



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

December 17, 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 07007001/2004-008 AND NOTICE OF VIOLATION - PADUCAH

Dear Mr. Brown:

On November 23, 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 November 23, 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 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.

Based on the results of this inspection, the NRC has determined that a Severity Level IV violation of regulatory requirements occurred. The violation was evaluated in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, which is included on the NRC's web site at <http://www.nrc.gov>. The violation is cited in the enclosed Notice of Violation (Notice), and the circumstances surrounding the violation are described in detail in the subject inspection report. The violation involved the failure to follow the corrective action procedure, which resulted in the failure to perform effectiveness reviews for some conditions adverse to quality. You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

Based on the results of this inspection, the NRC has also determined that two additional Severity Level IV violations of NRC requirements occurred. These violations are being treated as Non-Cited Violations (NCVs), consistent with Section VI.A of the Enforcement Policy. The NCVs are described in the subject inspection report. If you contest the violations or significance of the NCVs, 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 a 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, its enclosures, and your response will be made 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). As of October 25, 2004, the NRC initiated an additional security review of publicly available documents to ensure that potentially sensitive information is removed from the ADAMS database accessible through the NRC's web site. Interested members of the public may obtain copies of the referenced documents for review and/or copying by contacting the Public Document Room pending resumption of public access to ADAMS. The NRC Public Documents Room is located at NRC Headquarters in Rockville, MD, and can be contacted at (800) 397-4209.

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

Sincerely,

/RA/

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

Docket No. 07007001  
Certificate No. GDP-1

Enclosures:

1. Notice of Violation
2. Inspection Report 07007001/2004-008

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

## NOTICE OF VIOLATION

United States Enrichment Corporation  
Paducah Gaseous Diffusion Plant

Docket No. 70-7001  
Certificate No. GDP-1

During an NRC inspection conducted from September 26, through November 23, 2004, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

Technical Safety Requirement (TSR) 3.9.1 requires, in part, that written procedures shall be prepared, reviewed, approved, implemented, and maintained to cover the activities described in Safety Analysis Report (SAR) Section 6.11.4.1 and listed in Appendix A to SAR Section 6.11.

Appendix A to SAR Section 6.11 identifies "Quality Assurance" as an activity requiring an administrative procedure.

Procedure CP2-BM-CI1031, "Corrective Action Process at PGDP," Revision 13, had been approved to implement a portion of Quality Assurance requirements. Step 6.11.9.E of the procedure required that effectiveness reviews be performed for conditions adverse to quality (CAQs) involving TSR violations.

Contrary to the above, on November 23, 2004, in response to questions by the inspectors, it was determined that two CAQs involving TSR violations were closed without performing effectiveness reviews.

This is a Severity Level IV Violation (Supplement VI).

Pursuant to the provisions of 10 CFR 76.70, the United States Enrichment Corporation is hereby required to submit a written statement or explanation in reply to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector at Paducah, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). Your reply to these violations should be clearly marked as a "Reply to a Notice of Violation" and should include for the violations: (1) the reason for the violations, or, if contested, the basis for disputing the violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved. Your response may reference or include previously docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an Order or a Demand for Information may be issued as to why the certificate should not be modified, suspended, or revoked, or why such other action, as may be proper, should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

Enclosure 1

Because your response will be made 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), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the public without redaction. ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm.html> (the Public Electronic Reading Room). If personal privacy or proprietary information is necessary to provide an acceptable response, 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 (e.g., 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 Section 73.21.

As of October 25, 2004, the NRC initiated an additional security review of publicly available documents to ensure that potentially sensitive information is removed from the ADAMS database accessible through the NRC's web site. Interested members of the public may obtain a copy of your response for review and/or copying by contacting the Public Document Room pending resumption of public access to ADAMS. The NRC Public Documents Room is located at NRC Headquarters in Rockville, MD, and can be contacted at (800) 397-4209.

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

Dated this 17th day of December 2004.

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.: 07007001

Certificate No.: GDP-1

Report No.: 07007001/2004-008

Facility Operator: United States Enrichment Corporation

Facility Name: Paducah Gaseous Diffusion Plant

Location: Paducah, KY

Dates: September 26, through November 23, 2004

Inspectors: Bruce L. Bartlett, Senior Resident Inspector  
Mary L. Thomas, Resident Inspector

Approved by: Jay Henson, Chief  
Fuel Facility Inspection Branch 2  
Division of Fuel Facility Inspection

Enclosure 2

## **EXECUTIVE SUMMARY**

### **United States Enrichment Corporation Paducah Gaseous Diffusion Plant NRC Inspection Report 07007001/2004-008**

This inspection included aspects of certificatee plant operations and maintenance and surveillance. The report covered resident inspection activities, including follow-up to issues identified during previous inspections.

#### **Plant Operations**

- The certificatee identified two cylinders were heated that were filled above Technical Safety Requirements (TSR) and procedural weight limits. One non-cited violation for these errors was identified. While following up on the certificatee's corrective actions, the inspectors identified a violation for failing to perform effectiveness reviews of conditions adverse to quality involving TSR violations. (Paragraph 1.a)

#### **Maintenance and Surveillance**

- 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. (Paragraph 2.a)
- The inspectors questioned the reliability and availability of the Public Warning Siren System following a review of maintenance data. The inspectors determined that despite the adverse trend in equipment failures, the system remained capable of performing its intended safety function. The certificatee initiated appropriate action to correct the adverse trend in Public Warning Siren System equipment failures. (Paragraph 2.b)
- The inspectors identified a non-cited violation for operating equipment without a procedure and performing maintenance without instructions in a work package. The safety significance was minimal as equipment integrity was not compromised, the issues were isolated in nature, and corrective actions were taken to prevent recurrence. (Paragraph 2.c)

#### **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. Heating of Overfilled Cylinders in Violation of Technical Safety Requirement 2.1.4.6

##### (1) Scope and Observations (88100)

During the inspection period, the certificatee determined that two uranium hexafluoride (UF<sub>6</sub>) cylinders had been heated that were filled above procedural and Technical Safety Requirement (TSR) weight limits. The inspectors performed follow up to the certificatee's finding. The documents reviewed during this follow-up were:

- Assessment and Tracking Report (ATR) 04-4036A, Cylinder PP-2621 was filled beyond procedural and TSR limits;
- ATRC-04-4078, TSR was violated because cylinders were overfilled;
- ATRC-04-4690, Two ATRs closed without performing an effectiveness review;
- CP2-BM-CI1031, "Corrective Action Process at PGDP," Revision 13;
- CP4-TE-EA1001, "Customer Order Entry, Work Planning, and Preparation," Revision 3;
- CP4-CO-CN2051j, "C-360 UF<sub>6</sub> Transfer," Revision 26;
- CP4-CO-CM6023, "Shipment, Receipt and Inspection of UF<sub>6</sub> Cylinders," Revision 22; and
- Technical Safety Requirement 2.1.4.6, "Cylinder Heating - Cylinder Accountability Weight."

On October 8, 2004, operators determined that Cylinder PP-2621 was filled above procedural and TSR weight limits while performing a pre-heat inspection. The cylinder had been filled originally on June 14, 2004, in the C-360 Toll, Sampling and Transfer Building. The operators determined that the cylinder was later heated in an autoclave and its contents sampled. Heating of an overfilled cylinder without first verifying the void volume and verifying autoclave steam pressure control was set consistent with the amount of overfill was in violation of TSR 2.1.4.6.

The operators determined that the cylinder contained a total net weight of 21,157 pounds of UF<sub>6</sub>. The procedural and TSR limit was a total net weight of 21,030 pounds of UF<sub>6</sub>. However, the operators determined that the cylinder was above the alternate TSR limit of five percent void space. Since the five percent void space requirement was met, the possibility of the cylinder failing during heating was minimized.

In response, the operators performed a search of the Nuclear Material Control and Accountability System and determined that Cylinder PP-2571 had also been overfilled and heated. That cylinder was determined to also have a void space above five percent. The two cylinders were tagged as defective equipment, an ATR was initiated, and the certificatee began a root cause analysis.

The certificatee determined that the group responsible for selecting the cylinders and calculating the amount to be filled made an error in the target weights. This error resulted in the existing heel weights in the cylinders to not be accounted for in the calculation (heel is the small amount of material left in a cylinder after it is emptied).

In addition, when the operators weighed the cylinders, they too made an error in their calculations. Step 8.6.17 of Procedure CP4-CO-CN2051J required that the net weight of the cylinders be verified to be less than 21,030 pounds. The review of the calculations determined that the operators also did not add the weight of the heel to the cylinder tare weight before determining the amount to be filled. The calculations were performed once when the cylinders were filled and again before they were placed in the autoclave to be heated and sampled.

The inspectors reviewed the certificatee's root cause evaluation and corrective actions and determined that they were adequate and timely. Corrective actions included revising several procedures to clarify and strengthen the calculations, retraining those personnel involved, verifying that other personnel were knowledgeable of the calculations performed, verifying this error had not resulted in any other cylinders being filled above TSR or procedural limits, and issuing a lessons learned to all operators. The issue was of minimal safety significance, as the cylinders had void space above the five percent limit. Therefore, this non-repetitive 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 07007001/2004008-01).

During review of ATRC-04-4036A, the inspectors noted that certificatee personnel had classified it as a condition adverse to quality (CAQ). The inspectors questioned certificatee personnel regarding why a violation of the TSR was not considered to be a significant condition adverse to quality. Certificatee personnel informed the inspectors that there had been no actual safety significance to this event, the ATR had a root cause evaluation performed, corrective actions to prevent recurrence had been implemented, and CAQs which involved TSR violations were required to have effectiveness reviews performed.

However, certificatee personnel stated that while reviewing ATRC-04-4078 in response to the inspector questions, they had determined that the ATR was closed without an effectiveness review being performed. In addition, certificatee personnel also identified that ATRC-04-3158, involving a failure to perform a smoke watch as required by the TSRs (discussed in Inspection Report 07007001/2004-007), had also been closed without the performance of an effectiveness review. Subsequently, the certificatee informed the inspectors that additional guidance regarding TSR violations would be included in an upcoming revision to the corrective action procedure.

Technical Safety Requirement 3.9.1 required, in part, that written procedures shall be prepared, reviewed, approved, implemented, and maintained to cover the activities described in Safety Analysis Report (SAR) Section 6.11.4.1 and listed in Appendix A to SAR Section 6.11. Appendix A to SAR Section 6.11 identified "Quality Assurance" as an activity requiring an administrative procedure.

Step 6.11.9.E of Procedure CP2-BM-CI1031 required that effectiveness reviews be performed for conditions adverse to quality involving TSR violations. Contrary to the above, on November 23, 2004, in response to questioning by the inspectors, it was determined that two CAQs involving TSR violations were closed without performing effectiveness reviews (VIO 07007001/2004008-02).

(2) Conclusions

The certificatee identified two cylinders were heated that were filled above Technical Safety Requirements (TSR) and procedural weight limits. One non-cited violation for these errors was identified. While following up on the certificatee's corrective actions, the inspectors identified a violation for failing to perform effectiveness reviews for conditions adverse to quality involving TSR violations.

b. 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 concerns associated with the report at the time of the initial verbal notification.

<u>Number</u>	<u>Date</u>	<u>Status</u>	<u>Title</u>
41158	10/29/04	Open	NCSE/A 3972-11 did not establish the necessary moderation controls for the sump in the C-360 elevator pit to ensure that double contingency was maintained if a UF <sub>6</sub> release occurred in the transfer room.

(2) Miscellaneous Open Item Closures (92701)

(Closed) URI 07007001/2004003-002: Adequacy of the design of two pressure switches being supplied by one pressure tap. The certificatee identified recirculating cooling water instrument sensing lines that were blocked with rust and debris. The blockage was cleared and efforts begun to define the extent of condition. This item is closed to Violation 07007001/2004202-01.

## 2. Maintenance and Surveillance

### a. Maintenance and Surveillance Activity Reviews

#### (1) Scope and Observations (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; TSR 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 TSR and the SAR; and any deficiencies or out-of-tolerance values identified during the testing were documented, reviewed, and resolved by appropriate management personnel.

The inspectors observed that the certificatee staff effectively implemented work control practices and associated radiological controls during the listed maintenance activities listed below:

- Work Order (WO) 0417192, Install overpacks on expansion joints on Recirculating Cooling Water (RCW) Supply Header Number 6;
- WO 0417802, Repair Criticality Accident Alarm System (CAAS) piping on roof of Process Building C-337;
- WO 0414511, Replace filter screen in CAAS air strainer;
- WO 0414009, Annual and quarterly CAAS surveillance requirement for Process Building C-337 CAAS clusters;
- WO 0412662, Surveillance Requirement 2.4.4.11-2, Calibrate cell datum and cell deviation according to CP4-GP-IM6130;
- WO 0417106, Install patches on corrosion spots on RCW Supply Header Number 6;
- WO 0412273, Surveillance Requirement 2.3.4.23-1, Calibrate Nuclear Material Control & Accountability (NMC&A) scale in accordance with NMC&A Program requirements;
- CP2-SS-NM6033, "NMC&A Scale and Balance Program," Revision 12;
- GWP-353, Calibrate NMC&A large accountability cylinder scale in accordance with CP4-GP-IM6141, Revision 5; and
- CP4-GP-IM6141, "Uranium Accountability Scale Calibration," Revision 9.

(2) 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.

b. Adverse Trend On Maintenance of the Public Warning Siren System

(1) Scope and Observations (88102 and 88103)

During follow-up to a report that the Public Warning Siren System (PWS) was not able to be actuated from the McCracken County 911 Center, the inspectors identified multiple maintenance issues. The certificatee's PWS consisted of four sets of warning sirens located off plant property. At each of the four locations, there were two independent/redundant warning sirens. If one siren failed, the other siren was capable of performing the intended function of the PWS at that location. The sirens were tested on a daily basis using the system's internal computer program.

The inspectors reviewed the maintenance history for the past three years and observed an increasing trend of maintenance problems. The inspectors identified several examples of equipment that had failed and then been repaired, and then similar equipment on other sirens that had failed and then been repaired. The inspectors determined that certificatee personnel were addressing each problem in a prompt manner but that there was no broad overview of the PWS maintenance program.

Engineering personnel had discontinued the system health review for the PWS system, which was a vehicle for identifying adverse trends in system material condition. The failure to maintain a broad overview of the system reliability and availability had resulted in a failure to identify an adverse trend in equipment failures. However, the inspectors noted that this declining maintenance trend had not yet resulted in the ability of the PWS to perform its intended safety function.

The certificatee initiated ATRC-04-4437 to document the adverse trend of PWS maintenance problems and informed the inspectors that, a week or two prior to the inspector questions, they too had observed an increasing trend of problems. In addition, the certificatee stated that daily testing procedures would be reviewed and strengthened and that the system health report for PWS would be re-established.

(2) Conclusions

The inspectors questioned the reliability and availability of the Public Warning Siren System following a review of maintenance data. The inspectors determined that despite the adverse trend in equipment failures, the system remained capable of performing its intended safety function. The certificatee initiated appropriate action to correct the adverse trend of Public Warning Siren System equipment failures.

c. Operating Equipment Without the Use of a Procedure and Performing Work Without Instructions in a Work Package

(1) Scope and Observations (88103)

Over the course of this inspection period, the inspectors reviewed two separate instances where certificatee personnel had identified that equipment was operated without the use of a procedure and maintenance was performed without instructions in a work package. The inspectors also reviewed the following documents:

- ATRC-04-4153, Call from C-300 stated that they had water flow in C-310;
- ATRC-04-4159, Lifting lid off of a UX-30 overpack;
- ATRC-04-4164, Overpack pin stuck in lid;
- ATRC-04-4166, Attempts to remove pin without instructions in a work package;
- Control of Work Activities Talking Points; and
- CP2-GP-GP1032, "Work Control Process," Revision 12 .

The first example involved the opening of an inspector's test valve (ITV) on the High Pressure Fire Water System (HPFWS) in Product Withdrawal Building C-310, an augmented quality system. A maintenance mechanic was walking down the HPFWS to evaluate what equipment would be needed to repair a leaking ITV. During the walkdown, the person who had requested the maintenance suggested that the mechanic briefly open the valve to flush any debris off of the valve seat, as this might stop the leak. The maintenance mechanic proceeded to cycle the valve without instructions in an approved work package allowing him to do so. The mechanic also did not receive permission to cycle the valve from the Plant Shift Superintendent, as it could have impacted system operability.

The second instance involved the attempted removal of a stuck overpack lid pin in the C-360 Annex. The overpack was a quality class component. In this instance, the personnel involved believed that they were performing minor maintenance on this overpack and, thus, did not need a work package. However, the work that they were performing had the potential to create a non-conforming condition. Work of this magnitude on quality class components required a work package.

The certificatee took corrective actions to prevent recurrence of these types of unauthorized activities. The corrective actions included counseling the individuals involved and holding crew briefings for the certificatee staff. Operating equipment without a procedure and performing maintenance without instructions in a work package are violations of Quality Assurance Program requirements. However, the safety significance for each event was minimal as equipment integrity was not compromised.

In addition, corrective actions were taken to prevent recurrence. Therefore, these non-repetitive certificatee-identified and corrected violations are being treated as a non-cited violation (NCV) consistent with Section VI.A.8 of the NRC Enforcement Policy (NCV 07007001/2004008-03).

(2) Conclusions

The inspectors identified a non-cited violation for operating equipment without a procedure and performing maintenance without instructions in a work package. The safety significance was minimal as equipment integrity was not compromised, the issues were isolated in nature, and corrective actions were taken to prevent recurrence.

3. Exit Meeting Summary

The inspection scope and results were summarized on November 23, and December 6, 2004, with Plant Manager Steve Penrod and members of the facility management. 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

- \* S. Penrod, Plant Manager
- \* S. Cowne, Nuclear Regulatory Affairs Manager  
K. Ahern, Scheduling
- \* M. Boren, Nuclear Regulatory Affairs  
M. Buckner, Customer Services and Product Scheduling
- \* L. Jackson, Operations Manager
- \* P. Jenny, Plant Services Manager/Security Manager
- \* M. Keef, Production Support Manager
- \* J. Labarraque, Quality Assurance
- \* M. Mack, Operations  
M. McClure, Maintenance  
D. Page, Operations
- \* D. Snow, Industrial Health and Safety  
J. Sohl, Engineering  
D. Stadler, Nuclear Regulatory Affairs  
K. Stratemeyer, UF<sub>6</sub> Handling Manager
- \* M. Wayland, Maintenance Manager

\*Denotes those present at the exit meetings conducted on November 23, and December 6, 2004.

### 2. INSPECTION PROCEDURES USED

IP 88100	Plant Operations
IP 88102	Surveillance Observations
IP 88103	Maintenance Observations
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

<u>Item Number</u>	<u>Status</u>	<u>Type</u>	<u>Description</u>
07007001/2004003-02	Closed	URI	Design question of two differential pressure switches on one pressure tap.
07007001/2004008-01	Closed	NCV	TSR violation regarding heating overfilled cylinders.

07007001/2004008-02	Open	VIO	Failure to perform effectiveness reviews of CAQs involving TSR violations.
07007001/2004008-03	Closed	NCV	Operating equipment without a procedure and performing maintenance without instructions in a work package.
41158	Open	CER	NCSE/A 3972-11 did not establish the necessary moderation controls for the sump in the C-360 elevator pit to ensure that double contingency was maintained if a UF <sub>6</sub> release occurred in the transfer room.

#### 4. LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
ATR(s)	Assessment and Tracking Report(s)
CAAS	Criticality Accident Alarm System
CAQ	Condition Adverse to Quality
CFR	Code of Federal Regulations
GDP	Gaseous Diffusion Plant
HPFWS	High Pressure Fire Water System
ITV	Inspector's Test Valve
NCSE/A	Nuclear Criticality Safety Evaluation/Approval
NCV	Non-Cited Violation
NMC&A	Nuclear Material Control and Accountability
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
PDR	Public Document Room
PGDP	Paducah Gaseous Diffusion Plant
PWS	Public Warning Siren System
RCW	Recirculating Cooling Water
SAR	Safety Analysis Report
TSR	Technical Safety Requirement
UF <sub>6</sub>	Uranium Hexafluoride
URI	Unresolved Item
USEC	United States Enrichment Corporation
WO	Work Order