

March 20, 2000

Mr. James N. Adkins  
Vice President - Production  
United States Enrichment Corporation  
Two Democracy Center  
6903 Rockledge Drive  
Bethesda, MD 20817

SUBJECT: PORTSMOUTH INSPECTION REPORT 70-7002/2000001(DNMS)

Dear Mr. Adkins:

On March 6, 2000, the NRC completed a routine resident inspection at your Portsmouth Gaseous Diffusion Plant. The purpose of the inspection was to determine whether activities authorized by the certificate were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the inspectors discussed the findings with members of your staff.

Areas examined during the 6-week inspection period are identified in the report. Within these areas, the inspection consisted of a selective examination of procedures and representative records, interviews with personnel, and observations of activities in progress. No cited violations of NRC requirements were identified during the inspection.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

We will gladly discuss any questions you have concerning these observations.

Sincerely,

*/RA/*

Patrick L. Hiland, Chief  
Fuel Cycle Branch

Docket No. 70-7002  
Certificate No. GDP-2

Enclosure: Inspection Report 70-7002/2000001(DNMS)

See Attached Distribution

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 70-7002  
Certificate No: GDP-2

Report No: 70-7002/2000001(DNMS)

Facility Operator: United States Enrichment Corporation

Facility Name: Portsmouth Gaseous Diffusion Plant

Location: 3930 U.S. Route 23 South  
P.O. Box 628  
Piketon, OH 45661

Dates: January 25 through March 6, 2000

Inspectors: D. J. Hartland, Senior Resident Inspector  
C. A. Blanchard, Resident Inspector  
W.G. Snell, Senior Fuel Cycle Inspector  
R. G. Gattone, Fuel Cycle Inspector

Approved By: Patrick L. Hiland, Chief  
Fuel Cycle Branch  
Division of Nuclear Materials Safety

## EXECUTIVE SUMMARY

### United States Enrichment Corporation Portsmouth Gaseous Diffusion Plant NRC Inspection Report 70-7002/2000001(DNMS)

#### Operations

The inspectors concluded that plant management took effective corrective action in response to a failure to prevent recurring spurious autoclave containment shutdowns. (Section O1.1)

The inspectors concluded that plant management took appropriate corrective action to address the failure to implement the anomalous response procedure in response to a potential nuclear criticality safety non-compliance. (Section O1.2)

Selected plant shift superintendents and managers demonstrated a fairly good understanding of the content and implementation of procedural requirements for administrative controls for suspending activities on-site. A detailed review of a stop work notice indicated that it had been conservatively implemented. (Section O1.3)

Plant management had taken action to curtail overtime exceedance requests in Operations. The inspectors will continue to monitor the effectiveness of the actions taken. (Section O1.4)

#### Maintenance

The inspectors concluded that plant management took appropriate corrective action in response to a failure to use an in-hand procedure during a Criticality Accident Alarm System cluster change-out. (Section M1.1)

## Report Details

### I. Operations

#### **O1 Conduct of Operations**

##### **O1.1 Failure to Take Action To Prevent Recurring Autoclave Shutdown**

###### **a. Inspection Scope (88100)**

The inspectors followed up on recurring spurious containment shutdowns on Autoclave No. 3 in Building X-343.

###### **b. Observations and Findings**

On January 24, during a review of problem reports, the inspectors noted that the Plant Shift Superintendent (PSS) authorized the return to service of Autoclave No. 3 in Building X-343 following a containment shutdown on January 20, and the autoclave went into a containment shutdown again approximately 2 hours later. The inspectors discussed the issue with the PSS Section Manager, who initiated Problem Report 00-00477 to document the recurring problem and investigate the basis for returning the autoclave to service following the first shutdown.

The PSS Section Manager determined that the basis for returning the autoclave to service following the first shutdown was Engineering Evaluation Eval-SE-2000-0001, dated January 1, 2000, which documented the cause for two shutdowns that had occurred previously on December 9, 1999, and January 1, 2000. Engineering determined that the cause was the tripping of the watchdog timer, which monitored the operation of the autoclave programmable logic controller (PLC). As the PLC cycled through the autoclave logic, it generated a signal that was monitored by the timer. If the signal was absent at the expected interval, the timer relays initiated a containment shutdown. Plant staff conducted some testing at that time but did not identify any damaged components and could not replicate the problem; therefore, engineering concluded that the shutdowns were due to intermittent voltage spikes and did not recommend any additional actions.

The inspectors noted that the PSS authorized the return to service of the autoclave on January 20 without verifying that the assumptions in the engineering evaluation were still valid. An intermittent problem could have become more frequent or an additional failure mechanism could have been introduced. This appeared to have been the case, as plant staff later identified a bad connection on an electronic module as being the root cause for the spurious shutdowns. As a corrective action, plant staff intended to provide procedural guidance regarding the reuse of engineering evaluations. In addition, the PSS office conducted lessons learned training to stress the importance of investigating the cause of safety system actuations and taking action to prevent recurrence.

Failure to properly follow up on this issue prior to returning the autoclave to service on January 20 was a violation of Section 5.1.4 of Procedure XP4-SF-SF1110, "Plant Shift Superintendent Actions of Problem Reports." However, plant staff took immediate and effective corrective actions to address the issue and the autoclave's ability to perform it's

intended safety function was never in question. Therefore, this non-repetitive licensee corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

c. Conclusions

The inspectors concluded that plant management took effective corrective action in response to a failure to prevent recurring spurious autoclave containment shutdowns.

O1.2 Failure To Initiate Anomalous Response Procedure

a. Inspection Scope (88100)

The inspectors observed operations in Building X-705 for compliance with nuclear criticality safety (NCS) requirements and assessed plant staff's response to a potential violation.

b. Observations and Findings

On February 10, during a tour of Building X-705, the inspectors noted two containers of miscellaneous parts wrapped in plastic bags. The inspectors believed that the potential existed that uranium-bearing liquids could have collected and deformed the plastic into an inadvertent container, which would have been a violation of Part B of NCSA-705-076.A00, "Inadvertent Containers." The other control, the primary integrity of overhead piping and other vessels containing uranium-bearing liquids, was not compromised. The inspectors raised the issue with a building first line manager (FLM).

During a follow up of this concern, the inspectors learned that based on a minimal review, the plant determined that the plastic was configured such that it would have collected less than a safe volume (4.8 liter) as defined in the nuclear criticality safety approval (NCSA). Regardless, they removed the plastic wrap. The inspectors believed that compliance of the as-found condition with the NCSA was not that obvious and a more rigorous evaluation should have been conducted. In addition, the inspectors noted that plant staff did not initiate an anomalous condition response as required by Section 6.9 of XP2-EG-NS1031, "Nuclear Criticality Safety." The procedure required in part, that if an NCSA requirement appeared to have been violated, the PSS and NCS were to be notified for specific guidance to correct the situation.

The inspectors discussed the issue with the building manager who initiated Problem Report 00-0823. As an immediate corrective action, the building manager briefed operations personnel on the NCSA requirements and the anomalous condition response procedure. In addition, personnel walked down the building to verify compliance with the NCSA. Failure to initiate an anomalous condition response as required by Procedure XP2-EG-NS1031 was a violation. However, plant staff took immediate and effective corrective actions to address the issue. Therefore, this non-repetitive licensee corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

c. Conclusions

The inspectors concluded that plant management took appropriate corrective action to address the failure to implement the anomalous response procedure in response to a potential NCS non-compliance.

O1.3 Implementation of Procedures to Track Issues

a. Inspection Scope (88100)

The inspectors reviewed the plant staff's implementation of procedural requirements for administrative controls for suspending activities on-site.

b. Observations and Findings

The inspectors interviewed selected PSSs, the Power and Shift Operations Group Manager, and the PSS Section Manager. The inspectors also reviewed policies and procedures regarding daily operating instructions (DOIs) and stop work notices (SWNs), as well as other associated records.

Procedure UE2-SF-SF1030, "Stop Work Actions," stated that SWNs were required, in part, when: (1) there was a need to stop work activities which did not conform to specified requirements or which could endanger the health and safety of plant personnel or the public; and (2) all normal actions to correct a problem, or stop an activity until the problem was corrected have been exhausted. Procedure XP2-US-F01105, "COP-6 Policies and Instructions," stated, in part, that DOIs are used where specific, pertinent operational information or direction was required to be communicated to the line operations organization and could be in effect for an undetermined length of time.

All PSSs and managers interviewed demonstrated a good understanding of the content and implementation of these two procedures. In addition, interviewees were cognizant of recent guidance that had been provided to the PSSs from the PSS Section Manager concerning when to implement each of these procedures. Although not stated within the procedures, the general consensus of those asked during the interviews, was that the DOI was typically used to address issues within an individual organization while a SWN was typically used to address an issue that crossed organizational boundaries.

To evaluate the implementation of Procedure UE2-SF-SF1030, the inspectors conducted a detailed review of SWN No. 78, which stopped all activities associated with a specific NCSA. SWN No. 78 was issued in response to the determination that training on the NCSA had not been provided to applicable staff. Problem Report PR-PTS-0000039, dated January 4, 2000, documented the deficiency. In lieu of issuing SWN No. 78, the inspectors noted a DOI could have been used to track the issue because only one operation in one facility was affected. Alternatively, a procedural hold could also have been used to ensure that the procedure that required the training wasn't conducted. Nonetheless, a SWN was conservatively used to address the issue.

c. Conclusions

Selected PSSs and managers demonstrated a fairly good understanding of the content and implementation of procedural requirements for administrative controls for suspending activities on-site. A detailed review of SWN No. 78 indicated that it had been conservatively implemented.

O1.4 Implementation of Procedures to Limit Hours of Work

a. Inspection Scope (88100)

The inspectors reviewed the plant staff's implementation of Technical Safety Requirement (TSR) 3.2.2 and Procedure XP2-HR-LR1030, "Limitations on Hours of Work."

b. Observations and Findings

The inspectors interviewed selected PSSs, the Operations Organization Manager, the Power and Shift Operations Group Manager, the PSS Section Manager, and the Enrichment Plant Manager. The inspectors also reviewed policies and procedures regarding use of overtime, as well as other associated records.

TSR 3.2.2 required, in part, that: (1) administrative procedures be developed, implemented, and maintained to limit the working hours of facility staff who performed safety functions, (e.g., operators, maintenance personnel, etc.); (2) adequate shift coverage be maintained without routine heavy use of overtime such that personnel worked an 8-hour or 12-hour work day (i.e., a nominal 40 hour [could be as much as 48 hours] work week); (3) temporary use of overtime could not exceed specified limits without management preauthorization; and (4) routine exceedances from the specified limits was not authorized. The certificatee developed Procedure XP2-HR-LR1030, "Limitations on Hours of Work," to comply with TSR 3.2.2. The procedure required, in part, that the General Manager or the PSS on duty preauthorize individual requests to work beyond the TSR specified overtime limits, thus constituting an exceedance.

Based on staff interviews, the inspectors were informed that most of the Operations staff were routinely working up to the exceedance limits (e.g., 72 hours in 7 days). About 400 of approximately 520 Operations staff were qualified to perform nuclear safety functions. Based on a review of records since September 27, 1999, about 90 exceedance requests per Procedure XP2-HR-LR1030 were authorized monthly for the Operations staff and about 60 per month were worked. This was much greater than other applicable organizations such as Maintenance.

Based on the interviews, it was determined that some of the past reasons for why the Operations staff had such a high rate of exceedances included: (1) a lack of guidance for the PSSs to evaluate the requests; (2) Operations staff vacancies due to staff turnover; (3) a lag time of 4-10 months for new Operations personnel to complete required training; (4) management's preference to have more Operations staff on shift than was required by the TSR; (5) use of 12 hour shifts; and (6) scheduling conflicts that result in a lack of staff availability.

Based on interviews, it was understood by both the PSSs and management that exceedance request approvals were based on a safety analysis by PSSs exclusively, and that once a decision was made to disapprove a request few disapprovals were reversed. Those that were reversed were normally due to a receipt of additional information. Based on a review of overtime exceedance records generated during January and February 2000, two of about six requests that were initially disapproved were noted to have been reversed. Both were reversed by PSSs in accordance with the procedure. Of these two, one was reversed and approved when additional information was provided to the PSS. The records for the second exceedance that was reversed did not indicate the reason for the reversal.

Operations management had taken some actions to begin a reduction of the frequency of exceedance requests. Total exceedance requests were reduced from about 150 per month to about 120 per month from December 1999 to February 2000. Management's actions included: (1) providing more objective guidance to PSSs for evaluating exceedance request approvals; (2) initiating training of future Operations staff members before they are actually needed; and (3) requiring more information to be submitted with the exceedance requests than had been previously required. The effectiveness of plant management's actions to continue to reduce authorized overtime exceedances is an **Inspector Followup Item (IFI 70-7002/2000001-01)**.

c. Conclusions

Plant management had taken action to curtail overtime exceedance requests in Operations. The inspectors will continue to monitor the effectiveness of the actions taken.

**O8 Miscellaneous Operations Issues**

O8.1 Certificatee Event Reports (90712)

The certificatee made the following operations-related event report during the inspection period. The inspectors reviewed any immediate safety concerns indicated at the time of the initial verbal notification. The inspectors will evaluate the associated written report for the event following submittal, as applicable.

<u>Number</u>	<u>Date</u>	<u>Status</u>	<u>Title</u>
36719	2/22/00	Open	Safety System Actuation, Building X-326, smokehead actuation due to outgassing of compressor seal.

O8.2 Bulletin 91-01 Reports (97012)

The certificatee made the following reports pursuant to Bulletin 91-01 during the inspection period. The inspectors reviewed any immediate NCS concerns associated with the reports at the time of the initial verbal notifications. Any significant issues emerging from these reviews were discussed in separate sections of this report or will be discussed in future inspection reports.

<u>Number</u>	<u>Date</u>	<u>Title</u>
36631	1/26/00	24-Hour Report - NCS violation, Building X-103 Health Physics Source Vault, bags containing miscellaneous contents were discovered with an enrichment greater than 1 percent without an NCSA to cover storage.
36683	2/10/00	24-Hour Report - NCS violation, Building X-705, an iron support structure for a ventilator in the high bay area was found to have a depth of greater than 1.5" and did not have any drain openings.
36692	2/14/00	24-Hour Report - NCS violation, Building X-705, a vinyl covered foam padded chair was found in the high bay area with the vinyl covering worn open. The thickness of the foam padding was greater than the requirement for absorbent material specified in the NCSA.
36701	2/16/00	24-Hour Report - NCS violation, Building X-710 Laboratory, vertical spacing requirement for sample storage racks was not maintained.
36706	2/16/00	24-Hour Report - NCS violation, Building X-705, loss of tube integrity in recovery area pre-evaporator which resulted in potential for uranium to enter unanalyzed location.
36717	2/22/00	4-Hour Report - NCS violation, Building X-710, NCSA did not address movement of 5-inch cylinders.
36728	2/25/00	24-Hour Report - NCS violation, process piping opening was not completely covered or area manned following completion of maintenance activity.

O8.3 (Closed) VIO 70-7002/98013-01: Continued operation without NCSAs approved by the Plant Operations Review Committee. Plant staff determined that the root cause was that the review of the issues when identified only addressed safe plant operations and did not address compliance with "administrative" requirement in TSR 3.10.5. As a corrective action, training was provided to PSSs and other senior management individuals regarding guidance on actions to take when an administrative TSR is not met. Applicable plant procedures were also revised to incorporate this guidance. The inspectors have no other issues and this item is closed.

O8.4 (Closed) IFI 70-7002/98017-01: Adverse trend in disposition of potentially non-conforming conditions. Plant staff determined that the root cause was due to poor communications during PSS turnovers, inadequate and untimely resolution of technical issues, and poor documentation of the basis for reasonable assurance of operability. As a corrective action, a lessons learned was issued to the PSSs stressing the importance of properly resolving, documenting, and communicating issues identified by problem reports. In addition, procedural guidance was revised to require that PSSs

review all problem reports from the previous shift during turnover and include the reason for the inoperability of safety systems and components on tracking sheets. The inspectors have no other issues and this item is closed.

- O8.5 (Closed) VIO 70-7002/98014-01f: The procedure, approved to implement an organizational level assessment program as required by Compliance Plan Issue 27, did not specify criteria or provide guidance to ensure the development and implementation of an assessment program in a uniform manner. As documented in Inspection Report 70/7002-98014, the actions required by the issue were completed as of September 1, 1998. The inspectors have no further issues and this item is closed.
- O8.6 (Closed) URI 70-7002/98005-03: There was an apparent discrepancy between the safety analysis report and the certificatee's "see and flee" policy. The policy required that all plant personnel in the cascade buildings report to the area control rooms regardless of the size of a uranium hexafluoride release, while the accident analysis took credit in some cases for operator action in the field to mitigate an accident. As a corrective action, plant staff revised XP2-EP-EP1055, "Incident Command System," to provide guidance for performing TSR surveillances and other required operator actions during a building recall. Appropriate emergency response personnel were also provided training on the guidance. The inspectors have no other issues and this item is closed.

## **II. Maintenance**

### **M1 Conduct of Maintenance Activities**

#### **M1.1 Failure to Use In-Hand Procedure**

##### **a. Inspection Scope (88103)**

The inspectors observed maintenance activities to ensure compliance with certificate and procedural requirements.

##### **b. Observations and Findings**

On February 7, during a Criticality Accident Alarm System (CAAS) cluster change-out in Building XT-847, the inspectors arrived at the job site and noted that the work package containing the in-hand procedure was not opened for use but was laying off to the side. The inspectors also observed that sign-offs for procedure steps were not completed before beginning subsequent steps. The inspectors noted that the conditions were in violation of Step 6.2.3 of UE2-PS-PS1034, "Use of Procedures," which required, in part, that each step of in-hand procedure be read by a working companion before performing it and that sign-offs were completed before beginning the next step.

The inspectors discussed the issues with the FLM who initiated Problem Report 00-0771. As a corrective action, maintenance management performed crew briefings and required personnel to complete a self-study guide on the use of procedures. Failure to adhere to Procedure UE2-PS-PS1034 was a violation. However, the violation did not impact successful completion of the work activity and plant management took immediate and effective corrective actions to address the issue. Therefore, this non-repetitive licensee corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

c. Conclusions

The inspectors concluded that plant management took appropriate corrective action in response to a failure to use an in-hand procedure during the CAAS cluster change-out.

**M8 Miscellaneous Maintenance Issues**

- M8.1 (Closed) VIO 70-7002/97002-02: Entry into a TSR operational mode without meeting the conditions for the limiting conditions for operation (LCO). Plant staff determined that the root cause was a weakness in the process used to determine equipment operability at the time of transition to NRC oversight and inadequate administrative controls governing TSR LCOs. As a corrective action, plant staff developed a procedure which established a formal program to provide guidance for tracking LCOs and ensuring compliance with the TSRs. The inspectors have no further issues and this item is closed.

**III. Engineering**

**E8 Miscellaneous Engineering Issues**

- E8.1 (Closed) IFI 70-7002/98013-02: The inspectors noted that spurious failures with the autoclave sensors used to monitor the cylinder temperature continued to challenge autoclave safety systems. As a corrective action, plant staff systematically identified 13 different failure modes, and a contractor was consulted to resolve the failure modes. The contractor resolved the failure modes, and plant staff instituted preventive maintenance activities for the autoclave cylinder temperature sensors. The inspectors did not note any further failures and this item is closed.
- E8.2 (Closed) IFI 70-7002/98017-02: The inspectors noted that plant staff's corrective actions to a ruptured pipe caused by corrosion were not sufficiently comprehensive to ensure that other similar plant systems were not affected by the same failure mechanism. Specifically, after a recovery pre-evaporator off-gas pipe failed as the result of accelerated internal corrosion, the inspectors noted that the integrity of other systems that were exposed to corrosive solutions was unknown. As a corrective action, plant staff evaluated the integrity of several systems subjected to corrosive solutions and developed a non-destructive examination program to identify future deteriorated system conditions based on conservative metallurgical corrosion rates. The inspectors have noted that the plant staff has taken appropriate action to address deteriorated system conditions when identified and this item is closed.

**IV. Plant Support**

**P8 Miscellaneous Plant Support Issues**

- P8.1 (Closed) VIO 70-7002/98010-01: The inspectors identified that plant staff failed to place work restrictions on several emergency squad members whose self-contained breathing apparatus training was deficient. Plant staff determined the cause of the violation was an inadequate control process for ensuring that required training was correctly identified and that appropriate work limitations were not issued for employees with deficient training. In addition, the guidance for implementing training program requirements was inadequate, and plant staff did not understand or enforce training requirements. As a

corrective action, Procedure XP4-TR-TR1030, "Conduct of Training," was revised to include specific steps to place employees on a work restriction for deficient training. Specifically, cognizant organizational managers were required to issue deficient training restriction letters to employees and their respective FLMS. The inspectors noted that required training was current for selected emergency squad members and this item is closed.

## **V. Management Meetings**

### **X1 Exit Meeting Summary**

The inspectors presented the inspection results to members of the facility management on March 6, 2000. The facility staff acknowledged the findings presented and indicated concurrence with the facts, as stated. The inspectors asked the plant staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

## PARTIAL LIST OF PERSONS CONTACTED

### United States Enrichment Corporation

J. Anzelmo, Work Control Manager  
\*M. Brown, General Manager  
\*D. Couser, Training Manager  
J. Cox, Site & Facility Support Manager  
\*L. Fink, Commitment Management Manger  
S. Fout, Operations Manager  
R. Helme, Engineering Manager  
\*R. Lawton, Safety, Safeguards & Quality Manager  
\*P. Miner, Regulatory Affairs Manager  
\*P. Musser, Enrichment Plant Manager  
\*R. Smith, Production Support Manager  
K. Tomko, Environmental, Safety & Health Manager  
M. Wayland, Maintenance Manager

\*Denotes those present at the exit meeting on March 6, 2000.

## INSPECTION PROCEDURES USED

IP 88100: Plant Operations  
IP 88103: Maintenance  
IP 90712: In-office Reviews of Written Reports on Non-routine Events

## ITEMS OPENED, CLOSED, AND DISCUSSED

### Opened

70-7002/2000001-01	IFI	Effectiveness of plant management's actions to continue to reduce authorized overtime exceedances.
36719	CER	Safety System Actuation, Building X-326, smokehead actuation due to outgassing of W-2 compressor seal.

### Closed

70-7002/97002-02	VIO	Entry into TSR operational mode without meeting the conditions for the limiting conditions for operation.
70-7002/98005-03	URI	Apparent discrepancy between the safety analysis report and the certificatee's "see and flee" policy.
70-7002/98010-01	VIO	Failure to place work restrictions on 30 E-Squad members whose self-contained breathing apparatus training was deficient.
70-7002/98013-01	VIO	Continued operation without NCSAs approved by the Plant Operations Review Committee.

70-7002/98013-02	IFI	Action to correct autoclave thermocouple failures.
70-7002/98014-01f	VIO	Inadequate procedure approved to implement an organizational level assessment program.
70-7002/98017-01	IFI	Adverse trend in disposition of potentially non-conforming conditions.
70-7002/98017-02	IFI	Evaluate actions to identify and appropriately address piping systems exposed to corrosive solutions.

Discussed

None

**LIST OF ACRONYMS USED**

CAAS	Criticality Accident Alarm System
CER	Certificate Event Report
CFR	Code of Federal Regulations
DNMS	Division of Nuclear Material Safety
DOE	Department of Energy
DOI	Daily Operating Instruction
FLM	First Line Manager
IFI	Inspector Followup Item
LCO	Limiting Condition For Operation
NCS	Nuclear Criticality Safety
NCSA	Nuclear Criticality Safety Approval
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
PLC	Programmable Logic Controller
PSS	Pant Shift Superintendent
SAR	Safety Analysis Report
SWN	Stop Work Notice
TSR	Technical Safety Requirements
URI	Unresolved Item
USEC	United States Enrichment Corporation
VIO	Violation