

INSPECTION REPORT

1. LICENSEE OR CERTIFICATE HOLDER/LOCATION INSPECTED: United States Enrichment Corporation 6903 Rockledge Road Bethesda, MD 20817		2. NRC/REGIONAL OFFICE: U.S. Nuclear Regulatory Commission Region II 245 Peachtree Center Ave, NE, Suite 1200 Atlanta, GA 30303-1257	
REPORT NO: 2010-003			
3. DOCKET NUMBER: 70-7001	4. LICENSE OR CERTIFICATE NUMBER: GDP-1	5. DATE(S) OF INSPECTION: July 1 – September 30, 2010	

LICENSEE OR CERTIFICATE HOLDER:

The inspection was an examination of the activities conducted under your license or certificate as they relate to safety and/or safeguards and to compliance with the Nuclear Regulatory Commission (NRC) rules and regulations and the conditions of your license or certificate. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observations by the inspector. The inspection findings are as follows:

- 1. Based on the inspection findings, no violations were identified.
- 2. Previous violation(s) closed.
- 3. Reported events reviewed
- 4. The violation(s), specifically described to you by the inspector as non-cited violations, are not being cited because they were self-identified, non-repetitive, and corrective action was or is being taken, and the remaining criteria in the NRC Enforcement Policy, to exercise discretion, were satisfied.
Non-Cited Violation(s) was/were discussed involving the following requirement(s) and Corrective Action(s):

- 5. During this inspection, certain of your activities, as described below and/or attached, were in violation of NRC requirements and are being cited. This form is a NOTICE OF VIOLATION, which may be subject to posting in accordance with 10 CFR 19.11.
(Violations and Corrective Actions)
See Enclosure 1

LICENSEE OR CERTIFICATE HOLDER STATEMENT OF CORRECTIVE ACTIONS FOR ITEM 5, ABOVE

I hereby state that, within 30 days, the actions described by me to the inspector will be taken to correct the violation(s) identified. This statement of corrective actions is made in accordance with the requirements of 10 CFR 2.201 (corrective steps already taken, corrective steps which will be taken, date when full compliance will be achieved). I understand that no further written response to the NRC will be required, unless specifically requested.

Title	Printed Name	Signature	Date
LICENSEE/CERTIFICATE HOLDER REPRESENTATIVE			
NRC INSPECTOR	Michael O. Miller	D. Hartland for	11/5/10

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5. DATE(S) OF INSPECTION:

July 1 – September 30, 2010

6. INSPECTOR(S): Michael O. Miller, Regina Russell, Mark Chitty, Leonard Pitts, Manuel Crespo, David Hartland, Paul Startz

7. INSPECTION PROCEDURES USED: 86740, 88005, 88010, 88030, 88035, 88051, 88100, 88102, 88103

EXECUTIVE SUMMARY

This report covers a three-month period of inspection by resident inspectors and region-based inspectors. Inspectors performed a selective examination which was accomplished by direct observation of safety significant activities and equipment, tours of the facility, interviews and discussions with certificate-holder personnel, independent verification of safety system status and limiting conditions for operation, corrective actions, and a review of facility records. The NRC's program for overseeing the safe operation of uranium enrichment facilities is described in Manual Chapter 2600, "Fuel Cycle Facility Operational Safety and Safeguards Inspection Program," dated March 21, 2008.

The inspectors identified two violations of NRC requirements that had a significance which was more than minor during this inspection period.

Summary of Plant Status

The certificate holder performed routine operations throughout the inspection period. The operators commenced increasing plant load from summertime low power to winter higher power operations on September 1, 2010. The operators controlled product assay according to the production schedule.

Inspection Of Transportation Activities (IP 86740)

a. Inspection Scope and Observations

The inspectors performed a routine inspection of the certificate holder's transportation activities to determine whether an effective, management-controlled program was being maintained to ensure radiological and nuclear safety in the receipt, packaging, and delivery of licensed radioactive material and to ensure that transportation activities were in compliance with 10 CFR Parts 20 and 71.

The inspectors observed 30B cylinders being loaded, surveyed, and prepared for shipment. These observations included a review of the quality control records related to the construction of the overpacks. The inspectors observed personnel developing shipping manifests and related documents, marking packages, and applying package labeling. The inspectors conducted interviews to determine if the personnel performing those activities understood the related regulatory and procedural requirements. The inspectors observed radiation monitoring performed on two completed packages to ensure that external

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radiation and removable surface contamination were within allowable limits. The inspectors reviewed the shipping documentation to verify the accuracy and completeness of required elements of information and that the information was provided to the highway carrier. The inspectors also observed the placarding of the transport vehicle.

The inspectors reviewed the certificate holder's records to determine if transportation records for both incoming and outgoing licensed material were being retained as required and that transportation activities were being performed in accordance with the applicable transportation license and certificate of compliance. The inspectors reviewed management controls for transportation activities to determine if personnel with transportation authority and responsibility were designated in writing.

The inspectors reviewed the hazardous material training records for personnel performing transportation related activities. This review included a review of the training completion records for all personnel assigned to the 360 Annex. The purpose of this review was to determine that personnel had received the proper training, that the training was current, and that the training had been appropriately documented. While observing transportation activities, the inspectors discussed transportation-related training with the individuals to verify their participation in the training program and their knowledge of specific procedural requirements.

The inspectors reviewed the most recent audit of transportation activities to determine whether the audit was conducted in accordance with procedures and that identified deficiencies were corrected. The inspectors inspected overpacks and overpacks undergoing refurbishment to determine whether the maintenance of overpacks met quality assurance requirements. The inspectors asked to see copies of applicable foreign certificates to determine that the certificate holder possessed copies as required. In addition, the inspectors asked to see a sampling of licensed material shipment records from three years prior to the date of the inspection to determine whether the records had been maintained and that the records contained information as required. No safety significant were identified.

The inspectors reviewed ATRC-09-1056: Nonconforming Item Discovered at Waste Facility and found the following:

On February 18, 2009, the certificate holder shipped radioactive waste offsite. The shipment included six large containers transported on one truck. The certificate holder surveyed the containers and found that the containers' radiation levels were not distinguishable from background levels and were free of removable contamination. The certificate holder classified and offered the waste shipment to its contract carrier as low-level radioactive waste. The certificate holder determined that the shipment was exempted from U.S. Department of Transportation (DOT) requirements. The certificate holder designated the shipment as a non-exclusive use shipment and, as a result, did not label the containers or place placards on the truck.

The waste processor received the shipment on February 20, 2009, and later discovered 80 microcuries of americium (Am-241) in the shipment that was not listed on the shipping manifest. This discovery altered the required classification of the radioactive waste shipment which, in turn, altered the shipping, labeling, and placarding requirements.

The waste processor filed a U.S. DOT hazardous materials incident report on June 4, 2009, for the shipment at the request of the certificate holder because the shipment contained undeclared radioactive material. The report listed the date of the incident as May 5, 2009, and contained information relative to

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the shipment as well as a statement that there were no adverse consequences relative to the undeclared radioactive material. The report also stated no material was released, no packaging failed, and there was no threat to human health or to the environment. The processor reported that the waste material should have been designated as Low Specific Activity (LSA-1) excepted packaging, Class 7 placarding, and exclusive use conveyance instead of being designated as low-level radioactive waste with no placards and nonexclusive use conveyance.

The certificate holder entered this issue in its corrective action program and conducted a follow-up investigation. The certificate holder found that instrument technicians had placed a process gas leak detector head in the waste container along with other waste materials when they cleaned their shop. The process gas leak detector head contained 80 microcuries of Am-241. The certificate holder published an article describing this incident in its daily newsletter. The article discussed proper management of the leak detector heads and segregation of unusable or non-repairable heads for waste management.

10 CFR Part 76.60 required the certificate holder to comply with the applicable provisions of 10 CFR Part 71 for packaging and transportation of radioactive materials. 10 CFR Part 71.5 required compliance with 49 CFR requirements for packaging and transportation of radioactive material. 49 CFR required hazardous material shipments to be properly classed, described, packaged, marked, and labeled as required or authorized by applicable requirements or by an exemption. 49 CFR also required that shipping papers contain additional descriptions for radioactive materials that include Class 7 (radioactive) material and that the shipping papers provide the name of each radionuclide and its activity in the shipment. In addition, 49 CFR required proper labeling of each package of radioactive material, exclusive use shipment controls by the shipper, and proper placarding.

Contrary to the above, the certificate holder failed to account for a process gas leak detector head, which contained 80 microcuries of Am-241, in a shipment of radioactive waste. This resulted in improper classification of the shipment as non-regulated, low-level radioactive waste instead of Class 7 (radioactive) waste. In turn, the certificate holder did not prepare accurate shipping papers, did not use exclusive use conveyance, did not properly label the shipment containers (LSA-1), and did not place placards on the truck that would have identified the shipment as Radioactive-Class 7. This is a violation (VIO 07007001/2010-003-02).

The violation was determined to be more than minor because the radioactive waste shipment was transported in the public domain without the proper labeling and placarding. If the shipment had been involved in an accident or incident, emergency responders would not have been alerted by the labeling or placarding of the hazards relative to the radioactive material and would not have taken the necessary precautions for personal safety and public safety. The inspectors evaluated the violation using the NRC Enforcement Policy, Section 6.8, "Transportation." This violation met the description of noncompliance that involved shipping papers, marking, labeling, placarding, or loading, but did not amount to a Severity Level I, II, or III violation.

b. Conclusions

One violation was identified for failure to properly classify and ship radioactive waste.

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Management Organization and Controls (88005 and 88105)

a. Inspection Scope and Observations

The inspectors reviewed significant examples of the certificate holder's corrective actions program to determine if the program was being conducted in accordance with the certificate holder's procedures and certificate requirements.

The certificate holder utilized a computerized document management system referred to as the Assessment and Tracking Report (ATR) to manage problem identification and resolution activities. The inspectors reviewed multiple samples of ATRs related to problems with safety-related equipment, issues that required significant analysis such as root cause investigations, internal audit findings placed into the system to ensure tracking and completion of action items, and other issues that could significantly impact the safe operation of the facility. The inspectors attended and evaluated an initial ATR screening process and attended an engineering ATR screening meeting. The inspectors concluded that, overall, ATRs reviewed during the inspection and active evaluation processes supported the conclusion that the corrective action program was being conducted in accordance with plant procedures and certificate requirements.

However, the inspectors reviewed an anonymous entry, ATRC-09-2013, which was generated on August 15, 2009. The ATR documented an issue regarding quality control (QC) inspectors that worked approximately 36 continuous hours on a safety-related crane in tails withdrawal Building C-315. The work included a load test and monthly inspection required by the TSR, repairs, and paper close-out. Plant management's response that was documented in the ATR indicated that the QC inspectors were not under TSR hours of work limitations, and that no violation of plant procedures occurred since both inspectors involved were fit for duty the entire 36 hours.

Upon further review, the inspectors concluded that the QC inspector did, in fact, fall under the overtime limits of TSR 3.2.2.b, "Administrative Controls – Facility Staff" because they were performing maintenance and inspection activities on a TSR-related system. TSR 3.2.2.b stated that facility staff that performed safety functions should not be permitted to work: (1) more than 16 straight hours, (2) more than 16 hours in any 24-hour period, and (3) no more than 24 hours in any 48-hour period, all excluding shift turnover time. Procedure CP2-HR-LR1030, "Limitations on Hours of Work for TSR Personnel," Revision 3, Appendix A, defined personnel who perform a safety function as individuals who perform operation or maintenance of TSR-related systems, structures, or components (SSC). Contrary to the above, two QC inspectors exceeded the work hour limits of both TSR 3.2.2.b and CP2-HR-LR1030 when they performed maintenance of a TSR-related SSC during 36 consecutive hours of work. This is a violation (NOV 07007001/2010-003-01).

The inspectors reviewed the December 2009 cumulative listing of Regulatory Performance Indicators and Corrective Actions Program Report. The monthly assessment report provided a thorough overview of individual indicators and events, regulatory performance summary of violations and events, human performance program-related errors and events, and corrective action program performance indications and trends. The inspectors concluded that the monthly assessment compilation provided timely and relevant data to the management staff.

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The inspectors attended a Plant Operations and Review Committee meeting during the inspection and reviewed eight samples of 2009 and 2010 committee meeting minutes. The inspectors noted that meeting minutes indicated that the required quorum of members were present and that meeting minutes contained lists of old and new business, provided a record of comments from members, and included copies of approval memos. The inspectors concluded that the Plant Operations and Review Committee was functioning in accordance with plant procedures and certificate requirements.

The inspectors performed a review of audits and surveillances conducted during the previous twelve months. The audits had been performed at an appropriate frequency, were thorough, and adequately assessed certificate safety commitments. Interviews with plant personnel and discussions with operations personnel provided conformation that the certificate holder's quality assurance (QA) program was functioning in accordance with plant procedures.

b. Conclusions

One violation was identified regarding two QC inspectors that exceeded the work hour limits of TSR 3.2.2.b when they performed maintenance of a TSR-related system during 36 consecutive hours of work.

Operator Training (IP 88010)

a. Inspection Scope and Observations

This inspection was conducted to determine whether the certificate holder was complying with regulations and certificate requirements related to training employees and other personnel and to determine whether the certificate holder was implementing an adequate training program.

The inspectors evaluated the training program structure and determined that no substantive programmatic changes had occurred during the last year. The training program elements reviewed by the inspectors were in compliance with the certificate holder's requirements and regulations.

To ensure compliance with 10 CFR 19.12, "Instructions to Workers," the inspectors reviewed the training programs and materials for initial and refresher training for (1) storage, transfer, or use of radiation and/or radioactive material, (2) health protection problems associated with exposure to radiation and/or radioactive material, (3) applicable provisions of the Commission regulations for the protection of personnel from exposure either to radiation or to radioactive material, and (4) instructions in employee responsibility to report promptly to USEC-PGDP any condition adverse to quality. The inspectors confirmed that USEC-PGDP had maintained the required postings on bulletin boards.

The inspectors reviewed a self-assessment audit, C41-SA-10-02, of the systems approach training (SAT) program for all maintenance organizations. The self-assessment included an evaluation of the maintenance organization's compliance with SAR 6.6 and associated Procedure CP2-TR-TR-1032 "Conduct of SAT Training." The inspector concluded that the self-assessment process and the subsequent identification of deficiencies to be corrected indicated that the self-assessment effort was effective.

b. Conclusions

No findings of significance were identified.

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Radiation Protection (88030)

a. Inspection Scope and Observations

Inspectors observed portions of the cutting and removal of a compressor from the cascade in Building C-333. The inspectors observed that overall, the evolution was well-planned and coordinated and that personnel implemented effective practices to prevent the spread of radioactive contamination.

Inspectors reviewed program audits and assessments and noted that they were effectively performed to ensure that the radiation protection program was being implemented commensurate with the certificate. The assessments were also effective in the identification of negative trends and contributors to personnel exposures.

Inspectors observed calibration of a hand and foot monitor and reviewed records regarding DOP testing of portable HEPA units and radioactive source leak tests. An inspector was also fit-tested with a full-face respirator. The inspectors verified that the activities were performed in accordance with regulatory requirements.

Inspectors observed a routine contamination survey and reviewed survey documentation. The inspectors verified that surveys were performed in accordance with regulatory requirements and were adequately implemented to protect workers and to identify potential radiation hazard areas. Workers were cognizant of the active radiation work permits, and current radiation and contamination survey maps were available for review prior to entering area(s) of contamination.

The inspectors noted that overall, posting and labeling of radiological areas as well as general housekeeping in those areas were adequate. Inspectors also noted that occupational exposures were significantly less than limits stated in 10 CFR 20.1201.

b. Conclusions

No violations of significance were identified.

Radioactive Waste Management (IP 88035)

a. Inspection Scope and Observations

The inspectors performed a routine inspection of the certificate holder's radioactive waste management program to determine if the certificate holder had established and maintained adequate and controlled procedures and quality assurance programs to ensure compliance with the requirements of 10 CFR Parts 20 and 61 applicable to low-level radioactive waste form, classification, stabilization, and shipment manifests/tracking.

The inspectors reviewed procedures and noted that personnel responsible for processing radioactive waste were designated in writing. The inspectors reviewed the site characterization completed in 1999 and the results from sampling various radiological waste streams performed during the period May 2009 through February 2010.

The inspectors observed personnel preparing two different dry active-waste shipments and a shipment containing multiple containers of potentially fissile waste material to determine that the individual containers were properly characterized and labeled, and that each shipment as a whole was properly characterized

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and labeled with respect to quantity and radionuclide composition. The inspectors observed individuals performing radiation surveys of packages assembled on transport vehicles just prior to the shipments' departing the site. The inspectors also reviewed the waste manifests for those shipments and a random sampling of required records associated with previous shipments. The inspectors reviewed a sampling of the low-level radioactive waste (LLRW) storage licenses of recipients of LLRW from the Paducah Gaseous Diffusion Plant (PGDP).

The inspectors inspected LLRW material storage areas for stable placement of waste, posting and labeling, housekeeping around waste packages, and segregation from hazardous materials. This inspection included Fissile Control Areas and mixed waste 90-day accumulation areas. The inspectors reviewed the results of inspections and surveys performed by the certificate holder to determine that the surveys were properly documented, performed at the required frequency, and retained for the required period. The inspectors observed personnel performing qualitative and quantitative (Q2) waste assay characterizations and interviewed those individuals regarding their duties and responsibilities. The inspectors also performed a review of the calibration of instrumentation used in conducting Q2 operations in the C-335 building. This review included an evaluation of calibration source control methods. The inspectors also interviewed management personnel responsible for radioactive waste operations.

The inspectors reviewed radioactive waste management corrective action program entries from a two-month period to determine if identified deficiencies were adequately corrected. The inspectors inspected mixed radioactive waste collection containers for appropriate contents.

b. Conclusions

No violations of significance were identified.

Emergency Preparedness Exercise (IP 88051)

a. Inspection Scope and Observations

The inspectors observed the biennial graded exercise and determined that the exercise objectives and scenario adequately and thoroughly exercised major elements of the Emergency Plan. The scenario involved the simulated rupture of a cylinder full of liquid uranium hexafluoride and the subsequent hydrofluoric acid release. In addition, while personnel were responding to the release, a simulated fire occurred, resulting in personnel injuries and requiring the assistance of off-site fire departments. The extent and number of simulated injuries permitted participation by two of the area medical facilities that might receive injured personnel. The inspectors concluded that the scenario was realistic and posed multiple challenges to the certificate holder and to off-site response agencies.

The inspectors determined that the Incident Commander (IC) and other responding personnel performed in a manner that would have protected the workers' safety and resulted in timely mitigation of the release and the fire. The inspectors observed that the IC and the field staff, along with personnel in the Emergency Operations Center, were successful in managing a large number of verbal and written communications.

The general emergency response by EOC management and staff was successful in appropriately addressing the declared Emergency Action Level created by the simulated uranium hexafluoride release and the fire. The EOC properly evaluated emergency conditions and appropriately recommended protective actions. Certificate holder personnel performed emergency classification and external notifications according to procedural requirements.

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The inspectors observed several critiques and concluded that they were effective in identifying exercise issues and suggestions for improvements. In addition, the inspectors reviewed the certificate holder's tracking system for emergency exercise findings (Emergency Management Lessons Learned and the Assessment Tracking Report) and found that personnel were adequately implementing corrective actions to address previous findings.

b. Conclusions

No violations of significance were identified.

Plant Operations (IP 88100)

a. Inspection Scope and Observations

The inspectors determined that all required notices to workers were appropriately and conspicuously posted in accordance with 10 CFR 19.11 and 10 CFR 21.6. The inspectors confirmed that the certificate holder met the requirement to conspicuously post copies of NRC Form-3, "Notice to Employees," in sufficient quantities and locations to permit workers engaged in licensed activities to observe them on the way to or from any activity location to which the document was applicable. The inspectors walked down the postings at Posts 1, 15, 43, 48, and 229 (normal personnel accesses/egresses), Post 29 (Building-720 loading dock), and Post 18 (outside the fenced area next to the parking lot).

The inspectors observed routine operations in the cascade buildings and area control rooms, the feed vaporization facilities, product and tails withdrawal facilities, and the central control facility. The operations reviewed were performed in accordance with procedures.

The inspectors conducted a detailed quarterly walkdown of a representative sample of a selected safety system. The selected safety system was the criticality accident alarm system (CAAS). The inspectors reviewed CAAS operational data as maintained by the system engineer. The inspectors interviewed the system engineer, plant shift superintendent, area control room operators, regulatory compliance manager, and instrument mechanics. The inspector walked down the CAAS air supply systems, power supply support systems, detector/logic modules, and the horns in Buildings C-331, C-333, C-335, and C-337. No significant safety issues were identified.

The inspectors reviewed the certificate holder's review of an incident involving damage to the air capture system that occurred in Building C-337A on July 5, 2009. The certificate holder's investigation found that a crane carrying a UF₆ cylinder was mishandled and struck the air capture system due to lack of attention-to-detail by an operator. The certificate holder repaired the damage and took appropriate action to address the operator's lack of rigor in handling the cylinder. The inspectors had no further issues regarding the findings of the investigation and concluded that this was a violation of the certificate holder's procedures. However, the inspectors determined that the violation was of minor safety significance as the cylinder being improperly handled did not contain liquid UF₆ and the resulting damage to the cylinder and air capture system was also minor. Therefore, this failure constitutes a violation of minor significance and is not subject to formal enforcement action.

Conclusions

No significant observations or findings were noted.

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Maintenance and Surveillance Observations (IP 88102 and IP 88103)

a. Inspection Scope and Observations

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

b. Conclusions

No significant observations or findings were noted.

Exit Meeting Summary

The inspection scope and results for Management Organization and Controls, Operator Training, and Radiation Protection inspections were summarized on July 22, 2010, with Steve Penrod and members of his staff in an exit meeting.

The inspection scope and results for Radioactive Waste Management and Transportation were summarized on August 11, 2010, with Mike Boren in an exit meeting.

The inspection scope and results for the Emergency Preparedness exercise were summarized on September 2, 2010, with Steve Penrod and members of his staff in an exit meeting.

The inspection scope and results for the Integrated Inspection Report, 3rd Quarter 2010, were summarized on September 30, 2010, with Steve Penrod and members of his staff in an exit meeting. The inspectors asked the certificate holder staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

SUPPLEMENTARY INFORMATION

ATTACHMENT

Key Points of Contact

<u>Name</u>	<u>Title</u>
Joseph Barletto	Plant Shift Superintendent
Paul Bean	Quality Assurance Manager
Kevin Beasley	Plant Shift Superintendent
Mike Boren	Regulatory Compliance and Nuclear Operations
Rodney Cook	Plant Shift Superintendent
Ronald Dockery	Plant Shift Superintendent
Eddie Gray	Chief of Security
Sherrill Gunn	Operations Manager
Robert Helme	Engineering Manager
Jim Lewis	Plant Manager
Louis Moffatt, II	Cascade Group Manager
Steve Penrod	Vice President and General Manager
Vernon Shanks	Regulatory Affairs Manager
Steve Smith	Security Manager
Diane Snow	Manager, Environmental, Safety, and Health
Dave Stadler	Lead, Regulatory Engineer
April Tilford	Emergency Management
Billy Wallace	Plant Shift Superintendent
Derek Warford	Plant Shift Superintendent
Craig Willett	Maintenance Functional Manager

List of Items Opened, Closed, and Discussed

Opened

07007001/2010-003-01	NOV	Violation of TSR 3.2.2.b, limits on working hours of staff that perform safety functions.
07007001/2010-003-02	NOV	Violation of 10 CFR Part 71.5, "Transportation of licensed material," when USEC-PGDP offered Class 7 (radioactive) material for shipment as non-regulated, low level, radioactive waste.

Opened and Closed

07007001/2010-003-00	LER	EN 46105: Loss of One of Two Criticality Control Contingencies This EN was reviewed and closed in Report 70-7001/2010-203 on July 22, 2010, by HQ Criticality Safety Inspectors. PGDP: ATRC-10-1961 and 10-1965 and PAD-2010-09
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