U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	70-7002
Certificate No:	GDP-2
Report No:	70-7002/98011(DNMS)
Facility Operator:	United States Enrichment Corporation
Facility:	Portsmouth Gaseous Diffusion Plant
Location:	3930 U.S. Route 23 South P.O. Box 628 Piketon, OH 45661
Dates:	June 8 through July 20, 1998
Inspectors:	D. J. Hartland, Senior Resident Inspector C. A. Blanchard, Resident Inspector
Approved By:	Patrick L. Hiland, Chief Fuel Cycle Branch Division of Nuclear Materials Safety

EXECUTIVE SUMMARY

United States Enrichment Corporation
Portsmouth Gaseous Diffusion Plant
NRC Inspection Report 70-7002/98011(DNMS)

This inspection report includes aspects of plant operations, maintenance, engineering, and plant support. The report covers a six-week period of routine resident inspections.

Plant Operations

- The inspectors identified examples of inadequate equipment tagging in the plant. The inspectors also raised issues with regards to Engineering's oversite of the labeling program. In response, the certificatee initiated a review of the plant's labeling program to assess compliance with, and adequacy of, existing procedures. One inspector followup item was identified. (Section O1.1)

Maintenance

- The inspectors identified that the instrument mechanics worked past a procedural step without making the required verification signature. In response to continued problems with procedural adherence, the certificatee was evaluating additional measures to monitor performance in the plant, including increased management oversite and self-assessments. One non-cited violation was identified. (Section M1.1)

- The inspectors noted that the certificatee failed to implement corrective action to prevent an unnecessary challenge to an autoclave safety system. One violation was identified. (Section M1.2)

Engineering

- The inspectors identified that the certificatee violated the design basis of the plant by taking credit for the building evacuation horns to maintain the audibility requirements for the Criticality Accident Alarm System. One violation was identified. (Section E2.1)

Plant Support

- The inspectors noted that the certificatee's notification to the NRC of a potential compromise of classified information was untimely. The inspectors concluded that since the certificatee had a reasonable expectation that the documents were classified due to the markings, the notification was required to be made within 1 hour of discovery of the documents.

Report Details

I. Operations

O1 Conduct of Operations

O1.1 Safety System Component Labeling

a. Inspection Scope (88100)

The inspectors reviewed the implementation of the certificatee's equipment tagging program.

b. Observations and Findings

During a tour of the X-342 Building on July 8, the inspectors observed tagging on facility equipment. The inspectors noted that Autoclave No. 2 conductivity instrumentation and valves were not tagged. Additionally, the inspectors observed fragmented paper tagging on the conductivity instrumentation and valves for Autoclave No. 1. The Site Boundary Book for the X-342 Building identified the conductivity components as an AQ-NCS system. In discussions with the inspectors, the first line manager (FLM) explained that in the early 1990s the certificatee had a site-wide initiative to tag all equipment but, due to funding constraints, not all equipment received the appropriate tags. The FLM explained that the fragmented paper tags were not replaced during the initiative. The Building Manager issued Problem Report (PR) PTS-98-05261 to document the conditions, and the deficiencies were corrected.

The inspectors also identified equipment that was not tagged in selected areas of the X-330 Building. The inspectors noted that three of 15 pressure transducers were not tagged in an instrument cubical located in the tails withdrawal area, including a transducer that had been recently replaced. Additionally, the inspectors noted that some intermediate surge drum room and tails area steam system components were not tagged. In response, the X-330 Building custodian issued PRs PTS-98-05296, 98-05297, and 98-05298 to document the conditions and replaced the missing tags. Additionally, the inspectors noted that the custodian initiated building walkdowns to verify other components were properly tagged.

The inspectors also noted missing and deteriorated equipment identification tags during routine tours of the X-600 and X-640-1 Buildings. The inspectors observed that several equipment identification tags were not readable because the material used as tags did not withstand the X-600 Building environment. Additionally, the inspectors noted that gauges and a surge relief block valve did not have identification tags.

The inspectors reviewed Procedure XP2-GP-GP1030, "Work Control Process," and Work Order 9820054-01, "Install and Calibrate PBM-1678." The work order provided instructions to install and calibrate the pressure transducer that was recently replaced at Tails. The inspectors noted that action steps in the work order did not address equipment identification tagging. Additionally, the inspectors noted that Procedure XP2-GP-GP1030, which provided the guidance for preparing maintenance work activities, did not address equipment identification tagging.

The inspectors also reviewed the Procedure XP-SH-SH1037, "Identification of Equipment and Piping Systems." The procedure established the requirements and responsibilities for instituting and maintaining an identification program for equipment and piping systems. The procedure also required that a Plant Labeling Coordinator provide oversite and a point of contact for the development of the equipment and piping systems identification program. In addition, Procedure XP2-SH-SH1037 identified Engineering as responsible for the proper identification of equipment and piping. During followup the inspectors raised an issue with regards to the adequacy of Engineering's oversite of the labeling program.

In response to the inspectors' issues, the certificatee initiated a review of the plant's labeling program to assess compliance with, and adequacy of, existing procedures. The inspectors' review of the certificatee's completed assessment is an **Inspector Followup Item (IFI 70-7002/98011-01)**.

c. Conclusion

The inspectors identified examples of inadequate equipment tagging in the plant. The inspectors also raised issues with regards to Engineering's oversite of the labeling program. In response, the certificatee initiated a review of the plant's labeling program to assess compliance with, and adequacy of, existing procedures. One IFI was identified.

O8 Miscellaneous Operations Issues

08.1 Certificatee Event Reports (90712)

The certificatee made the following operations-related event reports during the inspection period. The inspectors reviewed any immediate safety concerns indicated at the time of the initial verbal notification. The inspectors will evaluate the associated written reports for each of the events following submittal, as applicable.

Number	Date	Status	Title
34397	06/15/98	Open	Potential compromise of classified information due to unsecured repository
34454	06/30/98	Closed	Steam plant opacity limit exceedence
34537	07/18/98	Closed	Potential NPDES exceedence due to heavy rains

08.2 Bulletin 91-01 Reports (97012)

The certificatee made the following reports pursuant to Bulletin 91-01 during the inspection period. The inspectors reviewed any immediate nuclear criticality safety concerns associated with the report at the time of the initial verbal notification. Any significant issues emerging from these reviews are discussed in separate sections of this report.

Number	Date	Title
34370	06/09/98	24-Hour Report - Loss of one control (moderation): free liquid in a DAW container
34384	06/10/98	24-Hour Report - Loss of one control (moderation): uncovered laundry hamper
34423	06/22/98	24-Hour Report - Polybottle holder drain holes were found blocked by sleeves placed in holders to maintain spacing of tail polybottles
34429	06/23/98	24-Hour Report - Liquid solution discovered in suction hose and around opening of small diameter collection container of 5" always safe vacuum cleaner
34501	07/10/98	24-Hour Report - Approximately 1 quart oil inside 2 plastic bags of saturated oily cloth inside DAW container
34513	07/15/98	24-Hour Report - Loss of one control (spacing) during transport of uranium bearing material

O8.3 (Closed) VIO 70-7002/97008-01: Failure to maintain minimum staffing levels for the Plant Shift Superintendent (PSS) position in the X-300 Building. The certificatee determined that the root cause for the violation was inattention to detail. As corrective action, the certificatee prepared "required reading" for PSS personnel to emphasize the requirements for minimum shift staffing, including the definitions for the watch stations and the boundaries that apply, as defined by existing plant procedures. This item is closed.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Procedural Adherence Issue

a. Inspection Scope (88102 and 88103)

The inspectors observed selected safety system surveillance and maintenance activities to verify that activities performed were in accordance with the Technical Safety Requirements (TSRs) and procedural requirements.

b. Observations and Findings

For the maintenance and surveillance activities listed below, the inspectors verified one or more of the following: testing was performed in accordance with procedures; test instrumentation was calibrated; limiting conditions for operation were met; removal and restoration of the affected components were properly accomplished; test results conformed with TSRs, procedural requirements, and were reviewed by personnel other than the individual directing the test; and, any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

Maintenance and Surveillance Activity

- Work Order No. 9824490-01, Test Autoclave No. 1 air volume containment Valve FV-1510X in Building X-342
- Work Order No. 9824490-02, Test Autoclave air volume containment Valves FV-1511X1 and FV-1511X2 in Building X-342
- Work Order No. 9824490-04, Test Autoclave No. 1 air volume containment Valve FV-1516X in Building X-342
- Work Order No. 9824490-05, Test Autoclave No. 1 air volume containment Valve FV-1504 in Building X-342
- Procedure XP4-TE-FD6702, "X-342 and X-343 Autoclave Quarterly Tests," Appendix A, Cylinder Wall High Temperature Test for Autoclave No. 1 in Building X-342.
- Procedure XP4-TE-FD6702, "X-342 and X-343 Autoclave Quarterly Tests," Appendix B, Cylinder High Pressure Test for Autoclave No. 1 in Building X-342.

On July 16, during a review of documents associated with an ongoing surveillance on Autoclave No. 3 at the X-343 Building, the inspectors noted that the instrument mechanics had worked past a procedural step without making the required verification signature. Step 8.2.24 of Procedure XP4-TE-IM6710, "X-342, X-343, and X-344 Autoclave Temperature Calibration," required that the instrument mechanic sign in the appendix to verify that a lead was reconnected per the previous step. Although the mechanic apparently reconnected the lead, the verification signature was not completed.

The certificatee documented the deficiency in PR PTS-98-05347. In response to continued problems with procedural adherence, the certificatee had previously performed a stand down during the first week of June to heighten the awareness of plant personnel. The certificatee was also evaluating some additional measures to monitor performance in the plant, including increased management oversite and self-assessments.

Failure to follow plant procedures is a violation of TSR 3.9.1. However, since the certificatee has taken action to address the problem, the failure is being treated as a **Violation of Minor Significance not subject to formal enforcement action, consistent with Section IV of the NRC Enforcement Policy (NUREG-1600, Revision 1). (NCV 70-7002/98011-02).**

c. Conclusions

In response to continued problems with procedural adherence, the certificatee was evaluating additional measures to monitor performance in the plant, including increased management oversite and self-assessments. One NCV was identified.

M1.2 Inadequate Action To Prevent Autoclave Shutdown

a. Inspection Scope

The inspectors reviewed the circumstances regarding a spurious autoclave containment isolation at the X-344 Building.

b. Observations and Findings

On June 30, X-344 Autoclave Operators responded to a high condensate level alarm on Autoclave No. 3 and noted that, although the containment valves had closed, no containment isolation signal was received. In addition, the operators verified that no indication of a uranium hexafluoride (UF_6) release inside the autoclave existed.

Upon further investigation, the certificatee determined that the high condensate level alarm was due to a spurious closure of the autoclave containment valves. The certificatee speculated that the containment isolation was due to a short or open circuit which resulted from electrical maintenance troubleshooting activities on Autoclave No. 4. The two autoclaves shared a common programmable logic control circuit.

The inspectors noted that a similar event occurred in August 1997, documented in PR PTS-97-7051. As corrective action to the August 1997 event, Operations staff issued a memorandum to multiple addressees, including cognizant maintenance and work control personnel, to include in applicable work instructions a precaution to isolate the autoclave being repaired. The precaution was not included in the troubleshooting work package for Autoclave No. 4.

10 CFR 76.93, "Quality Assurance," requires that the Corporation shall establish, maintain, and execute a quality assurance program satisfying each of the applicable requirements of American Society of Mechanical Engineers (ASME) NQA-1-1989, "Quality Assurance Program Requirements for Nuclear Facilities."

ASME NQA-1-1989, Basic Requirement 16, "Corrective Action," states that conditions adverse to quality (CAQS) shall be identified promptly and corrected as soon as possible.

C8 of Appendix A of XP4-BM-CI1002, "Problem Report Screening Process," lists inadequate work instruction as a specific example of a CAQ.

Contrary to the above, the certificatee did not take action to prevent the spurious containment isolation of Autoclave No. 3 in the X-344 Building on June 30, 1998. The certificatee's intended corrective action to prevent recurrence of an August 1997 event, to add a precaution to the work package to isolate Autoclave No. 4 during a maintenance activity, was not implemented. This is a **Violation (VIO 70-7002/98011-03).**

c. Conclusion

The inspectors concluded that the certificatee failed to take corrective action to prevent an unnecessary challenge to an autoclave safety system. One violation was identified.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) VIO 70-7002/98002-01: Failure to implement Procedure XP2-GP-GP1033, "Lifted Leads and Jumpers," during maintenance activities for "Q" systems. The certificatee determined that the root cause for the violation was that FLMs did not discuss lift leads and jumper (LL&J) procedural requirements during pre-job briefings. In addition, LL&J training was only given to group managers, front line managers, and planners, but not to craft personnel. As corrective action, the certificatee retrained FLMs to ensure pre-job briefs provided a thorough discussion of all items on the pre-brief checklist, including LL&J requirements. The certificatee also retrained planners to ensure that LL&J requirements were included in applicable work packages, and trained all maintenance craft personnel on the requirements of the LL&J program. The inspectors reviewed a sample of completed work packages to verify that LL&J procedural requirements were adequately implemented. This item is closed.

M8.2 (Closed) IFI 70-7002/98002-02: Inconsistent tagging of out-of-service equipment in Buildings X-342, 343, and 344. The Building X-342, 343, and 344 Facility Custodian issued written guidance to responsible FLMs that clarified the criteria for tagging out-of-service equipment. In addition, the certificatee performed a comparison of the tagging requirements and usage in the cascade facilities and determined that there was a general consensus on the criteria for tagging out-of-service cascade equipment. During the inspection period, the inspectors observed consistent use of tagging of out-of-service equipment in the plant. This item is closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Use of Daily Operating Instructions (DOIs) To Replace Procedural Requirements

a. Inspection Scope (88101)

The inspectors reviewed resolution of technical issues by engineering to verify compliance with the design basis of the plant.

b. Observations and Findings

On June 17, the inspectors identified an issue during review of engineering evaluation Eval-X220J-E1109R0-SE-01, Revision 1. The evaluation described the coverage provided by CAAS horns and included maps of the 200-foot immediate evacuation zone during a system actuation or when TSR actions for alarm inaudibility were implemented.

The inspectors noted that the evaluation concluded that either the building evacuation horns or the CAAS nitrogen horns would meet the TSR requirements for audibility in the CAAS clustered and slaved facilities. The evaluation recommended that applicable plant procedures be revised to include the guidance provided in the conclusion. The certificatee initiated a DOI on June 15, to implement the new guidance until the procedure was revised.

The inspectors reviewed Section 3.8 of the Safety Analysis Report (SAR) and noted that the building evacuation horns were not specifically listed in the safety system boundary (Q or AQ) for CAAS. The CAAS TSRs also did not require the building horns to maintain operability of the CAAS system. The procedure change request (PCR) to incorporate the

recommendations of the evaluation, which was in the final approval process, did not identify that the recommended actions involved a change to plant operations as described in the SAR and TSR. As immediate corrective action, on June 17 the certificatee canceled the DOI and revised the PCR to require the nitrogen horns to maintain operability of the CAAS.

Technical Specification Requirement 3.9.1 requires that written procedures shall be prepared, reviewed, approved, implemented, and maintained to cover activities described in SAR Section 6.11.4.1 and listed in Appendix A to SAR Section 6.11.

Appendix A to SAR Section 6.11 requires that "communications" shall be covered by written procedures.

Paragraph 3.3 of Procedure XP2-US-FO1105, "COP-6 Policies And Instructions," states, in part, that DOIs will not instruct anyone to replace guidance in approved procedures.

Contrary to the above, DOI 300-98-111 dated June 15, 1998, replaced guidance in approved Procedure XP2-CO-CA2030, "Operation of Criticality Accident Alarm System," to take credit for building evacuation horns to maintain operability of CAAS in affected facilities if local CAAS nitrogen horns were inoperable, **a Violation (VIO 70-7002-98011-04).**

c. Conclusion

The inspectors concluded that the certificatee violated the design basis of the plant by taking credit for the building evacuation horns to maintain the audibility requirements for the CAAS.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) VIO 70-7002/97008-03: Use of nonstandard 1S Cylinders without a valid Nuclear criticality Safety Analysis (NCSA). The certificatee determined that the root cause for the violation was a lack of understanding of procedure requirements for reviewing existing NCSAs for applicability to other similar activities. As corrective action, the certificatee conducted informal training sessions for Nuclear Criticality Safety (NCS) personnel to review current procedures governing NCSA preparation and discussed lessons learned. The certificatee also prepared NCSA-PLANT078.A00, "Use of Ledoux IS at PORTS," to authorize the use of the nonstandard cylinders. This item is closed.

E8.2 (Closed) CER 70-7002/97005-03 (97-10): Cylinder high pressure safety actuation while heating a 2 1/2-ton Russian cylinder. The certificatee determined that the root cause of the actuation was the release of trapped gases within the cylinder that developed due to the cold ambient environment in Russia where the cylinders were cooled. As corrective action, the certificatee revised applicable autoclave operating procedures to include an enhanced cylinder valve clarity check prior to cylinder heating and an alternate valving configuration to reduce the time required to burp cylinders. In addition, the certificatee reduced the rate of heat applied to the cylinders during the heating process. This item is closed.

E8.3 (Closed) CER 70-7002/97-12: Autoclave high condensate level shutoff actuation in the X-343 Building. The certificatee determined that the root cause of the actuation was the closure of the steam supply valve, removing the motive force for the condensate to drain. The steam valves closed due to the actuation of the low cylinder pressure safety system,

which was caused by insufficient heatup of the cylinder. As corrective action, the certificatee revised autoclave operating procedures to require a minimum of two hours of cylinder heating before feeding to the cascade.

IV. Plant Support

P8 Miscellaneous Plant Support Issues

P8.1 Untimely Notification Of Security Violation

a. Inspection Scope (88100)

The inspectors reviewed the circumstances regarding the certificatee's untimely notification of a security violation.

b. Observations and Findings

On July 9, at approximately 5:15 p.m., the acting Nuclear Regulatory Assurance (NRA) Manager discovered two documents that were labeled as classified documents in a locked desk drawer, an unapproved storage container for such documents. The documents had apparently been stored in the drawer for an extended period of time without the knowledge of the manager. The manager moved the documents to an appropriate storage container until the following morning. At approximately 9:00 a.m., the next day, plant security personnel confirmed that the documents contained classified information. In response, the certificatee made a 1-hour notification to the NRC.

During followup, the inspectors noted that the certificatee's notification of the violation was untimely. The inspectors concluded that, since the certificatee had a reasonable expectation that the documents were classified due to the markings, the notification was required to be made within one of discovery of the documents. In addition, even after the documents were confirmed to be classified, the certificatee did not make the notification until almost three hours later. The delay was apparently due to communication problems among the individuals involved which resulted in a delay in reporting the violation to the PSS office.

Technical Safety Requirement 3.9.1 requires that written procedures be implemented to cover activities described in SAR Section 6.11.4.1, and listed in Appendix A to SAR Section 6.11.

Appendix A to SAR Section 6.11 states that "investigations and reporting" shall be covered by a written procedure.

Paragraph 6.2.1.E of Procedure UE2-RA-RE1030, "Nuclear Regulatory Event Reporting," requires that the PSS verbally notify the appropriate NRC office of reportable events within the time requirements shown in Appendix A, of the procedure.

Paragraph L.4 of Appendix A to Procedure UE2-RA-RE1030 requires that any possible compromise of classified information or classified documents be reported verbally to the NRC immediately (within 1 hour).

Contrary to the above, on July 9, 1998, the certificatee did not verbally notify the NRC within 1 hour of discovering classified documents in an unapproved storage container, a possible compromise classified information. This is a **Violation (VIO 70-7002/98011-05)**.

c. Conclusion

The inspectors concluded that the certificatee's notification of the violation was untimely. The inspectors concluded that, since the certificatee had a reasonable expectation that the documents were classified due to the markings, the notification was required to be made within one hour of discovery of the documents.

P8.2 (Closed) VIO 70-7002/97003-11: Failure to tin cylinder valves and plugs with the material specified in ANSI N14.1-1990 as required by the transportation Certificate of Compliance. As corrective action, the certificatee issued a stop work notice preventing the transfer of all 30B Cylinders that had valve or plug changes performed on plant site pending resolution of the issue. The certificatee then requested and received an amendment to the NRC Certificate of Compliance that approved the use of the alternate solder material. This issue is closed.

P8.3 (Closed) VIO 70-7002/97004-03: Failure to secure confidential material before allowing uncleared personnel in Building X-330, Area Control Room (ACR) 2. As corrective action, the certificatee removed the confidential material from the ACR. To ensure other areas were in compliance with the regulations, a walkdown of the other ACRs containing classified operations was completed. The certificatee did not identify additional examples where labeling revealed classified restricted data. This issue is closed.

P8.4 (Closed) VIO 70-7002/97010-05: Failure to conduct public warning system (PWS) surveillances required by emergency procedure. The inspectors confirmed that the certificatee instituted the required PWS audible semi-annual testing through record review. Additionally, the certificatee issued Procedure XP2-EP-EP4001, "Test and Inspection of the Public Warning System," which addressed, in part, activities performed prior to a scheduled PWS which could alter the audible PWS surveillance. This issue is closed.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of the facility management on July 20, 1998. The facility staff acknowledged the findings presented.

PARTIAL LIST OF PERSONS CONTACTED

Lockheed Martin Utility Services (LMUS)

*J. M. Brown, General Manager
*S. Casto, Work Control Manager
*S. Fout, Operations Manager
*J. Morgan, Enrichment Plant Manager
*D. B. Waters, Acting Nuclear Regulatory Affairs Manager

United States Department of Energy (DOE)

J. C. Orrison, Site Safety Representative

United States Enrichment Corporation (USEC)

*L. Fink, Safety, Safeguards & Quality Manager
*J. H. Miller, USEC Vice President, Production

*Denotes those present at the exit meeting on July 20, 1998.

INSPECTION PROCEDURES USED

IP 88100:	Plant Operations
IP 88101:	Configuration Control
IP 88102:	Surveillance Observations
IP 88103:	Maintenance Observations
IP 97012:	Inoffice Reviews of Written Reports on Nonroutine Events

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

070-7002/98011-01	IFI	Monitor action to address equipment identification tagging
070-7002/98011-03	VIO	Failure to take action to prevent challenge to safety system
070-7002/98011-04	VIO	Use of DOI to replace guidance in approved procedure
070-7002/98011-05	VIO	Failure to verbally notify the NRC within 1 hour of discovering possible compromise classified information

Closed

070-7002/98011-02	NCV	Failure to complete verification sign-off as required by procedure
070-7002/98002-01	VIO	Failure to implement Procedure XP2-GP-GP1030, "Lifted Leads and Jumpers," for "Q" items
070-7002/98002-02	IFI	Inconsistent tagging of out-of-service equipment in Buildings X-342, 343, and 344

070-7002/97003-11	VIO	Failure to follow transportation Certificate of Compliance
O70-7002/97004-03	VIO	Failure to secure confidential material before allowing unclear personnel ARC
070-7002/97010-05	VIO	Failure to conduct public warning system surveillances required by emergency procedure
070-7002/97008-03	VIO	Use of nonstandard 1S cylinders without a valid NCSA
070-7002/97005-03	CER	Cylinder high pressure safety actuation while heating a 2 ½-ton Russian cylinder
070-7002/97-12	CER	Autoclave high condensate level shutoff actuation in the X-343 Building
070-7002/97008-01	VIO	Failure to maintain minimum staffing levels for the PSS position in the X-300 Building

Discussed

None

Certification Issues - Closed

None

LIST OF ACRONYMS USED

ACR	Area Control Room
ANSI	American National Standards Institute
ASME	American Society of Mechanical Engineers
CER	Certificate Event Report
CFR	Code of Federal Regulations
CofC	Certificate of Compliance
IFI	Inspection Followup Item
IP	Inspection Procedure
LCO	Limiting Condition for Operation
LMUS	Lockheed Martin Utility Services
NCS	Nuclear Criticality Safety
NCSA	Nuclear Criticality Safety Approval
NCV	Non-cited Violation
NOV	Notice of Violation
NRA	Nuclear Regulatory Assurance
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
PSS	Plant Shift Superintendent
QAP	Quality Assurance Plan
SAR	Safety Analysis Report
TSR	Technical Safety Requirement
UF6	Uranium Hexaflouride
USQ	Unreviewed Safety Question
VIO	Violation