

May 5, 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 70-7002/2000002(DNMS)

Dear Mr. Adkins:

On April 17, 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 violations of NRC requirements were identified during the course of the inspection period.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter will be placed in the NRC Public Electronic Reading Room (PERR) link at the NRC homepage, namely ><http://www.nrc.gov/NRC/ADAMS/index.html>.

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 70-7002/2000002(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: 70-7002/2000002(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: March 7 through April 17, 2000

Inspectors: D. J. Hartland, Senior Resident Inspector
C. A. Blanchard, Resident 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 70-7002/2000002(DNMS)

Operations

The inspectors identified several potential nuclear criticality safety non-compliances. The inspectors noted that plant staff took appropriate actions to address the issues, none of which resulted in the loss of double contingency. (Section O1.1)

Maintenance

The inspectors concluded that the root cause of an incident involving an ejected pipe plug during cleaning of the side purge piping was a failure to perform a rigorous safety review prior to raising the pressure above that authorized by the approved procedure. Plant staff took appropriate corrective action in response to the incident. (Section M1.1)

The inspectors identified some deficiencies in the use of lifted lead and jumper logs during a review of maintenance work packages, indicating the need for increased rigor during documentation of the packages. (Section M1.2)

Engineering

The inspectors identified that plant staff was using a non-conservative method for performing a required surveillance for hooks on liquid uranium hexafluoride (UF_6) cylinder lifting fixtures. As corrective action, plant staff took appropriate action to evaluate the structural integrity of the components and revised the applicable procedure to incorporate the more conservative acceptance criteria. (Section E2.1)

Plant Support

The inspectors identified several examples of poor housekeeping and radiological contamination control practices. The examples were promptly addressed and no spread of contamination was discovered. The inspectors will followup on the actions taken by plant management to address the generic problems. (Section R1.1)

Report Details

I. Operations

O1 Conduct of Operations

O1.1 Deficiencies in Implementation of Nuclear Criticality Safety Controls

a. Inspection Scope (88100)

The inspectors observed activities in various plant facilities for compliance with nuclear criticality safety (NCS) requirements and assessed the plant staff's responses to anomalous NCS conditions.

a. Observations and Findings

The inspectors observed the implementation of NCS requirements while touring plant facilities and identified the following deficiencies:

- The inspectors identified two examples where flammable material was present in poly bottle storage areas, and the examples represented potential non-compliances with NCS requirements. On March 17, the inspectors observed that approximately one cubic foot of packing paper was lodged within a poly bottle storage area on the operating floor of Building X-326. The paper had apparently blown into the area due to wind from a door open to the outside. On March 30, the inspectors observed welding rods on a vinyl-covered chair located in a poly bottle storage area in Building X-343. The chair was apparently placed in the area during an autoclave maintenance activity. Both areas contained postings specifying that no flammable material was to be stored or left unattended in the storage area.

Plant staff responded to each condition and determined that the double contingency principle had not been violated in each case. The governing nuclear criticality safety evaluation analyzed the scenario where small amounts of flammable material were inadvertently left in the storage areas.

- On March 17, inspectors noted inconsistent posting of a temporary staging area for side purge recovery waste material on the operating floor of Building X-326. Specifically, the area was posted with Nuclear Criticality Safety Approval (NCSA) PLANT 070.A00, "Miscellaneous Waste Accumulation Areas," requirements, but each barrel within the storage area had a separate posting for NCSA 0326_043, "Side Purge Recovery Cleaning Operation." Plant staff determined that the barrels were correctly posted and the area posting was a legacy issue from a previous storage area.
- On April 7, while touring Building X-705, the inspectors observed pallets containing miscellaneous parts that were wrapped in plastic that was cut open. The condition was apparently due to a response to an issue identified by the

inspectors and documented in NRC Inspection Report 70-7002/2000001(DNMS). That issue was related to the plastic wrapped around the parts that could have been deformed in such a manner that uranium-bearing solution from an overhead leak could potentially have accumulated in excess of 4.8 liters, resulting in a violation of NCSA 0705-076.A00, "Inadvertent Containers." In response, plant staff cut open the plastic to prevent solution from accumulating. However, the inspectors believed that the potential existed with the plastic open that solution could then collect in an unfavorable geometry inside the plastic. NCS staff responded and determined that the as-found condition did not violate the double contingency principle, as the plastic was not leak-tight and would not have allowed uranium-bearing solution to collect in excess of the NCSA-0705-076.A00 requirements.

For each of the above NCS concerns, the plant staff's actions were in accordance with Procedure XP2-EG-NS1031, "Nuclear Criticality Safety." Specifically, the inspectors noted that plant staff established boundaries around the affected area and equipment, notified the Plant Shift Superintendent (PSS) and NCS staff, issued a problem report (PR), and performed an incident investigation. The anomalous conditions were corrected after evaluations were performed by NCS engineers. The root causes of the deficiencies were poor housekeeping and inattention to detail. As corrective action, plant staff conducted crew briefings to stress the importance of compliance with NCS requirements.

c. Conclusions

The inspectors identified several potential NCS non-compliances. The inspectors noted that plant staff took appropriate actions to address the issues, none of which resulted in the loss of double contingency.

O8 Miscellaneous Operations Issues

O8.1 Certificatee Event Reports (90712)

The certificatee made the following operations-related event reports 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 reports for each of the events following submittal, as applicable.

<u>Number</u>	<u>Date</u>	<u>Status</u>	<u>Title</u>
36763	3/07/00	Open	Safety System Actuation, Building X-342, Manual Actuation of Autoclave Containment Safety System

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 are discussed in separate sections of this report, or they will be discussed in future inspection reports.

<u>Number</u>	<u>Date</u>	<u>Title</u>
36767	3/8/00	24-Hour Report - NCS violation, NCSA Was Violated When a 5-Gallon Bucket Containing Used Oil Was Placed Within Two Feet of Another Container
36769	3/8/00	24-Hour Report - NCS violation, NCSA Was Violated When a Personal Protective Equipment (PPE) Drum Was Left Unattended With the Lid Ajar
36782	3/9/00	24-Hour Report - NCS violation, NCSA Was Violated When a Cell Calibration Test Buggy Was Connected to the Wrong Port on a Local Control Center Manifold Which Could Have Allowed UF ₆ to Enter the Vacuum Pump Oil
36790	3/13/00	24-Hour Report - NCS violation, NCSA Was Violated When Two Seal Test Buggy Vacuum Pumps Were Found to Have Oil Volumes Greater Than the One Quart Requirement
36841	3/28/00	4-Hour Report - NCS violation, NCSA Was Violated When Uranium Oxide Samples Containing Greater Than 15 Grams of Uranium-235 Were Found in an Unanalyzed Storage Location
36879	4/10/00	24-Hour Report - NCS violation, NCSA Was Violated When Samples Containing Greater Than 500 Parts Per Million of Uranium-235 Were Not Properly Segregated

O8.3 (Closed) VIO 70-7002/99001-01: Failure to Take Action to Prevent Challenges to Safety Systems Prior to Returning Equipment to Service

The certificatee determined that the cause of the violation was errors in judgement by plant personnel. As corrective action, the applicable alarm response procedures were revised to require that the PSS be notified when a safety system actuated. Additionally, Procedure XP4-SF-SF1110, "Plant Shift Superintendent Actions On Problem Reports," was revised to clarify the required actions prior to returning equipment to service following a safety system actuation. Additionally, operability training was conducted for Operations and Maintenance first line managers (FLMs). The inspectors have no

further issues, and this item is closed.

- O8.4 (Closed) VIO 70-7002/99007-04: NCSA Violation for Improper Valve Storage at Building X744H

Plant staff determined that the root cause of the violation was that stores/warehouse personnel failed to follow the NCSA implementing procedure. Additionally, NCS staff did not obtain sufficient information on the valves relating to the mass and nature of the contamination to adequately assess the anomalous condition that was identified. As corrective action, plant staff developed a method for documenting and tracking non-destructive analysis survey results and the movement of equipment in the stores areas and warehouses. Additionally, formal classroom training was completed for NCS anomalous condition responders to emphasize the importance of a questioning attitude regarding compliance with NCS requirements. The inspectors have no further issues, and this item is closed.

- O8.5 (Closed) Event Report 35732: High Condensate Level Shutoff Actuation on Autoclave Number (No.) 2 in Building X-344

Plant staff determined that the root cause was the lack of procedural controls to ensure autoclaves were drained of condensate prior to restarting them following a short duration shutdown. As corrective action, applicable procedures were revised to require that the PSS be notified of autoclave operability; PRs are generated anytime an autoclave heating cycle is interrupted; and corrective actions are taken to prevent recurrence prior to restart of the autoclave. The inspectors have no further issues, and this item is closed.

- O8.6 (Closed) VIO 70-7002/99003-02: Failure to Implement Confined Space and Radiation Work Permit (RWP) Requirements for Plant Staff

The inspectors identified that air samples and contamination surveys were not performed prior to entering a cell housing as required by the RWP, and the attendee did not maintain contact with operators inside the housing as required by Procedure XP2-SH-IH1032, "Confined Space Program." Corrective actions included training cognizant plant staff on the requirements for procedural compliance, conducting pre-job briefings, and ensuring that the staff understand their job responsibilities prior to performing infrequently performed tests or evolutions. During the current inspection period, the inspectors observed that plant staff performed a confined space entry in accordance with the applicable RWP and Procedure XP2-SH-IH1032, and no additional issues were noted. This item is closed.

II. Maintenance

M1 Conduct of Maintenance Activities

M1.1 Plug Ejected During Side Purge Pipe Cleaning

a. Inspection Scope (88103)

The inspectors followed up on an incident involving the ejection of a pipe plug during the cleaning of the side purge piping.

b. Observations and Findings

On March 21, during an attempt to free up a stuck “pig” used to clean out side purge piping, a mechanical plug used as a pressure boundary was ejected from a valve body, penetrating the ceiling before falling back to the cell floor. The incident created a small cloud of dust which resulted in a “see and flee.” Subsequent surveys performed by emergency responders did not detect any airborne radioactivity or spread of contamination to uncontrolled areas.

The pigging operation involved pneumatically propelling bullet-shaped foam plugs (pigs) through long sections of side purge piping to remove material left from the December 1998 fire. During the operation on March 19, a “hard bristled” pig was launched and became stuck within a valve body. An attempt to free the pig by launching an additional “soft foam” pig to form a pressure seal was not successful. The dislodging of the pigs was then turned over to maintenance for “troubleshooting.”

During the followup investigation, plant staff determined that maintenance personnel raised the pressure in the piping up to 130 pounds per square inch gage (psig) per the advice of the vendor when the mechanical plug failed on March 21. However, Procedure XP2-CO-CA2417, “X-326 Side Purge Piping Waste Removal,” which pressure tested the piping to 50-70 psig, was not revised to authorize raising the pressure to 130 psig. Additionally, the procedure did not provide guidance for removal of a stuck pig, and a PR was not generated which would have alerted plant management of the need for a rigorous safety review prior to raising the pressure.

As corrective action, plant staff revised the procedure to specify the maximum allowable pressure and develop limitations for off-normal activities involving stuck pigs. Additionally, a lessons learned was issued to appropriate plant staff regarding the requirements for issuing PRs when abnormal conditions were encountered. Also, interim guidance was provided to engineering personnel until procedural requirements were approved to establish bounds during troubleshooting activities on non-safety systems.

Raising the pressure in the piping to 130 psig, which resulted in the plug failure, without revising Procedure XP2-CO-CA2417 to authorize it, is a violation. However, no release of radioactive contamination to uncontrolled areas resulted and plant staff took appropriate corrective actions. Therefore, this certificatee-identified, non-repetitive, certificatee-corrected violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1 of the NRC Enforcement Policy.

c. Conclusions

The inspectors concluded that the root cause of the incident involving the ejected plug during cleaning of the side purge piping was a failure to perform a rigorous safety review prior to raising the pressure above that authorized by the approved procedure. Plant staff took appropriate corrective action in response to the incident. One NCV was identified.

M1.2 Lifted Lead and Jumper Log Deficiencies

a. Inspection Scope (88103)

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

b. Observations and Findings

On March 22, during a review of work packages in Building X-343, the inspectors noted some deficiencies with the use of lifted lead and jumper logs, each involved different maintenance personnel. The deficiencies included failure to document the specific procedure or work instruction step being implemented; failure to document the specific lead being removed using a unique identifier; and the use of arrows to signify subsequent entries after the first line was completed. An additional example was noted where the dates in the “restored by” and “verified by” columns appeared to be recorded by the same individual rather than by the individuals initialing the spaces.

The inspectors discussed the issues with maintenance management who documented them in PR 00-01638. As corrective action, maintenance management issued a daily operating instruction to affected personnel to discuss the deficiencies and emphasize the importance of properly completing the logs.

c. Conclusions

The inspectors identified some deficiencies in the use of lifted lead and jumper logs during a review of maintenance work packages, indicating the need for increasing rigor during documentation of the packages.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) VIO 70-7002/99009-02: Failure to Correct Deficiencies in the Preventative Maintenance Program for Rail Track and Associated Equipment

Plant staff determined that the root cause of the violation was that plant management did not adequately assess the safety significance of deficiencies that had previously been identified when the corrective actions were deferred. As corrective actions, plant staff ceased site railcar movement until railcars, rails, and associated equipment were inspected using an enhanced inspection process per revised Procedure

XP2-GP-BG1030, "Oversite, Inspection and Maintenance of PORTS Railroad." The inspectors noted no further failures, and this item is closed.

- M8.2 (Closed) Event Report 35556: Transformer Failure Resulting in Release of Approximately 8500 Gallons of Oil Into the Cobble Bed in Switchyard X-533

Plant staff declared an "Alert" and took appropriate actions to prevent the oil runoff from escaping to the environment. Plant staff determined that the transformer experienced an electrical fault that generated enough internal pressure to rupture the tank and spill the oil. The inspectors noted that the transformer was under a normal load during the time of the event and that preventive maintenance (PM) was current. As corrective action, plant staff intended to install continuous oil combustible gas monitoring systems on transformers in Switchyards X-530 and X-533 to enhance the ability to detect developing degraded transformer conditions. The inspectors noted that PM frequency and testing activities exceeded industry standards and that the failure rates of these transformers were not unusual. The inspectors noted no further failures, and this item is closed.

- M8.3 (Closed) Event Report 35576: High Condensate level Shutoff Actuation on Autoclave No. 2 in Building X-344

Plant staff determined that the root cause for the event was inadequate cleaning of the interior of the autoclave following maintenance which resulted in the accumulation of debris in the drain line. As corrective action, training was provided to appropriate personnel regarding foreign material exclusion practices and autoclave shell cleaning. Additionally, applicable procedures were revised to enhance foreign material excursion controls and instructions for performing boroscopic inspections and flushing of the drain lines. The inspectors noted no further issues, and this item is closed.

- M8.4 (Closed) Event Report 35673: The Building X-343 North Crane Brake Actuated While Moving a 14-Ton Liquid UF₆ Tails Cylinder From an Autoclave

The crane brake actuated after the hoist motor breaker tripped due to an overcurrent condition. The hoist breaker tripped because the hoist motor control system was improperly adjusted and resulted in an excessive current demand. The plant staff determined that the root cause for the improperly adjusted control system was conflicting procedural guidance. Procedure XP4-TE-EM6450, "X-343 Crane Static Stepless Alignment," was revised to clearly identify each adjustment step required by the vendor manual. The inspectors noted no further system actuations, and this item is closed.

- M8.5 (Closed) Event Report 35955: High Condensate Level Shutoff Actuation on Autoclave No. 2 in Building X-344

Plant staff determined that the event resulted when the slope of the condensate line, which had been modified by maintenance personnel, did not allow proper condensate drainage. As corrective action, a lessons learned was conducted with maintenance

personnel to emphasize the importance of closely following drawings when installing modifications. Additionally, applicable engineering design procedures were revised to incorporate a walk through inspection checklist to provide verification of required modification activities. The inspectors have no further issues, and this item is closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Liquid Cylinder Lifting Fixture Hook Surveillance Deficiency

a. Inspection Scope (88100)

The inspectors reviewed the engineering evaluation of a modification to the cylinder lifting hooks used during liquid UF₆ cylinder movement. Additionally, the inspectors reviewed the methods used to perform the required surveillance for these lifting hooks.

b. Observations and Findings:

The inspectors observed that plant staff had modified the cylinder lifting hooks associated with the 2-½ ton UF₆ cylinder lifting fixtures. Specifically, approximately 30 percent of the hook's end was cut off. In discussion with the inspectors, plant staff explained that the shortened hook end allowed the hook to fully engage on the rim of the cylinder because, prior to the modification, the hook end would press against the cylinder and limit full engagement. The inspectors verified that the four lifting hooks used to lift the 2-½ ton liquid cylinders were rated at the appropriate load (5 tons) and they properly engaged the cylinder rim.

The inspectors reviewed the engineering design evaluation and noted that the hook modification was properly analyzed. However, the inspectors noted that the required inspection method for the hooks did not consider the modification. The inspectors noted that plant staff had committed to inspect the lifting hooks per the requirements of American National Standards Institute (ANSI) B30.10, "Hooks," as delineated in Technical Safety Requirement (TSR) 2.1.3.12 for the feed facilities and TSR 2.5.3.10 for the withdrawal facilities. ANSI B30.10, Section 10-1.2.3 required the throat opening to be measured to ensure no more than 15 percent growth.

The inspectors noted that the vendor's deformation mark from which the measurement was taken was removed when the end of the hook was cut off. Plant staff apparently placed a new mark on the portion of the hook that remained. The inspectors identified that the measurement from the new mark would impact the 15 percent growth acceptance criteria. Specifically, permanent hook deformation would be greater than 15 percent growth measured at the cut-off ends versus the end of an unmodified hook. The inspectors determined that plant staff had not evaluated this non-conservative change.

In response to the inspectors finding, the PSS contacted Code Inspection, who immediately verified that the hooks had passed all current surveillances with no

measured deformation. Additionally, the PSS issued PR 00-01712 that requested engineering to perform an operability evaluation. The justification for continued use of the hooks was based on the review of current surveillance results. As corrective action, plant staff revised Procedure XP4-QA-QI6915, "Inspection and Testing of UF₆ Handling Slings and Lifting Fixtures," to incorporate a more conservative acceptance criteria for the hook surveillance.

c. Conclusion

The inspectors identified that plant staff were using a non-conservative method for performing a required surveillance for modified hooks on liquid UF₆ cylinder lifting fixtures. Plant staff took appropriate action to evaluate the component's structural integrity and revised the applicable procedure to incorporate the more conservative acceptance criteria.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) Compliance Plan Issue 44: Criticality Accident Alarms For Nearby Buildings

The description of the noncompliance for this issue was that several leased buildings located within 200 feet of buildings with criticality accident alarm system clusters did not have evacuation horns and lights activated by these clusters. Additionally, horns from adjacent alarmed buildings could not be heard within most of the unalarmed buildings. The inspectors reviewed the certificatee's closure package and toured the site to verify that evacuation horns and lights were installed in the affected buildings, or the buildings were removed from the 200-foot evacuation zone. This item is closed.

E8.2 (Closed) Event Report 35777: Building X-330 South Tails Crane Hoist Brake Actuation While Moving a 14-ton Liquid Tails Cylinder to a Cooling Position.

Plant staff determined that the root cause was that an undocumented legacy modification had been made to the pendant strain relief mechanism which caused several wires to break. In response to this finding, plant staff inspected all liquid handling cranes and found that the South Tails Crane was the only one using this type of strain relief mechanism. As corrective action to this and other similar events, plant management committed to perform an integrated review of liquid UF₆ cylinder handling, including crane system walkdowns. The inspectors will use existing inspector followup item (IFI) 70-7002/99007-02 to track completion of this initiative. This item is closed.

IV. Plant Support

R1 Radiation Protection Controls

R1.1 Radioactive Contamination Control Deficiencies

a. Inspection Scope (83822)

The inspectors toured various plant areas and observed radiological contamination control practices.

b. Observations and Findings

The inspectors observed radiological contamination control practices while performing routine tours of the plant during the inspection period and identified several deficiencies including:

- On March 21, during an inspection in Building X-330, the inspectors identified inappropriately marked tools in a contamination area at Tails. Specifically, the inspectors noted that the tools in the contaminated area were not consistently marked yellow to identify that the tools may be contaminated. The responsible health physicist explained that anything leaving the contaminated area was surveyed but that the tool marking enhanced the identification of potentially contaminated tools.

Additionally, on the building operating floor, a contamination boundary chain did not encompass all of the potentially contaminated water leaking in that area (i.e., some water had spread outside of the boundary). Plant staff expanded the boundary to include all of the potentially contaminated water. PR 00-01561 was issued to document the deficiencies. No spread of contamination was identified.

- On April 6, during a tour of the cascade buildings, the inspectors noted several contamination control issues associated with water that had puddled on the operating floors caused by steam leaks on the cell floors. The inspectors noted that areas containing the potentially contaminated water were not posted or restricted within a boundary. Additionally, water was observed leaking from the cell floor to the track alley area outside of the Low Assay Withdrawal area. As immediate corrective action, plant staff established boundaries around the water and surveyed the areas for contamination. In all cases, plant staff determined that there was no spread of contamination. PR 00-01889 was issued to document the deficiencies.
- Throughout the inspection period, the inspectors observed issues which could have promulgated the spread of radiological contamination. Specifically, the inspectors observed packing material, PPE, paper, and other debris that had the potential to spread contamination if blown from contaminated areas. Additionally, the inspectors observed used, disposable PPE deposited within and outside the step-off pads at boundary control areas. Also, areas of the cascade buildings were cluttered with barrels of used PPE staged for disposal, tools needing to be surveyed for release, and legacy parts/equipment.

The inspectors discussed the generic radiological issues with plant management. Plant management acknowledged that the steam leaks, accumulation of contaminated equipment, and housekeeping issues did have the potential to promulgate contamination and were being addressed. Specifically, plant management's actions to address contamination control issues included evaluating the methods used and timeliness to address steam leaks; assigning dedicated plant staff to remove legacy

equipment and waste to reduce the quantity of contaminated waste; and using the floor sweepers in the process buildings to aid in addressing housekeeping issues. Plant management also implemented a contamination boundary assessment team to identify and correct those deficiencies. The effectiveness of plant management's actions to improve contamination control practices is an **Inspection Followup Item (IFI 70-7002/2000002-01)**.

c. Conclusion

The inspectors identified that poor housekeeping practices and deficient identification of radiological areas had the potential to spread contamination. The issues identified were promptly addressed and no spread of contamination was found. An inspection Followup Item was identified.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of the facility management on April 17, 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 April 17, 2000.

INSPECTION PROCEDURES USED

IP 83822: Radiation Protection
IP 88100: Plant Operations
IP 88103: Maintenance
IP 90712: In-office Reviews of Written Reports on Non-routine Events

ITEMS OPENED, CLOSED, AND DISCUSSED

<u>Opened</u>	<u>Item Type</u>	<u>Summary</u>
36763	CER	Safety System Actuation, Building X-342, manual actuation of autoclave containment safety system
2000002-01	IFI	Poor contamination control practices
<u>Closed</u>		
70-7002/99001-01	VIO	Failure to take action to prevent challenges to safety systems prior to returning equipment to service
70-7002/99003-02	VIO	Plant staff failed to implement confined space and radiation work permit requirements for worker safety
70-7002/99007-04	VIO	NCSA violation for valve storage at Building X-744H
70-7002/99009-02	VIO	Failure to correct deficiencies in the preventative

			maintenance program for rail track and associated equipment
35556	CER		“Alert” declaration due to transformer oil leak in Switchyard X-533
35576	CER		Safety System Actuation, Building X-344, Autoclave No. 2 high condensate level shutoff actuation
35673	CER		Safety System Actuation, Building X-343, south crane brakes activated upon loss of power while moving a liquid UF ₆ cylinder
35732	CER		Safety System Actuation, Building X-344, Autoclave No. 2 high condensate level shutoff actuation
35777	CER		Safety System Actuation, Building X-330 Tails area, hoist brakes on South Crane actuated while lowering a 14- ton liquid UF ₆ cylinder
35955	CER		Safety System Actuation, Building X-344, Autoclave No. 2 high condensate level shutoff actuation
Compliance Plan Issue 44			Criticality accident alarms for nearby buildings

Discussed

None

LIST OF ACRONYMS USED

ANSI	American National Standards Institute
CER	Certificate Event Report
CFR	Code of Federal Regulations
DNMS	Division of Nuclear Material Safety
FLM	First Line Manager
IFI	Inspector Followup Item
NCS	Nuclear Criticality Safety
NCSA	Nuclear Criticality Safety Approval
NCV	Non-Cited Violation
No.	Number
NRC	Nuclear Regulatory Commission
PERR	Public Electronic Reading Room
PM	Preventative Maintenance
PPE	Personal Protective Equipment
PR	Problem Report
psig	Pounds per Square Inch Gage
PSS	Plant Shift Superintendent

RWP	Radiation Work Permit
SAR	Safety Analysis Report
TSR	Technical Safety Requirement
UF ₆	Uranium Hexafluoride
VIO	Violation