

April 28, 2004

EA-04-053

Mr. Mark Peifer  
Site Vice-President  
Duane Arnold Energy Center  
Nuclear Management Company, LLC  
3277 DAEC Road  
Palo, IA 52324

SUBJECT: DUANE ARNOLD ENERGY CENTER  
[NRC INVESTIGATION REPORT NO. 3-2003-021]

Dear Mr. Peifer:

This refers to the investigation completed by the NRC Office of Investigations on February 6, 2004. The purpose of the investigation was to review a potential deliberate violation of procedures for moving items in the Spent Fuel/Cask Pool at Duane Arnold Energy Center (DAEC) without Health Physics personnel being present.

Based on the results of this investigation, one apparent willful violation was identified and is being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. The current Enforcement Policy is included on the NRC's Web site at [www.nrc.gov](http://www.nrc.gov); select **What We Do, Enforcement**, then **Enforcement Policy**.

On July 23, 2003, a refueling floor supervisor working on the DAEC refuel floor failed to notify Health Physics, and ensure that a Health Physics technician was present, prior to relocating irradiated reactor parts/items in the DAEC Spent Fuel/Cask Pool. The supervisor knew through prior communications with Health Physics personnel that Health Physics personnel were required to be present during this operation and did not ensure that Health Physics was present. Since the NRC has not made a final determination in this matter, no Notice of Violation is being issued for these investigation findings at this time. In addition, please be advised that the number and characterization of the apparent violation described above may change as a result of further NRC review.

A closed predecisional enforcement conference to discuss this apparent willful violation has been scheduled for 1:00 p.m. on June 1, 2004, at the NRC Region III Office, 2443 Warrentville Road, Suite 210, Lisle, Illinois 60532-4352. The conference is closed to public observation because it involves the findings in an Office of Investigation report that has not been publically disclosed. The decision to hold a predecisional enforcement conference does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference is being held to obtain information to assist the NRC in making an enforcement decision. This may include information to determine whether a violation occurred, information to determine the significance of a violation, information related to the identification of a violation, and information related to any corrective actions taken or planned. The conference will provide an opportunity for you to provide your perspective on these matters and any other information that you believe the NRC should take into consideration in making an enforcement decision.

You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding the apparent violation is required at this time.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>.

Sincerely,

*/RA/*

Cynthia D. Pederson, Director  
Division of Reactor Safety

Docket No. 50-331  
License No. DPR

Enclosure: Factual Summary, OI Report Case No. 3-2003-021

cc w/encl: E. Protsch, Executive Vice President -  
Energy Delivery, Alliant;  
President, IES Utilities, Inc.  
C. Anderson, Senior Vice President, Group Operations  
J. Cowan, Executive Vice President and Chief Nuclear Officer  
J. Bjorseth, Plant Manager  
S. Catron, Manager, Regulatory Affairs  
J. Rogoff, Vice President, Counsel, & Secretary  
B. Lacy, Nuclear Asset Manager  
Chairman, Linn County Board of Supervisors  
Chairperson, Iowa Utilities Board  
The Honorable Charles W. Larson, Jr.  
Iowa State Senator  
D. McGhee - Department of Public Health

M. Peifer

-2-

You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding the apparent violation is required at this time.

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S. Catron, Manager, Regulatory Affairs  
J. Rogoff, Vice President, Counsel, & Secretary  
B. Lacy, Nuclear Asset Manager  
Chairman, Linn County Board of Supervisors  
Chairperson, Iowa Utilities Board  
The Honorable Charles W. Larson, Jr.  
Iowa State Senator  
D. McGhee - Department of Public Health

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DATE	04/22/04		4/28/04					

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\*4/22/04 Discussed with J. Dixon-Herrity, OE, who advised that OE did not need to review this letter prior to issue.

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**FACTUAL SUMMARY**  
**OFFICE OF INVESTIGATIONS REPORT NUMBER 3-2003-021**

The Office of Investigations (OI) Report No. 3-2003-021 involves a refuel floor supervisor (supervisor) at the Duane Arnold Energy Center (DAEC), who relocated items in the Spent Fuel/Cask Pool (pool) without having a health physics technician (HPT) present to monitor radiological conditions as required by DAEC procedure ACP1407.2. This concern involved potential health and safety issues as a result of the activities conducted by the supervisor.

On the morning of July 23, 2003, prior to relocating items in the pool, the supervisor discussed the required work within the pool with an HPT who indicated that the supervisor would need to contact the HPTs in their training meeting to see if they had anyone who could support coverage of pool work. At that time, the supervisor told the HPT that he would like to enter the contaminated area to visually locate the items in the pool that he would later work with, specifically, the grapple hooks. He did not mention to the HPT that he intended to move anything in the pool. On the afternoon of July 23, 2003, the supervisor failed to notify Health Physics and ensure that an HPT was present prior to relocating irradiated reactor parts/items in the DAEC Spent Fuel/Cask Pool.

Based on the information developed during the OI investigation, it appears that the supervisor had sufficient understanding of the requirement to have an HPT present when moving items in the Spent Fuel/Cask Pool. Also, the supervisor was experienced in refuel floor activities, technically competent, and appropriately trained.

As a result, OI concluded that the refuel floor supervisor deliberately violated a station procedure by moving items in the pool without Health Physics coverage.

Enclosure