

January 19, 2001

Mr. J. M. Brown
Vice President - Operations
United States Enrichment Corporation
Two Democracy Center
6903 Rockledge Drive
Bethesda, MD 20817

SUBJECT: PORTSMOUTH INSPECTION REPORT 70-7002/2001001(DNMS)
AND NOTICE OF VIOLATION

Dear Mr. Brown:

On December 29, 2000, the NRC completed a routine resident inspection at the 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.

Based on the results of the inspection, the NRC has determined that one violation of NRC requirements occurred. The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding the violation are described in detail in the enclosed report. The violation is of concern because we continue to identify problems regarding your staff's adherence to plant procedures. In addition, problem reports were not generated in a timely manner after the inspectors raised the issues with your staff.

The NRC has concluded that information regarding the reason for the violation, the corrective actions taken and planned, and the date when full compliance will be achieved has been addressed adequately in the enclosed inspection report. Therefore, you are not required to respond to this violation unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed notice.

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

J. Brown

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We will gladly discuss any questions you have concerning this inspection.

Sincerely,

/RA/

Patrick L. Hiland, Chief
Fuel Cycle Branch

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

Enclosures: 1. Notice of Violation
2. Inspection Report 70-7002/2001001(DNMS)

cc w/encls: P. D. Musser, Portsmouth General Manager
P. J. Miner, Manager, Regulatory Affairs/Commitment Management, Portsmouth
H. Pulley, Paducah General Manager
S. A. Toelle, Director, Nuclear Regulatory Affairs, USEC
Portsmouth Resident Inspector Office
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R. M. DeVault, Regulatory Oversight Manager, DOE
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NOTICE OF VIOLATION

United States Enrichment Corporation
Portsmouth Gaseous Diffusion Plant

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

During an NRC inspection conducted from November 21, 2000, through December 29, 2000, one violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, Revision 1, the violation is listed below:

Technical Safety Requirement 3.9.1 requires, in part, that written procedures shall be prepared, reviewed, approved, and implemented for activities described in Appendix A to Safety Analysis Report Section 6.11.

Safety Analysis Report Section 6.11, Appendix A, describes investigations and reporting, coolant system operation, and equipment control as activities for which procedures shall be implemented. In addition:

- A. Step 8.2.16 of Procedure XP4-TS-CY7647, "Field Test Of Cryo-Seal Coolant Stop Leak," requires that the injection apparatus be pressurized to 20-25 psi higher than the coolant pressure.
- B. Steps 2.1.7 and 6.1.7 of Procedure XP2-BM-CI1030, "Problem Reporting," requires a problem report to be generated for a procedure violation and be provided to the Plant Shift Superintendent prior to the end of the shift that the issue was identified.
- C. Step 5.9 of Procedure XP2-SH-IS1034, "Accident Prevention/Equipment Control Tags," requires that all employees observe and follow any special conditions/instructions on caution tags.

Contrary to the above:

- A. On December 19, 2000, laboratory personnel pressurized the injection apparatus to approximately 82 psi higher than the coolant pressure during sealant injection in Cell 33-2-2 and did not generate a problem report for the procedure violation prior to the end of the shift on the following day after a discussion with the inspectors.
- B. On December 26, 2000, plant staff did not follow the special condition on a caution tag, which specified that the Extended Range Product Station crane breaker was to be left off/open. The breaker was found unattended in the closed position, and plant staff did not generate a problem report for the procedure violation by the end of the shift after discussion with the inspectors.

This is a Severity Level IV violation (Supplement VI). **(VIO 070-07002/2001001-01)**

The NRC has concluded that information regarding the reasons for Violation 70-7002/2001001-01, the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance will be achieved are already adequately addressed in this Inspection Report. Therefore, a specific response to Violation 70-7002/2001001-01 is not required. However, you are required to submit a written statement or explanation, pursuant to 10 CFR 76.70, if the description therein does not accurately reflect your corrective actions or

your position. In that case, or if you choose to respond, clearly mark response as a "Reply to a Notice of Violation," and send it to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region III, and a copy to the NRC Resident Inspector at Portsmouth, within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

If you contest this enforcement action, you should also provide a copy of your response, with the basis for denial, to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

Because your response will be placed in the NRC Public Electronic Reading Room (PERR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PERR without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (for example, explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 19th day of January 2001

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report No: 70-7002/2001001(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: November 21, 2000, through December 29, 2000

Inspectors: D. J. Hartland, Senior Resident Inspector
S. R. Caudill, 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 70-7002/2001001(DNMS)

Operations

The inspectors noted problems during the inspection period with cold weather protection of fire water systems in the cascade buildings due to poor material condition and a lack of rigorous inspections. In response, plant staff took immediate action to heighten awareness across the site and intended to prepare a plant-wide procedure to enhance existing guidance. (Section O1.1)

Maintenance

The inspectors identified four examples of failure to follow plant procedures, including two examples of failure to generate a problem report in a timely manner. (Section M1.1)

Engineering

The inspectors concluded that the monitoring of vent emissions at the cold recovery station in the process buildings was consistent with certificate requirements. Operations management took appropriate action to address the adjustment of an alarm setpoint by an operator without procedural guidance. (Section E1.1)

Report Details

I. Operations

O1 Conduct of Operations

O1.1 Cold Weather Protection

a. Inspection Scope (88100)

The inspectors reviewed controls for ensuring that plant equipment was not negatively impacted by cold weather.

b. Observations and Findings

The inspectors noted repeated problems during the inspection period with cold weather protection of Technical Safety Requirement (TSR) related high pressure fire water sprinkler systems in Buildings X-330 and X-333. None of the problems impacted the operability of those systems. However, during followup, the inspectors noted problems with material condition of the cascade buildings ventilation systems including partially open outside-air louvers, as well as the unavailability of fans used to re-circulate warm air from the cell floor that were located next to sprinkler system risers. The inspectors also noted a lack of rigor by plant staff in the inspections of those systems during cold weather to ensure no negative impact.

The inspectors discussed these issues with the Plant Shift Superintendent (PSS) who documented them in Problem Reports (PRs) 00-5994 and 00-6003. In response, the PSS office issued daily operating instructions (DOI) to heighten awareness plant-wide and ensure that adequate cold weather protective actions were taken. The DOI included requirements for operators to verify that ventilation louvers and fans were configured for winter operation. In addition, operators were required to take temperature readings from each sprinkler system riser and then document these readings in the first line manager (FLM) log. Any temperatures found below 40°F were required to be reported to the PSS and to the fire department for further evaluation. As long-term corrective action, plant staff intended to prepare a plant-wide procedure to combine and enhance those requirements that existed in lower tiered procedures.

c. Conclusions

The inspectors noted problems during the inspection period with cold weather protection of fire water systems in the cascade buildings due to problems with material condition and a lack of rigorous inspections. In response, plant staff took immediate action to heighten awareness across the site and intended to prepare a plant-wide procedure to enhance existing guidance.

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>
37556	11/29/00	Open	Safety System Actuation, Building X-343 Autoclave No. 3 experienced a High Condensate Level Shutdown actuation while the autoclave was in Mode II (Heating).
37580	12/08/00	*Closed	Inbound shipment of healed cylinders was discovered to have external radiation readings exceeding the limits of 10 CFR 71.47.

* Root cause investigation and corrective actions, as necessary, to be performed by shipper of the cylinders.

O8.2 Bulletin 91-01 Reports (97012)

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

<u>Number</u>	<u>Date</u>	<u>Title</u>
37591	12/12/00	24-Hour Report - NCS violation; NCS personnel discovered a seal can storage area in Building X-333 with two groups of seal cans spaced less than the 48" edge to edge spacing required by the Nuclear Criticality Safety Approval.

O8.3 (Closed) CER 36719 (ER-00-01): Actuation of cascade automatic data processing smoke detection system in the Building X-326 Extended Range Product Station. Plant staff determined that the root cause was a compressor seal failure. The probability of seal failures, as discussed in the accident analysis, was high but the consequences were negligible. The inspectors have no further issues, and this item is closed.

O8.4 (Closed) CER 37106 (ER-00-03): Criticality Accident Alarm System (CAAS) rendered incapable of performing its design function during past process building evacuation horn testing. Plant staff determined that the root cause was that the horn testing procedures were inadequate in that they did not address entering TSR limiting conditions for

operation (LCOs) for CAAS audibility during the testing. As corrective action, plant staff revised applicable procedures to address LCO actions during the horn testing. Failure to enter TSR LCOs during horn testing was a violation. However, the testing was of short duration and plant staff took immediate and effective actions to address the issue. Therefore, this certificatee identified and corrected violation is being treated as a Non-cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

- 08.5 (Closed) IFI 70-7002/2000006-02: Corrective actions to address guidance for response and status control for standing alarms. Plant staff developed Procedure XP2-PO-PO1010, "Alarm Status Control," which provided evaluation guidance and ensured that alarm status and compensatory measure information was readily available to operations personnel for alarms that could not perform their intended safety function. The inspectors have no further issues and this item is closed.

II. Maintenance

M1 Conduct of Maintenance Activities

M1.1 Procedural Adherence Deficiencies

a. Inspection Scope (88103)

The inspectors observed maintenance activities to assess for compliance with certificate requirements.

b. Observations and Findings

The inspectors identified examples of failure to follow approved procedures while observing selected maintenance activities in the plant:

- On December 19, the inspectors observed laboratory personnel inject sealant into the Cell 33-2-2 coolant system in Building X-333 per Procedure XP4-TS-CY7647, "Field Test Of Cryo-Seal Coolant Stop Leak." The sealant was a silicon-based liquid monomer which reacted with moisture at a leak site in the coolant system to form a solid polysiloxane.

The solution was injected into the coolant system by pressurizing a scuba tank containing the sealant using a cylinder of pressurized nitrogen gas. After aligning the valves on the injection apparatus, the laboratory personnel pressured the scuba tank up to 185 psi., but no flow of the solution to the coolant system was observed. After some troubleshooting, the staff determined that the coolant condenser vent valve, through which the solution was to be fed to the coolant system, was not open as required. When the valve was opened, flow was immediately observed and the solution was injected into the coolant system without incident.

While observing the evolution, the inspectors discussed with the laboratory personnel any limitations regarding the injection apparatus pressure. The individuals stated that the procedure limited the pressure to 200 psi. Afterwards, the inspectors reviewed the procedure, which required that the nitrogen regulator be set at 200 psi. However, Step 8.2.16 of the procedure required that the pressure of the injection apparatus be 20-25 psi above the coolant pressure, which was at about 103 psi at the time.

The inspectors discussed the issue with the individuals the following day but a problem report was not generated until the inspectors notified the production support manager of the apparent procedure non-compliance on December 21. As corrective action, plant management issued a lessons learned bulletin to emphasize the importance of following procedures as written and issuing problem reports in a timely manner.

Technical Safety Requirement 3.9.1 required, in part, that written procedures shall be prepared, reviewed, approved, and implemented for activities described in Appendix A to Safety Analysis Report (SAR) Section 6.11. Safety Analysis Report Section 6.11, Appendix A, described investigations and reporting and coolant system operation as activities for which procedures shall be implemented. In addition, Step 8.2.16 of Procedure XP4-TS-CY7647, "Field Test Of Cryo-Seal Coolant Stop Leak," required that the injection apparatus be pressurized to 20-25 psi higher than the coolant pressure. Also, Steps 2.1.7 and 6.1.7 of Procedure XP2-BM-C11030, "Problem Reporting," required a problem report to be generated for a procedure violation and provided to the PSS prior to the end of the shift that the issue was identified. Contrary to the above, on December 19, laboratory personnel pressurized the injection apparatus to approximately 82 psi above the coolant pressure and did not generate a problem report for the procedure violation prior to the end of the shift on the following day after a discussion with the inspectors. These are **violations. (70-7002/2001001-01a)**

- On December 26, during a routine walkdown at the Extended Range Product (ERP) Station in Building X-326, the inspectors noted a caution tag was hung on the crane breaker that indicated that the crane was inoperable for movement of liquid cylinders and that the breaker was to be maintained in the off/open position. The tag was hung per TSR 2.5.3.10 which required the crane to be tagged out of service within one hour of being declared inoperable. However, the inspectors noted that the breaker was in the closed position and that the crane was energized.

The inspectors discussed the issue with the operations FLM who indicated that the breaker was probably closed by maintenance personnel troubleshooting a problem with the crane, but they apparently did not open the breaker prior to leaving the area. In response, the FLM ensured that the breaker was reopened but did not document the issue on a problem report. The following morning, the inspectors discussed the issue with the operations Building Manager who discovered the breaker closed again and the area unattended. The Building Manager opened the breaker, moved the tag to the pendent, and documented the issue in Problem Report 00-0602.

In addition, as immediate corrective action, the crane maintenance crew was counseled on the use of caution tags and a lessons learned was issued to stress the importance of initiating problem reports in a timely manner for non-compliant conditions. Also, operations issued a DOI to require a caution tag for an inoperable crane to be hung on the pendent/radio operator until the applicable procedures were changed to specify the location.

Technical Safety Requirement 3.9.1 required, in part, that written procedures shall be prepared, reviewed, approved, and implemented for activities described in Appendix A to Safety Analysis Report Section 6.11. Safety Analysis Report Section 6.11, Appendix A, described investigations and reporting and equipment control as

activities for which procedures shall be implemented. In addition, Step 5.9 of Procedure XP2-SH-IS1034, "Accident Prevention/Equipment Control Tags," required that all employees observe and follow any special conditions/instructions on caution tags. Also, Steps 2.1.7 and 6.1.7 of Procedure XP2-BM-C11030, "Problem Reporting," required a problem report to be generated for a procedure violation and provided to the PSS prior to the end of the shift that the issue was identified. Contrary to the above, on December 26, plant staff did not follow the special condition on the caution tag, as the ERP crane breaker was left unattended in the closed position, and did not generate a problem report of the procedure violation by the end of the shift after discussion with the inspectors. These are **violations. (70-7002/2001001-01b).**

c. Conclusions

The inspectors identified four examples of failure to follow plant procedures, including two examples of failure to generate a problem report in a timely manner.

III. Engineering

E1 Conduct of Engineering

E1.1 Space Recorder Setpoint Issue

b. Inspection Scope (88100)

The inspectors reviewed an issue regarding the setpoint for the cold recovery space recorders in the process buildings.

b. Observations and Findings

On December 15, during a discussion with the cold recovery operator in Building X-330, the inspectors discovered that the operator was adjusting the alarm setpoint for the space recorder that monitored the radioactivity from the vent emissions from that area. The operator explained that the setpoint needed to be adjusted because it varied based upon the background radiation of the instrumentation as well as the assay of the material being processed. However, the inspectors noted that operations did not have procedural guidance for adjusting the setpoint, as instrument maintenance was responsible for performing that activity. In response, operations management generated PR 00-05873 and requested an engineering evaluation to ensure that monitoring of the emissions was consistent with certificate requirements.

During followup, the inspectors noted that operation of the space recorders at higher background levels, which required the recorders to be adjusted to higher sensitivity settings, could result in the alarm setpoint being above the conservative operational limit of 10 parts per million uranium as described in the SAR. The inspectors discussed the issue with plant staff, who generated PR 00-0225 for further review. As immediate corrective action, operations shut down cold recovery operations in Building X-330 pending resolution of the issue. Cold recovery operations in Building X-333 was allowed to continue, as the governing procedure required that the recorder be monitored every half hour while operating at higher sensitivity settings.

The inspectors noted that the issue had minimal safety significance, as venting operations would have to continue for several hours at elevated emission concentrations before baseline effluent limits would be exceeded. Operations performed hourly checks of the recorder and laboratory personnel analyzed samples every four hours while venting operations were in progress, as required by plant procedures, to ensure that operational limits were not being exceeded. Continuous vent monitors provided additional assurance that emission limits were not being challenged. If the alarm was to actuate spuriously, operators were required to follow procedural requirements for standing alarms to ensure that appropriate compensatory actions were taken.

In response to the operator's unauthorized adjustment of the alarm setpoint, operations management investigated and determined that the practice was an isolated one and issued a lessons learned to applicable personnel. Given the minimal safety significance, as vent emissions monitoring capability was not compromised, adjustment of the alarm setpoint without procedural guidance is considered a minor violation not subject to formal enforcement action.

c. Conclusions

The inspectors concluded that the monitoring of vent emissions at the cold recovery station in the process buildings was consistent with certificate requirements. Operations management took appropriate action to address the adjustment of the alarm setpoint by an operator without procedural guidance.

IV. Plant Support

P8 Miscellaneous Plant Support Issues

- P8.1 (Closed) IFI 70-7002/99013-01: Characterization and cleanup of the southwest corner of Building X-326 that had become contaminated as a result of the December 1998 purge cascade cell fire. The inspectors verified that the area was restored to conditions prior to the fire and this item is closed.
- P8.2 (Closed) IFI 70-7002/2000002-01: Effectiveness of plant management's actions to improve contamination control practices. Actions taken included weekly walkdowns of facilities by multi-craft teams and the addition of contamination control self-assessments to the operations schedule of activities. In addition, contamination control/housekeeping training was conducted for applicable plant staff. The inspectors have noted an improvement in this area 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 December 29, 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

*P. Musser, General Manager
J. Anzelmo, Work Control Manager
*D. Couser, Training & Procedures Manager
J. Cox, Plant Services Manager
L. Cutlip, Acting Engineering Manager
*D. Fosson, Operations Manager
S. Fout, Enrichment Plant Manager
R. Lawton, Nuclear Safety & Quality Manager
*P. Miner, Regulatory Affairs/Commitment Management Manager
*R. Smith, Plant Support Manager
M. Wayland, Maintenance Manager

*Denotes those present at the exit meeting on December 29, 2000.

INSPECTION PROCEDURES USED

IP 88100: Plant Operations
IP 88103: Maintenance
IP 88100: Engineering
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>
37556	CER	Safety System Actuation, Building X-343 Autoclave No. 3 experienced a High Condensate Level Shutdown actuation while the autoclave was in Mode II (Heating).
<u>Closed</u>		
70-7002/2001001-01	VIO	Failure to adhere to plant procedures.
70-7002/2000006-02	IFI	Corrective actions to address guidance for response and status control for standing alarms.
70-7002/2000002-01	IFI	Effectiveness of plant management's actions to improve contamination control practices.
70-7002/99013-01	IFI	Characterization and cleanup of the southwest corner of Building X-326 that had become contaminated as a result of the December 1998 purge cascade cell fire.
37580	CER	Inbound shipment of healed cylinders was discovered to have external radiation readings exceeding the limits of 10 CFR 71.47.

36719 (ER 00-01)	CER	Actuation of cascade automatic data processing smoke detection system in the Building X-326 Extended Range Product Station.
37106 (ER 00-03)	CER	Criticality Accident Alarm System rendered incapable of performing its design function during past process building evacuation horn testing.

Discussed

None

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
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
ERP	Extended Range Product
FLM	First Line Manger
IFI	Inspection Follow-up Item
LCO	Limiting Condition For Operation
NCS	Nuclear Criticality Safety
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
PERR	Public Electronic Reading Room
PR	Problem Report
PSS	Plant Shift Superintendent
SAR	Safety Analysis Report
TSR	Technical Safety Requirements
USEC	United States Enrichment Corporation
VIO	Violation