitals. CNSC staff responded that hospitals currently have training programs that follow the SAT methodology. As such, it will be used as a guidance document for hospitals and is intended to outline a requirement for Class I facilities. The Commission further enquired as to why REGDOC-2.2.2 would not apply to all nuclear facilities. CNSC staff responded that while most Class II facilities are using SAT methodology, full adherence at this time would not be possible. As such, REGDOC-2.2.2 is intended as a guidance document for these facilities.
 46. The Commission enquired about whether feedback was received from uranium mines, mills and fuel processing facilities. CNSC staff responded that the Canadian Nuclear Association typically represents these facilities and that it responded during the consultation. The Commission further enquired whether efforts were made to engage stakeholders who did not participate in the consultation period. CNSC staff confirmed that they use various methods to engage all stakeholders during all public consultations, and discussed these methods.
 47. The Commission asked CNSC staff why this training document did not exist in the past and whether it replaces any other documents. CNSC staff responded that there are other documents that provide guidance on selected areas of training, but that this is the first document that formalizes the CNSC's fulsome oversight program for licensee training systems. Moving forward, other CNSC documents that contain information related to training will be analyzed for overlap with REGDOC-2.2.2 and adjusted accordingly.
 48. The Commission invited industry representatives to comment on REGDOC-2.2.2. A Bruce Power representative stated that Bruce Power is satisfied with the second version of the document and that industry comments were properly considered. The Bruce Power representative further explained why industry was concerned with the first version of the document and how the second version addressed those concerns. The Commission enquired how many positions would fall under the SAT methodology at Bruce Power. The Bruce Power representative stated that most positions employ some element of SAT analysis, which varies depending on risk levels.

49. The Commission asked whether REGDOC-2.2.2 states that licensees must identify which positions will fall under SAT methodology. The Bruce Power representative responded that Bruce Power has already identified these positions in its current training programs. CNSC staff further stated that licensees are currently required, as part of their licence conditions, to provide information to the CNSC on positions that require SAT.
50. The Commission noted that there is no mention of prerequisites for training in REGDOC-2.2.2. CNSC staff responded that, with SAT methodology, evaluations are based on the task(s) that the individual must perform. The Commission asked whether it would be useful to add information in REGDOC-2.2.2 addressing minimum knowledge and skill prerequisites should be considered. The Bruce Power representative responded that knowledge and skill evaluation is done in the hiring process and gave an example to the Commission.
51. The Commission enquired about whether SAT methodology is an industry standard worldwide and whether there is a CSA standard on this methodology. CNSC staff responded that it is an industry standard. Other programs, which are variations of SAT methodology, are also used. The Commission further noted that international training standards may be needed. CNSC staff responded that the IAEA has guidance documents for nuclear power plants but there are gaps that needed to be filled. CNSC staff confirmed that there are currently no plans for CSA to produce a standard on this topic.
52. The Commission asked when Class 1B facilities will be expected to adopt REGDOC-2.2.2. CNSC staff responded that they are working with two Class 1B licensees to ensure that they are up-to-date before their licence renewals in 2015. CNSC will work with licensees to ensure full alignment with this REGDOC.
53. The Commission noted minor inconsistencies between the French and English versions of REGDOC-2.2.2, as well as editorial errors. CNSC staff will correct the errors and clarify the inconsistencies.
54. After considering the recommendations submitted by CNSC staff, the Commission approves regulatory document REGDOC-2.2.2, *Personnel Training*, for publication and use.

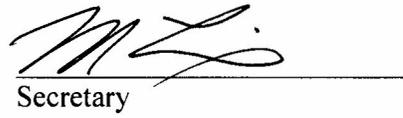
DECISION

Closure of the Public Meeting

55. The meeting closed at 4:17 pm on June 19, 2014.


Recording Secretary

AUG 2 5 2014
Date


Secretary

AUG 2 5 2014
Date

APPENDIX A

CMD	DATE	File No
14-M29	2014-05-22	Edocs #4439089
Notice of Meeting of June 19, 2014		
14-M30	2014-06-04	Edocs #4433762
Study of Consequences of a Hypothetical Severe Nuclear Accident and Effectiveness of Mitigation Measures – Oral presentation by CNSC staff		
14-M30.A	2014-06-11	Edocs #4453738
Study of Consequences of a Hypothetical Severe Nuclear Accident and Effectiveness of Mitigation Measures – Oral presentation by CNSC staff		
14-M31	2014-06-03	Edocs #4448133
Agenda of the meeting of the Canadian Nuclear Safety Commission to be held on Thursday, June 19, 2014, in the Public Hearing Room, 14 th floor, 280 Slater Street, Ottawa, Ontario		
14-M31.A	2014-06-12	Edocs #4454514
Revised agenda of the meeting of the Canadian Nuclear Safety Commission to be held on Thursday, June 19, 2014, in the Public Hearing Room, 14 th floor, 280 Slater Street, Ottawa, Ontario		
14-M31.B	2014-06-17	Edocs #4456300
Revised agenda of the meeting of the Canadian Nuclear Safety Commission to be held on Thursday, June 19, 2014, in the Public Hearing Room, 14 th floor, 280 Slater Street, Ottawa, Ontario		
14-M32	2014-06-12	Edocs #4454644
Approval of Minutes of Commission Meeting held May 7 and 8, 2014		
14-M33	2014-06-18	Edocs #4454916
Status Report on Operating Reactors units as of June 18, 2014		
14-M34	2014-06-03	Edocs #4448133
Regulatory Document REGDOC 2.2.2, <i>Personnel Training</i> , Oral presentation by CNSC staff		
14-M34.A	2014-06-11	Edocs #4453896
Regulatory Document REGDOC 2.2.2, <i>Personnel Training</i> , Oral presentation by CNSC staff – Presentation by CNSC staff		
14-M35	2014-06-02	Edocs #4447369
Regulations Amending Certain Regulations Made under the nuclear Safety and Control Act (Miscellaneous Program) – CMD 14-M35 contains prescribed information and is not publicly available		

14-M35.A 2014-06-11 Edocs #4453702

Regulations Amending Certain Regulations made under the nuclear Safety and Control Act (Miscellaneous Program) – Presentation by CNSC staff - The presentation contains prescribed information and is not publicly available

14-M36 2014-06-05 Edocs #4450058

Event Initial Report – Cameco Corporation: Status Update of January 2014 Event at the Port Hope Conversion Facility

14-M36.A 2014-06-11 Edocs #4450058

Event Initial Report – Cameco Corporation: Status Update of January 2014 Event at the Port Hope Conversion Facility – Presentation by CNSC staff