UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET SW SUITE 23T85
ATLANTA, GEORGIA 30303-8931

July 16, 2004

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

SUBJECT: NRC INSPECTION REPORT 07007001/2004-005 - PADUCAH (OFFICE OF INVESTIGATIONS REPORT NO. 3-2003-014)

Dear Mr. Brown:

On June 22, 2004, the NRC completed a routine resident inspection at the Paducah 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 on June 22, 2004, the NRC inspectors discussed the findings with members of your staff.

This inspection consisted of an examination of activities conducted under your certificate as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your certificate. Areas examined during the routine resident inspection are identified in the enclosed report. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities in progress, and interviews with personnel.

This also refers to an investigation completed by the NRC's Office of Investigations (OI). The investigation (3-2003-014) was completed on March 23, 2004, and involved a review to determine if a construction engineer deliberately violated radiological procedures. Based on the evidence developed, the investigation did not substantiate this issue. A copy of the synopsis to this OI report is included as Enclosure 2 to this letter.

However, based on the results of this investigation, the NRC has determined that a Severity Level IV violation of NRC requirements occurred. The violation is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the Enforcement Policy. This NCV is described in the subject inspection report. If you contest the violation or significance of the NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001, with copies to the Regional Administrator, Region II, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001, and the NRC Resident Inspector at the Paducah Gaseous Diffusion Plant.

In accordance with 10 CFR 2.390 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/reading-rm/adams.html (the Public Electronic Reading Room).

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

Sincerely,

/RA/

Jay Henson, Chief
Fuel Facility Inspection Branch 2
Division of Fuel Facility Inspection

Docket No. 07007001
Certificate No. GDP-1

Enclosures:
1. Inspection Report 07007001/2004-005
2. Synopsis to OI Report 3-2003-014

cc w/encls:
R.B. Starkey, Paducah General Manager
S. R. Cowne, Paducah Regulatory Affairs Manager
P. D. Musser, Portsmouth General Manager
S. A. Toelle, Director, Nuclear Regulatory Affairs, USEC
Paducah Resident Inspector Office
R. M. DeVault, Regulatory Oversight Manager, DOE
G. A. Bazzell, Paducah Facility Representative, DOE
Janice H. Jasper, State Liaison Officer

Distribution w/encls: (See page 3)

USEC 1

USEC 3

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.:	07007001
Certificate No.:	GDP-1
Report No.:	07007001/2004-005
Facility Operator:	United States Enrichment Corporation
Facility Name:	Paducah Gaseous Diffusion Plant
Location:	Paducah, KY
Dates:	May 12, through June 22, 2004
Inspectors:	Bruce L. Bartlett, Senior Resident Inspector Mary L. Thomas, Resident Inspector Wayne L. Britz, Fuel Facility Inspector
Approved by:	Jay Henson, Chief Fuel Facility Inspection Branch 2 Division of Fuel Facility Inspection

Enclosure 1

EXECUTIVE SUMMARY

United States Enrichment Corporation
Paducah Gaseous Diffusion Plant
NRC Inspection Report 07007001/2004-005

This inspection included aspects of certificatee operations, maintenance, and plant support. The report covered a six-week period of resident and region-based inspection activities, including follow-up to issues identified during previous inspections.

Operations

- Routine operations activities were conducted in accordance with written procedures. Routine communications among operators were adequate. Nuclear criticality safety requirements were adequately addressed during routine operations activities. The certificatee took appropriate action to address some minor deficiencies with alarm response procedures. (Paragraph 1.a)

- The inspectors identified a minor violation for the failure to transfer quality records to records management. Some members of the operations staff misunderstood what constituted a completed record and, thus, were not transmitting the records to records management, even though all of the information was entered on the record. The certificatee took appropriate action to address the issue. (Paragraph 1.b)

- The inspectors determined that because the certificatee had no requirement to review the number of valve turns from year to year, nor was there a requirement to lubricate the valve stem, it did not question the degraded material condition of valve RCW-631-3W. The certificatee issued an assessment and tracking report to evaluate the issue. (Paragraph 1.c)

- Plant activities were performed safely and in accordance with certificate requirements. No significant housekeeping issues were observed. (Paragraph 1.d)

Maintenance and Surveillance Testing

- Maintenance and surveillance activities were conducted appropriately and in accordance with approved procedures. Acceptance criteria contained in surveillance procedures were adequate and, when required, assessment and tracking reports were initiated. The certificatee appropriately addressed problems with pressure indicators during fire water pump testing. (Paragraph 2.a)

- The procedures for surveillance, calibration, and maintenance were properly approved by certificatee management. These procedures included instructions and schedules for performing maintenance activities and conducting post-maintenance functional testing of the equipment. (Paragraph 2.b)

- The inspectors determined that surveillance and calibration test records and the tracking system for surveillances and calibrations were adequate and were in compliance with the certificate. (Paragraph 2.c)

Plant Support

- The NRC Office of Investigations did not substantiate that a construction engineer deliberately violated radiological procedures. A non-cited violation was identified for changing the contaminated filters without health physics coverage and in a non-radiologically controlled area. (Paragraph 3.a)

Attachment:
Partial List of Persons Contacted
Inspection Procedures Used
List of Items Opened, Closed, and Discussed
List of Acronyms

REPORT DETAILS

1. Plant Operations

a. Conduct of Operations - Routine Operations Activities

(1) Inspection Scope (88100 and 88105)

The inspectors observed routine operations activities and discussed routine operations with staff and management. In addition, the inspectors reviewed the applicable area control room (ACR) log books and routine surveillance forms. The inspectors observed operators respond to various alarms and reviewed the following documents:

- NRC Identified ATRC-04-2294, Alarm Response Procedures That Contain Nomenclature That Is Not Consistent with the Alarm;
- CP3-CO-CO1020, "Control Room Activities," Revision 3;
- CP3-CO-CO2028, "Repetitive Tasks Schedule," Revision 22;
- CP4-CO-CN2075, "Operation of the Cascade Recirculating Cooling Water (RCW) System," Revision 15;
- CP4-CO-CN6020t, "TSR Surveillance - Test Firing of the PYR-A-LARM Type 1, High Voltage UF6 Detection System in C-331/333/335/337," Revision 13;
- CP4-CO-CN6054d, "TSR Surveillance, C-360 Autoclave Pressure Decay Test," Revision 13;
- CP4-CO-CN6069, "Periodic Regulatory Checks," Revision 27;
- CP4-CO-AR8333, "Alarm Response for C-333," Revision 12; and
- CP4-CO-AR8335, "Alarm Response for C-335," Revision 12.

(2) Observations and Findings

The inspectors observed routine operations in the cascade buildings and area control rooms, the feed vaporization facility, product and tails withdrawal facilities, and the central control facility. The appropriate nuclear criticality safety requirements were implemented for the routine activities observed. The operations staff were alert and generally knowledgeable of the current status of equipment associated with their assigned facilities.

The inspectors compared the alarm response procedures for two selected ACRs against the installed plant equipment. The inspectors noted that all alarms that were required by NRC regulations or commitments had an alarm response procedure. However, some alarm responses did not have titles that exactly matched the installed instrument, some alarms not required by NRC regulations did not have response procedures, and some

alarm responses for equipment on the same panel were not located near each other in the procedure (a poor human factors condition).

The certificatee issued ATRC-04-2294, corrected the labeling nomenclature promptly, and added at least one alarm response to Procedure CP4-CO-AR8333. In addition, operations personnel intended to evaluate adding other alarm response procedures, as well as re-arrange the alarm response for items located on the same panel near each other in the procedure.

(3) Conclusions

Routine operations activities were conducted in accordance with written procedures. Routine communications among operators were adequate. Nuclear criticality safety requirements were adequately addressed during routine operations activities. The certificatee took appropriate action to address some minor deficiencies with alarm response procedures.

b. Operations Recordkeeping

(1) Inspection Scope (88100 and 88105)

The inspectors followed up on an issue documented in an assessment and tracking report (ATR) pertaining to record management in Process Building C-331. The inspectors discussed the issue with certificatee staff and management. In addition, the inspectors reviewed the following documents:

- NRC Identified ATRC-04-2182, C-331, Unit 1, Cell 8 Independent Assay Verification forms did not have originals attached;
- NRC Identified ATRC-04-2273, Documents kept by operations for extended periods of time;
- CP2-EG-NS1033, "Enrichment and Exempt Waste Verification," Revisions 6-10;
- CP4-CO-CN2075, "Operation of the Cascade Recirculating Cooling Water (RCW) System," Revision 15;
- CP4-CO-CN2076, "Control of Cascade Assay," Revision 4;
- UE2-TO-RM1030, "Records Management Program, " Revision 4 and
- C12-SA-01-05, "QA Records and Records Management" Self Assessment.

(2) Observations and Findings

During the inspectors' review of independent assay verification (IAV) forms in Process Building C-331, the inspectors determined that several IAV forms were greater than 90 days old. The IAV forms were stored in both fire-proof file cabinets and in notebooks on shelves in the ACR. These records were quality records in accordance with

Procedure CP2-EG-NS1033 and were required to be transmitted to records management and document control (RMDC) every 90 days or by turnover agreement.

The inspectors searched the operations task database and determined that the monthly task to send records greater than 60 days old to RMDC for Process Building C-331 had not been performed for the month of April, nor had it been performed in a timely manner since 2000. During followup, the inspectors reviewed quality records for nuclear criticality safety approval controls for recirculating cooling water and blow out preventor verification in three other process buildings and found similar issues in those areas.

Through discussions with the records management and operations staffs, the inspectors determined that there was a misunderstanding on the part of the operations staff as to what constituted a completed record. Some members of the operations staff believed that if a record was still in use, it was not considered completed, even though all of the required information was entered on the record. In response, the certificatee took effective corrective action by turning over the quality records identified by the inspectors to RMDC.

Failure to turn over quality records to RMDC for storage every 90 days or by turnover agreement is a violation of Procedure UE2-TO-RM1030. However, most of the quality records identified by the inspectors were being kept in fire-proof file cabinets. Therefore, the inspectors determined that this issue constituted a violation of minor safety significance and is not subject to formal enforcement action in accordance with Section IV of the NRC Enforcement Policy.

(3) Conclusions:

The inspectors identified a minor violation for the failure to transfer quality records to records management. Some members of the operations staff misunderstood what constituted a completed record and, thus, were not transmitting the records to records management, even though all of the information was entered on the record. The certificatee took appropriate action to address the issue.

c. Degraded Material Condition of High Pressure Fire Water System Block Valve RCW-631-3W

(1) Inspection Scope (88100 and 88102)

The inspectors observed the closing of block valve RCW-631-3W as part of the annual verification of flow surveillance of High Pressure Fire Water Pumps 2 and 3. The inspectors reviewed the annual valve cycling records for the previous six years, 1998 to 2003, in addition to the following documents:

- ATRC-04-2416, Issues related to Technical Safety Requirements (TSR) Annual Pump Test;
- CP4-CO-CA6016f, "TSR Surveillance - High Pressure Fire Water System Sectional Valve Cycling," Revision 2; and

- NFPA [National Fire Prevention Association] 25, "Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems," 1995 Edition.

(2) Observations and Findings

During the inspectors' observation of the closing of block valve RCW-631-3W, the inspectors observed that the pinion gear was in poor material condition, as only three teeth were making contact with the stem gear used to close the valve. The inspectors noted that it took 337 turns to fully close the valve. The inspectors then reviewed annual valve cycling records for the previous six years, 1998 to 2003, and noted that the number of turns to close had increased from 124 in 2002 to 221 in 2003.

The inspectors discussed this observation with the recirculating cooling water (RCW) operations staff and the system engineer. The operators noted the relatively large number of turns and discussed it among themselves, but did not pursue the matter further until questioned by the inspectors.

The inspectors noted that there was no requirement to check the data from the previous year to determine if the number of turns was increasing, a possible indication of a degraded material condition, in Procedure CP4-CO-CA6061f, TSRs 2.3.4.9 and 2.4.4.6, "Fire Protection System - High Pressure Fire Water Distribution Mains," or NFPA 25. The only requirement was that the valve be in the fully open position to meet TSRs 2.3.4.9 and 2.4.4.6.

In addition, the inspectors also noted that the valve type was not in the preventative maintenance program for lubrication on a periodic basis per NFPA 25. However, the certificatee was not committed to that portion of NFPA 25. In response, the certificatee documented the issues in ATRC-04-2416 for further evaluation.

(3) Conclusions

The inspectors determined that because the certificatee had no requirement to review the number of valve turns from year to year, nor a requirement to lubricate the valve stem, it did not question the degraded material condition of valve RCW-631-3W. The certificatee initated an ATR to evaluate the issue.

d. Operational Safety Review

(1) Inspection Scope (IP 88020 and TI 2600/003)

The inspectors reviewed operational activities to determine that if they were performed safely and in accordance with certificate requirements.

(2) Observations and Findings

The inspectors reviewed event reports, monthly safety meeting minutes for various operational groups, injury summaries, and assessment and tracking reports. The inspectors toured and observed operations in the production areas. Criticality safety limit signs and radiological signs were properly posted. Observed activities were

performed safely and in accordance with approved plant procedures. Personnel observed were donning safety equipment and monitoring properly per the requirements of their work package permits. There were no significant issues observed where housekeeping could have affected the radiological safety or emergency egress of the facility.

(3) Conclusions

Plant activities were performed safely and in accordance with certificate requirements. No significant housekeeping issues were observed.

e. Miscellaneous Operations Issues

(1) Bulletin 91-01 Reports (92700)

The certificatee staff made the following report pursuant to Bulletin 91-01 during the inspection period. The inspectors evaluated any immediate nuclear criticality safety (NCS) concerns associated with the report at the time of the initial verbal notification.

Number	Date	Status	Title
40805	06/10/04	Open	Failure of the manual motor trip system for Cell 6 in Building C-310, a Safety Related Item (SRI) relied upon in Nuclear Criticality Safety Evaluation (NCSE) 052 'Enrichment Cascade During Normal Operations at the Paducah Gaseous Diffusion Plant.'

2. Conduct of Maintenance and Surveillance

a. Maintenance and Surveillance Activity Reviews

(1) Inspection Scope (88102 and 88103)

For the maintenance and surveillance activities listed below, the inspectors verified one or more of the following: activities observed were performed in a safe manner; testing was performed in accordance with procedures; measuring and test equipment was within calibration; Technical Safety Requirement Limiting Conditions for Operations were entered, when appropriate; removal and restoration of the affected components were properly accomplished; test acceptance criteria were clear and conformed with the Technical Safety Requirements (TSR) and the Safety Analysis Report (SAR); and any deficiencies or out-of-tolerance values identified during the testing were documented, reviewed, and resolved by appropriate management personnel.

- Work Order (WO) 0403664, Quarterly Functional Testing Surveillance of Autoclave 3 in Toll, Transfer and Sampling Building;

- WO 0403899, Calibrate Emergency Valve Closure System in Tails Withdrawal Building C-315;
- WO 0404138, Replace filter screen in CAAS air system strainer in Process Building C-337;
- WO 0404281, Annual Surveillance of Criticality Accident Alarm System Clusters "T" and "N," and Quarterly Surveillances for Clusters N, T, U, V, W, X, Y, AK;
- WO 0404283, Surveillance Requirement 2.3.4.11-3 and 2.4.4.8-3, Calibrate the switches that provide the automatic start signals to the HPFWS pump number 2;
- WO 0407555, Surveillance Requirement 2.3.4.11-4 and 2.4.4.8-4, Verify HPFWS pump number 2 will flow at least 90% of its rated capacity at it rated pressure;
- CP4-CO-CA6016h, "TSR Surveillance -High Pressure Fire Water Pumps 2 and 3 Annual Performance Test," Revision 1;
- CP4-CO-CA6016f, "TSR Surveillance - High Pressure Fire Water System Sectional Valve Cycling," Revision 2;
- ATRC-04-2416, Issues related to TSR Annual Pump Test;
- ATRC-04-2432, Enhancement of high pressure fire water annual pump test procedures;
- WO 0407556, Surveillance Requirement 2.3.4.11-4 and 2.4.4.8-4, Verify HPFWS pump number 3 will flow at least 90% of its rated capacity at it rated pressure;

(2) Observations and Findings

The inspectors observed that the certificatee staff effectively implemented work control practices and associated radiological controls during the above listed maintenance activities. The inspectors observed the reactive and preventive maintenance processes to repair a plug in a cell manifold and inspect electrical equipment, a process motor, and supply fans to instrument cabinets.

The inspectors interviewed the maintenance staff performing the work and reviewed procedures, permits, reviews, and signatures in the work packages. The inspectors review included verifications that appropriate confined space issues were considered. The inspectors verified that functional testing was performed prior to returning the components to operational status. The inspectors interviewed the individuals performing and overseeing the work and noted that the individuals had detailed knowledge of the equipment, the work orders, and the safety controls impacted by the maintenance.

The inspectors also reviewed the certificatee's system for scheduling safety significant preventive maintenance (PM) work items. The inspectors determined that the certificatee had an effective method for scheduling and tracking safety significant PMs.

During the annual TSR pump test of High Pressure Fire Water Pump Number 2, the inspectors observed that a digital discharge pressure indicator (PI) was not providing the expected pressure corresponding to the amount of flow through the pump for the first two flow levels in Procedure CP4-CO-CA6016h. The inspectors noted that there were four PIs indicating pump discharge pressure, one analog PI just off the discharge and one analog and two digital PIs after the check valve on the discharge line.

The inspectors questioned the plant staff regarding which PI was used for the test as no guidance was provided in Procedure CP4-CO-CA6016h. The inspectors learned that the practice had been to use the digital PI that did not appear to be reading correctly. After discussion with plant staff, the first two flow level tests were repeated using the analog PI after the check valve.

There was some concern regarding the operator's ability to read the discharge pressure on this PI as there was excessive needle movement. In response, the plant staff declared the High Pressure Fire Water Pump Number 2 inoperable until both digital PIs were calibrated and testing of the pump was successfully completed. The system engineer entered these issues into the corrective action program as ATRC-04-2416 and ATRC-04-2432.

The operator checked all four discharge pressure PIs during the performance of the annual pump test of High Pressure Fire Water Pump Number 3 to confirm that the digital PI that was normally used during the test was reading accurately. No problems occurred during that pump test.

(3) Conclusions

Maintenance and surveillance activities were conducted appropriately and in accordance with approved procedures. Acceptance criteria contained in surveillance procedures were adequate and, when required, assessment and tracking reports were initiated. The certificatee appropriately addressed problems with pressure indicators during fire water pump testing.

b. Work Control Procedures and Work Control Authorizations

(1) Inspection Scope

Work control procedures for maintenance activities were reviewed to verify that they were properly approved by certificatee management, and included instructions for performing maintenance activities and conducting post-maintenance functional testing of the equipment.

(2) Observations and Findings

The inspectors reviewed the surveillance, calibration, and maintenance information available on the intranet. There was good information available on equipment history, work schedules, daily communication meetings, and reports. The inspectors reviewed the configuration management program manual and its implementing procedures, assessment & tracking reports, and the "two-working day look ahead reports" and determined that they provided a detailed status of current work and the post-maintenance functional testing to be performed. The procedures and maintenance work packages examined were reviewed and approved by certificatee management.

(3) Conclusions

The procedures for surveillance, calibration, and maintenance were properly approved by certificatee management. These procedures included instructions and schedules for performing maintenance activities and conducting post-maintenance functional testing of the equipment.

c. Surveillance Testing and Calibrations of Equipment

(1) Inspection Scope

The inspectors reviewed surveillance and calibration test records and the tracking system for required tests and calibrations to determine compliance with the certificate.

(2) Observations and Findings

The inspectors reviewed maintenance calibrations and checks on the high-high load trip on the freezer/sublimers, the pressure alarm tests on the autoclaves in the Toll, Transfer, and Sampling Building C-360, and the temperature calibration for the condenser cooling water to determine compliance with the certificate. The inspectors observed and reviewed pre-job briefings, work packages, procedures, preparation, donning and use of personnel safety equipment, and other safety aspects of the jobs.

The surveillances and calibrations reviewed were properly tracked and documented. Functional tests were performed prior to returning equipment to service. Required test reviews were performed according to procedural requirements. The inspectors determined that the surveillance and calibration test records and the tracking system for surveillances and calibrations were adequate and were in compliance with the certificate.

(3) Conclusions

Based upon the reviews, the inspectors determined that the surveillance and calibration test records and the tracking system for surveillances and calibrations were adequate and were in compliance with the certificate.

3. Plant Support

a. Failure to Follow Procedure During Vacuum Cleaner Filter Replacement

(1) Inspection Scope (88100)

The inspectors reviewed an investigation performed by the NRC Office of Investigations that determined if a construction engineer deliberately violated radiological procedures.

(2) Observations and Findings

On May 13, 2004, a certificatee health physics (HP) employee observed an engineer changing the filters on four vacuum cleaners. The vacuums had apparently been used earlier that day to support work on fans that were known to be contaminated. The vacuums were marked "non-fissile use only" and "caution radioactive material," as required by Procedures CP2-GP-MS2034, "Use of High Efficiency Filter Equipped Vacuum Cleaners," and UE2-HP-RP1030, "Conduct of Radiological Operations."

The engineer was changing the contaminated filters without HP coverage and in a non-radiologically controlled area in violation of Procedure UE2-HP-RP1030. The spread of contamination was limited to portions of the exterior of the four vacuum cleaners and four small dust piles on a gravel parking lot. The four dust piles were removed and transported to a radioactive material storage area along with the four vacuum cleaners. The engineer and two nearby individuals submitted urine samples that indicated no uptake of radioactive material.

The OI investigation did not substantiate that the construction engineer deliberately violated radiological procedures. As corrective action, the engineer's radiation worker qualifications were suspended until completion of re-training. Since there was no significant spread of contamination or personnel exposure to radioactive material, the certificatee-identified and corrected violation is being treated as a non-cited violation (NCV) consistent with Section VI.A.8 of the NRC Enforcement Policy. (NCV 07007001/2004005-01)

(3) Conclusion

The NRC Office of Investigations did not substantiate that a construction engineer deliberately violated radiological procedures. A non-cited violation was identified for changing the contaminated filters without Health Physics coverage and in a non-radiologically controlled area.

4. Exit Meeting Summary

The inspectors presented the inspection results to General Manager Russ Starkey and members of the facility management on June 22, 2004. The inspectors asked the certificatee staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT

1. PARTIAL LIST OF PERSONS CONTACTED

United States Enrichment Corporation

* R. Starkey, General Manager
* S. Cowne, Nuclear Regulatory Affairs Manager
* K. Ahern, Schedule Manager
  R. Helme, Engineering Director
* L. Jackson, Operations Manager
* M. Keef, Production Support Manager
* J. Labarraque, Quality Assurance
* D. Page, Plant Shift Superintendent
* S. Penrod, Plant Manager
* K. Stratemeyer, UF_6 Handling Manager
* M. Wayland, Maintenance Manager

* Denotes those present at the exit meeting on June 22, 2004.

2. INSPECTION PROCEDURES USED

IP 88020	Regional Criticality Safety Inspection Program
IP 88025	Maintenance and Surveillance Testing
IP 88100	Plant Operations
IP 88101	Configuration Control
IP 88102	Surveillance Observations
IP 88103	Maintenance Observations
IP 88105	Management Organization and Control
IP 92700	Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities
IP 92701	Follow-up

3. LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Item Number	Status	Type	Description
70-7001/2004005-01	Closed	NCV	Failure to follow radiological procedures for handling contaminated vacuum cleaners.
40805	Open	CER	Failure of the manual motor trip system for Cell 6 in Building C-310, a Safety Related Item (SRI) relied upon in Nuclear Criticality Safety Evaluation (NCSE) 052 'Enrichment Cascade During Normal Operations at the Paducah Gaseous Diffusion Plant.'

4. LIST OF ACRONYMS USED

ACR	Area Control Room
ADAMS	Agencywide Documents Access and Management System
ATR(s)	Assessment and Tracking Report(s)
CFR	Code of Federal Regulations
DFFI	Division of Fuel Facility Inspection
DOE	Department of Energy
GDP	Gaseous Diffusion Plant
HP	Health Physics
IAV	Independent Assay Verification
NCS	Nuclear Criticality Safety
NCSE	Nuclear Criticality Safety Evaluation
NCV	Non-Cited Violation
NFPA	National Fire Protection Association
NRC	Nuclear Regulatory Commission
OI	Office of Investigation
PARS	Publicly Available Records
PDR	Public Document Room
PGDP	Paducah Gaseous Diffusion Plant
PI	Pressure Indicator
PM	Preventive Maintenance
PSS	Plant Shift Superintendent
RCW	Recirculating Cooling Water
RMDC	Records Management and Document Control
SAR	Safety Analysis Report
SRI	Safety Related Item
TSR	Technical Safety Requirement
USEC	United States Enrichment Corporation
WO	Work Order

SYNOPSIS

This investigation was initiated on June 9, 2003, by the U.S. Nuclear Regulatory Commission, Office of Investigations, Region III, to determine if a construction engineer deliberately violated radiological procedures at the U.S. Enrichment Corporation Paducah Gaseous Diffusion Plant (PGDP).

Based on the evidence developed, the allegation that a construction engineer deliberately violated radiological procedures at PGDP was not substantiated.

APPROVED FOR RELEASE - SES, 7/16/04

~~NOT FOR PUBLIC DISCLOSURE WITHOUT APPROVAL OF THE FIELD OFFICE DIRECTOR, OFFICE OF INVESTIGATIONS, REGION III~~

Enclosure 2