

CHAIRMAN Resource

From: Jeffrey Steinmetz <jeffmsteinmetz@yahoo.com>
Sent: Friday, August 24, 2018 7:02 PM
To: Katanic, Janine
Cc: Effie.Turnbull-Sanders@coastal.ca.gov; Donne.Brownsey@coastal.ca.gov; Sara.Aminzadeh@coastal.ca.gov; Mark.Vargas@coastal.ca.gov; Ryan.Sundberg@coastal.ca.gov; Aaron.Peskin@coastal.ca.gov; Carole.Groom@coastal.ca.gov; CHAIRMAN Resource; CMRBARAN Resource; CMRBurns Resource; CMRCaputo Resource; CMRWright Resource; rob.edwards@blueyonder.co.uk; contact@gregpalast.com; jim.risen@firstlook.org; spotlight@globe.com; patricia.wen@globe.com; pfeiffer@globe.com; todd.wallack@globe.com; mark@markhertsgaard.com; joe.davidson@washpost.com
Subject: [External_Sender] NRC Incomplete BACKGROUND AND BASIS concerning near-miss drop events

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Janine Katanic,

The "[INSPECTION CHARTER TO EVALUATE THE NEAR-MISS LOAD DROP EVENT AT SAN ONOFRE NUCLEAR GENERATING STATION](#)" document is grossly understating the severity and negligence of the situation at the San Onofre Nuclear Power Plant. In your BACKGROUND AND BASIS section you failed to mention the Aug 3rd incident was the second time an incident like this occurred. This fact is not denied by San Onofre and can be collaborated by talking with the [Whistleblower David Fritch and seen in the linked video](#).



Fritch at CEP Meeting

A worker at the San Onofre nuclear power plant exposes a near catastrophe incident at a public meeting on August...

<https://adamswebsearch2.nrc.gov/webSearch2/main.jsp?AccessionNumber=ML18229A203>

The fact that a similar incident occurred in the recent past at San Onofre shows that San Onofre and Holtec management did not take the proper steps to avoid the second very serious incident that occurred on August 3rd. The limiting of this site investigation to only the incident on Aug 3rd shows the NRC is condoning this negligence and the previous negligence of San Onofre Nuclear Power Plant and Holtec. [Per NRC statistics it is very clear San Onofre Nuclear Power Plant has history of neglecting safety issues raised by nuclear plant workers](#). This same flipped attitude towards safety is obviously still standard operating procedure per for San Onofre Nuclear Power Plant, and was confirmed by the Whistleblower David Fritch.

San Onofre had the worst employee safety complaint record of all US nuclear power plants: <https://sanonofresafety.files.wordpress.com/2011/11/safetyallegationson-site2007-20121.jpg>

Holtec history of negligence at Diablo Canyon Nuclear power Plant:

According to Holtec technical specifications, the fuel assembly baskets and basket shims are required to prevent criticality. Holtec did not inspect the inside bottom of the canisters (as required by their license) before loading the four San Onofre canisters and now there is no way to unload them.

(5) What is the status of the NRC investigation on the basket shim issue?

(6) How can canisters be unloaded, if needed?

Holtec loaded over half the Diablo Canyon canisters incorrectly -- with hotter fuel assemblies on the outer diameter of the fuel baskets. This may work for roasting a pig, but not storing spent nuclear fuel, since it can damage the fuel assemblies. Since these canisters have not been opened, the NRC has no idea the damage this is causing the fuel in these canisters.

These are all examples of Holtec poor quality engineering, and poor quality loading and management. It also shows mismanagement by Southern California Edison and PG&E. The fact Edison was warned about the loading problems at Diablo Canyon and yet still chose Holtec to do the loading, is one more example of poor contract management by Edison, similar to the steam generator mismanagement cited by the NRC in this Notice of Violation. <http://pbadupws.nrc.gov/docs/ML1335/ML13357A058.pdf>

The NRC needs to add the first "near miss load drop event" to the BACKGROUND AND BASIS section of the "INSPECTION CHARTER TO EVALUATE THE NEAR-MISS LOAD DROP EVENT AT SAN ONOFRE NUCLEAR GENERATING STATION" for this inspection to have any meaning. The continued risk San Onofre Nuclear Power Plant, and Holtec put the public in by allowing them to operate unchecked is criminal on the part of the NRC. The NRC is pretending known significant events did not occur at San Onofre and is further endangering the public.

Sincerely,
Jeff Steinmetz



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BOULEVARD
ARLINGTON, TEXAS 76011-4511

August 17, 2018

MEMORANDUM TO: Eric J. Simpson, CHP, Health Physicist
Fuel Cycle and Decommissioning Branch
Division of Nuclear Materials Safety

W. Chris Smith, Reactor Inspector
Engineering Branch 1
Division of Reactor Safety

Marlone X. Davis, Transportation & Storage Safety Inspector
Inspections & Operations Branch
Division of Spent Fuel Management

THROUGH: Janine F. Katanic, PhD, CHP, Chief /RA/ LLH for
Fuel Cycle and Decommissioning Branch
Division of Nuclear Materials Safety

FROM: Troy W. Pruett, Director /RA/
Division of Nuclear Materials Safety

SUBJECT: INSPECTION CHARTER TO EVALUATE THE NEAR-MISS LOAD
DROP EVENT AT SAN ONOFRE NUCLEAR GENERATING
STATION

A special inspection has been chartered to review the licensee's follow-up investigation, causal evaluation, and planned corrective actions regarding the near-miss drop event involving a loaded spent fuel storage canister at the San Onofre Nuclear Generating Station (SONGS) Independent Spent Fuel Storage Installation (ISFSI) on Friday, August 3, 2018. (License Nos. NPF-10 and NPF-15, Docket Nos. 50-361, 50-362 and 72-41).

CONTACT: Janine F. Katanic, PhD, CHP, FCDB/DNMS
(817) 200-1151

BACKGROUND AND BASIS

On Friday, August 3, 2018, at approximately 1:30 pm (PST), SONGS was engaged in operations involving movement of a loaded spent fuel storage canister into its underground ISFSI storage vault (HI-STORM UMAX storage system). As the loaded spent fuel canister was being lowered into the storage vault using lifting and rigging equipment, the licensee's personnel failed to notice that the canister was misaligned and was not being properly lowered. The licensee continued to lower the rigging and lifting equipment until it believed that the canister had been fully lowered to the bottom of the storage vault. However, a radiation protection technician identified elevated radiation readings that were not consistent with a fully lowered canister. The licensee then identified that the loaded spent fuel canister was hung up on a metal flange near the top of the storage vault, preventing it from being lowered, and that the rigging and lifting equipment was slack and no longer bearing the load of the canister.

In this circumstance, with the important to safety (ITS) rigging and lifting equipment completely down in the lowest position, the ITS equipment was disabled from performing its designed safety function of holding and controlling the loaded canister from a potential canister drop condition. The licensee reported that the canister was resting on a metal flange within the storage vault. It was estimated that the canister could have experienced an approximately 17-18 foot drop into the storage vault if the canister had slipped off the metal flange or if the metal flange failed. This load drop accident is not a condition analyzed in the dry fuel storage system's Final Safety Analysis Report (FSAR).

In response to the discovery that the canister was not fully lowered, the licensee took immediate actions to restore control of the load to the rigging and lifting devices. The estimated time the canister was in an unanalyzed credible drop condition was approximately 45 minutes to 1 hour in duration. The licensee regained control of the load, repositioned the canister, and lowered the canister into the storage vault. The licensee halted all dry fuel storage movement operations in order to fully investigate the incident and develop corrective actions to prevent a recurrence. In addition, the licensee has shared the operational experience with another site with a similar dry fuel storage system.

Region IV became aware of the SONGS "near-miss" incident on Monday, August 6, 2018, when the licensee provided a courtesy notification and described it as a "near-miss" or "near-hit" event. The reporting requirements of the incident are still being evaluated by the Region and discussed with the licensee.

On August 7 and 16, 2018, Region IV and NMSS representatives participated in conference calls with licensee representatives in order to gather additional facts regarding the circumstances of the incident and the licensee's investigation. Region IV is evaluating the information provided by the licensee and is coordinating with the Division of Spent Fuel Management, NMSS.

The NRC is chartering this special inspection pursuant to Management Directive 8.3, "NRC Incident Investigation Program," and NRC Inspection Manual Chapter 0309, "Reactive Inspection Decision Basis for Reactors."

The purpose of the inspection is to investigate the occurrence; interview personnel; observe equipment; and review relevant documentation, including the results of the licensee's investigation and causal analysis, and development and implementation of actions to prevent

recurrence. The licensee has committed to not resume fuel loading operations until after this special inspection and associated reviews are complete. Once the licensee has confirmed its plans to resume fuel loading operations, inspectors will also observe the loading operations to ensure that the corrective actions are adequate. These observations may be conducted as part of this special inspection or as an independent inspection activity, as directed by regional management.

SCOPE

The inspection should seek to address the following items at a minimum:

1. Identify and review all pertinent records, documents, and procedures related to the licensee's downloading operations at the ISFSI pad including but not limited to: worker training and qualifications; rigging equipment qualification, testing, and preventative maintenance; and lifting equipment qualification, testing, and preventative maintenance. Evaluate the adequacy of the above noted procedures, worker training and equipment testing and preparation.
2. Evaluate the adequacy of the loading procedure(s) with respect to verification of MPC movement, centering the MPC over the ISFSI vault, lowering the MPC, and positioning the MPC within the ISFSI vault. Interviews with personnel involved in the ISFSI loading operations should be conducted to evaluate licensee and contractor communications between crane/VCT operators, rigging and spotting staff, cask loading supervisors, radiation protection staff, and licensee oversight personnel. Evaluate the adequacy of pre-job briefings that may have taken place prior to fuel loading operations.
3. Review and evaluate the licensee's immediate corrective actions taken after the event for adequacy of notifications to the licensee and safety assessments performed immediately following the event. Review the licensee's inspection documentation and/or analysis to determine whether the vault's divider shell experienced any damage that would inhibit the component from performing its designed safety function.
4. Based on the review of procedures and interviews of personnel involved with loading operations, evaluate the adequacy of procedure adherence.
5. Interview personnel associated with the event to develop a timeline to ensure the licensee's investigation contained all necessary information to identify all contributing factors and develop adequate corrective actions.
6. Review the licensee's root cause investigation results, to determine whether the review thoroughly identified all contributing factors and that final corrective actions will be adequate to prevent reoccurrence. Evaluate whether prior operational experience relating to complications or issues associated with canister downloading operations was identified and considered as part of the licensee's root cause investigation and corrective action development.
7. Review the licensee's planned actions that will address the point loading condition that was experienced by the affected canister. If applicable, review the licensee's analysis that demonstrated the canister will continue to perform as designed for continued storage OR review licensee's inspection plan to safely remove or lift the canister from the vault to support inspection of the bottom of the canister to demonstrate the canister did not

receive any damage that would inhibit the component from continuing to perform as designed.

8. Investigate the licensee's procedures for reportability to the NRC and determine if the licensee made the correct decision regarding notifications made to the NRC for this event.
9. As directed by regional management, observe resumption of fuel loading operations to verify that corrective actions were effective in addressing deficiencies that contributed to the event. This should include evaluation of procedure and/or equipment enhancements; review or observation of training and briefings provided to riggers, crane operators, spotters and observers, supervisors and other personnel involved in fuel loading operations.
10. Determine if the inspection should be elevated to an AIT and promptly notify regional management of any recommendation to escalate the special inspection to an AIT.

GUIDANCE

The NRC is chartering this special inspection pursuant to Management Directive 8.3, "NRC Incident Investigation Program," and NRC Manual Chapter 0309, "Reactive Inspection Decision Basis for Reactors." The Manual Chapter and Management Directive identify Inspection Procedure 93812, "Special Inspection," for specific use in reviewing events. Planned Dates of Inspection are September 10-14, 2018.

This inspection should emphasize fact-finding in its review of the circumstances surrounding the near-miss canister drop event. Safety concerns identified that are not directly related to near-miss drop event should be reported to NRC management for appropriate action.

Daily briefings with NRC management should occur to discuss the team's progress and preliminary observations.

In accordance with Manual Chapter 0610, a report documenting the results of the inspection should be issued within 30-45 days of the completion of the inspection.

This Charter may be modified should NRC inspectors find significant new information that warrants review. Should you have any questions concerning this charter, please contact Janine F. Katanic at 817-200-1151.

INSPECTION CHARTER TO EVALUATE THE NEAR-MISS LOAD DROP EVENT AT SAN ONOFRE NUCLEAR GENERATING STATION – DATED AUGUST 17, 2018

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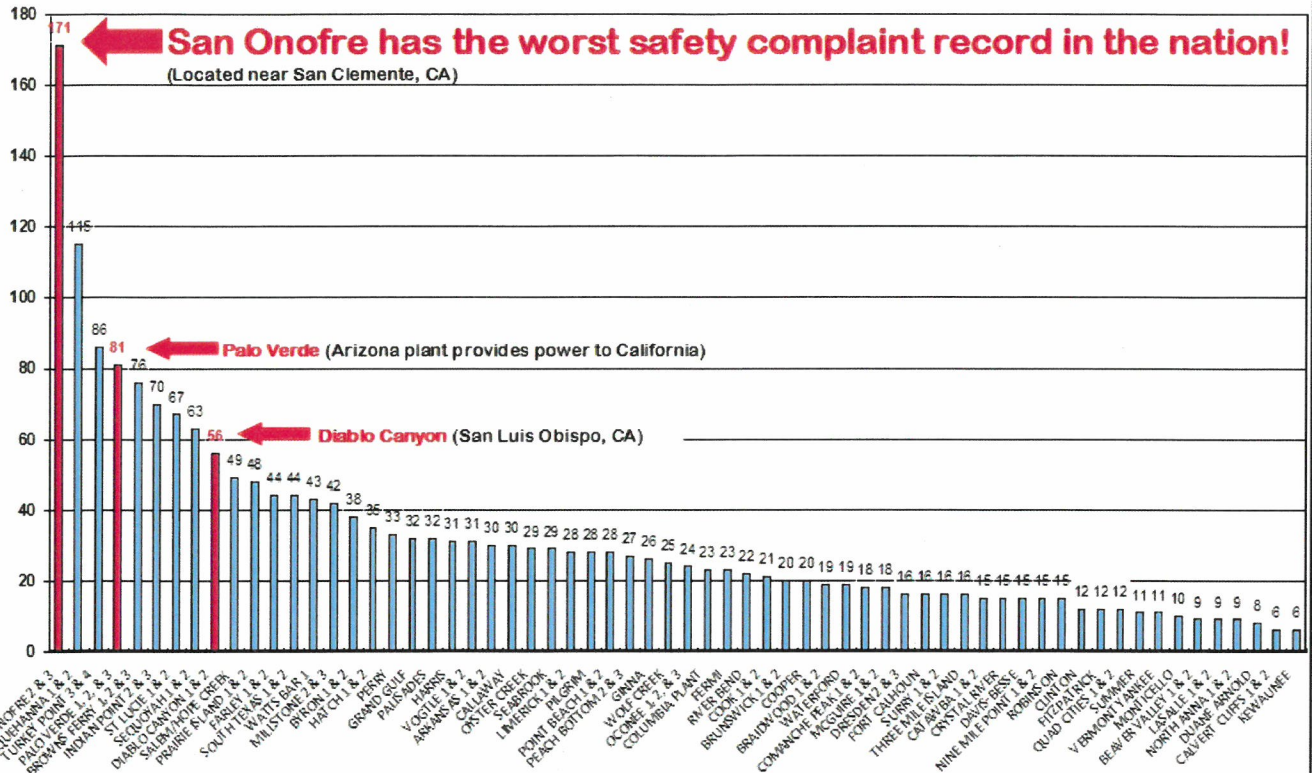
ADAMS ACCESSION NUMBER: **ML18229A203**

SUNSI Review ADAMS: Non-Publicly Available Non-Sensitive Keyword:
 By: LLH Yes No Publicly Available Sensitive NRC-002

OFFICE	DNMS:FCDB	DNMS:DD	DNMS:D
NAME	JFKatanic	LLHowell	TWPruett
SIGNATURE	/RA/ LLH for	/RA/	/RA/
DATE	8/17/18	8/17/18	8/17/18

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Safety Complaints from On-Site Employees & Contractors U.S. Nuclear Power Plants 2007 to 2012 (6 years)



The Nuclear Regulatory Commission (NRC) refers to these complaints as "Allegations from On-Site Sources" (current/former power plant employees/contractors and anonymous allegers). These are reports of impropriety or inadequacy of NRC-related safety or regulatory concerns. One allegation report may contain multiple allegations; however, the NRC counts it as one allegation in these statistics (Note: A concern about a safety-conscious work environment (SCWE) problem at a facility is an important allegation. However, a Notice of Violation cannot be issued, because there is no applicable NRC regulation.) There are 64 U.S. nuclear power plants & 104 reactors. Plants with multiple reactors are noted.

Source: www.nrc.gov/about-nrc/regulatory/all-egations/statistics.htm

SanOnofre Safety.org



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BLVD
ARLINGTON, TEXAS 76011-4511

December 23, 2013

EA-13-083

Mr. Tom Palmisano
Senior Vice President and
Chief Nuclear Officer
Southern California Edison Company
San Onofre Nuclear Generating Station
P.O. Box 128
San Clemente, CA 92674-0128

SUBJECT: SAN ONOFRE NUCLEAR GENERATING STATION – FINAL SIGNIFICANCE
DETERMINATION OF WHITE FINDING AND NOTICE OF VIOLATION, NRC
INSPECTION REPORT 05000361/2012009 AND 05000362/2012009

Dear Mr. Palmisano:

This letter provides you the final results of our significance determination of the preliminary White finding identified in NRC Inspection Report 05000361/ 2012009; 05000362/ 2012009 (NRC's Agencywide Documents Access and Management System (ADAMS) Accession [ML13263A271](#)) dated September 20, 2013. The finding involved the failure to verify the adequacy of the thermal-hydraulic and flow-induced vibration design of the Unit 3 replacement steam generators, which resulted in significant and unexpected steam generator tube wear and the loss of tube integrity on Unit 3 Steam Generator 3EO-88 after 11 months of operation.

In a letter dated October 21, 2013, ([ML13296A018](#)), you provided a response to the NRC staff's preliminary determination regarding this finding. Your response included your agreement that the finding has low-to-moderate safety significance and is, therefore, appropriately characterized as a White finding. After considering the information developed during the inspection and the additional information you provided in your letter, the NRC has concluded that the finding is appropriately characterized as White, a finding of low to moderate safety significance.

You have 30 calendar days from the date of this letter to appeal the staff's determination of significance for the identified White finding. Such appeals will be considered to have merit only if they meet the criteria given in the IMC 0609, Attachment 2. If you choose to appeal, you must send your appeal to the Regional Administrator, Region IV, 1600 East Lamar Blvd., Arlington, Texas 76011-4511.

The NRC has also determined that the failure to verify the adequacy of the thermal-hydraulic and flow-induced vibration design of the Unit 3 replacement steam generators is a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," with an associated violation of

Technical Specification 5.5.2.11, "Steam Generator Program." The circumstances surrounding the violation were described in detail in NRC Inspection Report 05000361/2012009 and 05000362/2012009. In accordance with the NRC Enforcement Policy, this violation is considered an escalated enforcement action because it is associated with a White finding.

The NRC has concluded that the information regarding the reason for the violation is already adequately addressed on the docket through detailed inspection reports and your response letter dated October 21, 2013. Additional information regarding the reason for the violation is not required, unless the description therein does not accurately reflect the reasons for the violation or your position. However, you are required to respond to this letter and provide the results of your evaluation of the extent of condition related to the reasons for the violation.

Specifically, if you determine that any reason for this violation may apply to work activities during decommissioning and dry cask storage, including oversight of contractor activities, then for each such reason, your reply should include: (1) the corrective steps that have been taken and the results achieved, (2) the corrective steps that will be taken, and (3) the date when all associated corrective actions will have been implemented. If you determine that no reason for this violation could reasonably apply to decommissioning or dry cask storage activities, then your reply should include a statement to that effect. You should follow the instructions specified in the enclosed Notice when preparing your response.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, will be made available electronically for public inspection in the NRC Public Document Room or from ADAMS, accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the public without redaction.

Sincerely,

/RA/

Marc L. Dapas
Regional Administrator

Dockets: 50-361, 50-362
Licenses: NPF-10, NPF-15

Enclosure: Notice of Violation

cc w/encl:
Electronic Distribution for San Onofre
Nuclear Generating Station

cc: Distribution for San Onofre Nuclear Generating Station

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S:\RAS\ACES\ENFORCEMENT_EA CASES - OPEN\SONGS_EA-13-083_SG Tube Integrity White Finding\Final Action\FINAL WHITE_EA-13-083_SONGS_12-13-13.docx

ADAMS	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> SUNSI Review Complete	Reviewer Initials: RSB
<input checked="" type="checkbox"/> Publicly Available	<input type="checkbox"/> Non-publicly Available	<input type="checkbox"/> Sensitive	<input checked="" type="checkbox"/> Non-sensitive	
Category:		KEYWORD: EA-13-083		
RIV:	BC	BC	SES:ACES	RC
BHagar	GWerner	RLantz	RSBrowder	KSFuller
/RA/	/RA/	/RA/	/RA/	/RA/
12/11/13	12/11/13	12/10/13	12/10/13	12/11/13
C:ACES/ORA	OE	D:DRP	DRA	RA
HJGepford	RCarpenter	KKennedy	SReynolds	MLDapas
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12/12/13	12/12/13	12/16/13		12/23/13

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NOTICE OF VIOLATION

Southern California Edison
San Onofre Nuclear Generating Station

Docket No. 50-362
License No. NPF-15
EA-13-083

During an NRC inspection conducted on December 3, 2012, through June 7, 2013, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

10 CFR Part 50, Appendix B, Criterion III, "Design Control," states, in part, that design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.

Technical Specification 5.5.2.11, "Steam Generator Program," Section b, "Performance criteria for SG [steam generator] tube integrity," states, in part, that steam generator tube integrity shall be maintained by meeting the performance criteria for tube structural integrity and accident induced leakage.

Technical Specification 5.5.2.11 b.1, "Structural integrity performance criterion," states, in part, that all in-service steam generator tubes shall retain structural integrity over the full range of normal operating conditions, to include retaining a safety factor of 3.0 against burst under normal steady state full power operation primary-to-secondary differential pressure.

Technical Specification 5.5.2.11 b.2, "Accident induced leakage performance criterion," states, in part, that leakage shall not exceed 0.5 gallons per minute per steam generator for a main steam line break accident.

Contrary to the above, design control measures were not established to provide for verifying or checking the adequacy of certain designs. Specifically, on January 28 and April 2, 2008, the licensee's design control measures did not provide for verifying or checking the adequacy of design Documents L5-04GA504 (SO23-617- 1-C157), "Evaluation of Tube Vibration," Revision 3, and L5-04GA521 (SO23-617-1- C683), "Three-Dimensional Thermal and Hydraulic Analysis," Revision 3, developed by Mitsubishi, for the flow-induced vibration and thermal-hydraulic designs. As a result, the licensee did not verify or check the output of the thermal-hydraulic code and input to the vibration code to be in accordance with ASME Section III, Appendix N, "Dynamic Analysis Methods."

Consequently, the inadequate thermal-hydraulic and flow-induced vibration design resulted in non-conservative flow conditions, which led to fluid-elastic instability of a group of tubes in the Unit 3 replacement steam generators. This resulted in one tube leaking, which prompted the licensee to shut down the plant on January 31, 2012. In March 2012, in-situ pressure testing on Unit 3 steam generator 3EO-88 revealed that eight tubes had failed to meet the performance criteria for structural integrity and

Enclosure

accident induced leakage. Specifically, during in-situ pressure testing, tubes R106C78, R102C78, R104C78, R100C80, R107C77, R101C81, R98C80, and R99C81 in steam generator 3EO-88 failed to meet the structural integrity criterion limit of three times the normal steady state primary-to-secondary differential pressure of 5250 psig, with the tubes failing at test pressures ranging from 2874 psig to 5026 psig. In addition, tubes R106C78, R102C78, and R104C78 failed to meet the accident-induced leakage criterion of not exceeding 0.5 gpm leakage per steam generator at a main steam line break pressure of 3200 psig, with each tube having leakage rates of approximately 4.5 gpm, prior to exceeding 3200 psig.

This violation is associated with a White Significance Determination Process finding.

Pursuant to the provisions of 10 CFR 2.201, Southern California Edison Company is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001 with a copy to the Regional Administrator, Region IV, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation; EA 13-083." The reply should include a written explanation for the evaluated extent of conditions. Particularly, if you determine that any reason for this violation may apply to work activities during decommissioning and dry cask storage, including oversight of contractor activities, then for each such reason, your reply should include: (1) the corrective steps that have been taken and the results achieved, (2) the corrective steps that will be taken, and (3) the date when all associated corrective actions will have been implemented. If you determine that no reason for this violation could reasonably apply to decommissioning or dry cask storage activities, then your reply should include a statement to that effect.

Your response may reference or include previous 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 license 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, with the basis for your denial, to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001.

Because your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's Agencywide Documents Management System (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html>, 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. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information.

If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

Dated this 23rd day of December 2013