

U.S. NUCLEAR REGULATORY COMMISSION
REGION III

Docket No: 70-7002
Certificate No: GDP-2

Report No: 70-7002/99017(DNMS)

Facility Operator: United States Enrichment Corporation

Facility Name: Portsmouth Gaseous Diffusion Plant

Location: 3930 U.S. Route 23 South
P.O. Box 628
Piketon, OH 45661

Dates: December 14, 1999, through January 24, 2000

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 70-7002/99017(DNMS)

Operations

The inspectors noted that the year 2000 contingency planning and precautions taken by plant staff were comprehensive. The inspectors also observed that no operational problems or abnormalities occurred during transition into the new year. (Section O1.1)

The inspectors concluded that plant staff failed to implement adequate corrective actions to ensure process motor load alarms were correctly adjusted. The inspectors noted that plant staff updated the normal cell operations procedure to clearly address the motor load alarm adjustment requirements and developed a comprehensive alarm response procedure in response to a previous violation but failed to effectively implement the actions. One corrective action violation was identified. (Section O1.2)

The inspectors noted that a failure to follow a procedure resulted in a minor railcar event. The certificatee took appropriate action to address the issue. (Section O1.3)

Maintenance

The inspectors identified a non-compliance with the criteria for marking a procedure step "Not Applicable," as the purpose of the procedure was changed and should have been processed as a temporary procedure change. The violation was of minor safety significance as the Safety Analysis Report requirement to minimize exposure to technetium-99 was maintained. (Section M1.1)

Engineering

The inspectors concluded that plant was performing battery surveillances as required by the Technical Safety Requirements to ensure system operability. The inspectors identified that the specific gravity surveillance was not performed in accordance with the vendor manual recommendations. In response, plant staff performed an engineering evaluation which concluded that there was no impact on operability. (Section E2.1)

Report Details

I. Operations

O1 Conduct of Operations

O1.1 Y2K Contingency Planning

a. Inspection Scope (88100)

The inspectors reviewed plant staff's year 2000 (Y2K) contingency planning and observed plant operations during the transition into the new year.

b. Observations and Findings

The certificatee assembled a team consisting of staff from affected organizations who developed and implemented contingency actions for the Y2K transition. The actions included: ensuring all backup diesel generators, batteries, and emergency lighting were fully operational; confirming critical supplies and parts were available; providing backup capability of critical communications; requiring operator review of applicable emergency procedures; providing additional staffing for affected organizations (i.e., power operations); and ensuring that no cell maintenance, crane operation, or cylinder changes at the autoclaves and withdrawal stations were in progress during the transition. The inspectors determined that the contingency planning and actions taken were comprehensive. The inspectors also observed that no operational problems or abnormalities occurred during transition into the new year.

c. Conclusion

The inspectors determined that the Y2K contingency planning and precautions taken by plant staff were comprehensive. The inspectors also observed that no operational problems or abnormalities occurred during transition into the new year.

O1.2 Failure To Adjust Cell Motor Load Alarms

a. Inspection Scope (88100)

The inspectors reviewed the certificatee's corrective actions to a previous violation to ensure that cell motor alarm set points were adjusted as required. In addition, the inspectors toured plant facilities and assessed existing conditions for compliance with procedures and other certificate requirements.

b. Observations and Findings

During a tour in Area Control Room No. 1 in Building X-333 on January 4, 2000, the inspectors observed that several load alarms were not adjusted as required by Procedure XP4-CO-CN2106, "Normal Cell Operations in X-333." Procedure XP4-CO-CN2106, Section 8.14, required, in part, that operators adjust the cell motor load alarm set points at 10 percent above and below the nominal motor load each shift. Specifically, the inspectors identified that the motor load alarm set points for all the

stages of Cells 33-8-2, 33-8-4, 33-8-8, 33-8-9, and 33-7-2 were not adjusted as required by Procedure XP4-CO-CN2106. As immediate action, operators adjusted the motor load alarms as required by the procedure and issued Problem Report PR-PTS-00-00055.

The inspectors reviewed the safety function of the load monitors. The inspectors noted that the Safety Analysis Report (SAR) stated that a change in cell motor amperage load, indicated by the motor ammeter, was the operator's initial indication of several potential system and equipment abnormalities. The inspectors also noted that the SAR accident analysis credited operator timely response to the load alarms to mitigate accidents initiated by equipment failure.

The inspectors reviewed the certificatee's actions to previously identified Violation 70-7002/98018-01 issued on March 17, 1999. The violation addressed plant staff's failure to adjust the motor load monitor set-points to ± 10 percent the nominal motor load as procedurally required in Building X-326. The certificatee's corrective actions to address this violation included the following:

- Added to the normal cell operation procedures the required action steps to adjust and monitor motor load alarm set points as required by the SAR for each process building. Previously, the requirements were addressed in the process power system procedure for Buildings X-333 and X-330 but not adequately addressed in a procedure for Building X-326;
- Required all operators and first line managers (FLMs) to receive training on applicable normal cell operation and motor load alarm response procedures;
- Observed performance of operators adjusting motor load monitors and ensured knowledge of requirements, and;
- Developed alarm response procedures for the area control rooms that addressed specific adjustment instruction.

The inspectors reviewed the effectiveness of the motor load training. The process operator and FLM training included a review of the pertinent SAR accident analysis, which credited operator timely response to motor load alarms to mitigate accidents initiated by equipment failure. In addition, the training addressed the methods used to adjust each type of motor load alarm and required actions for responding to an alarm, as described in the normal cell operation and alarm response procedures. The inspectors noted that the alarm response procedures clearly described the operator's immediate and supplementary actions and the possible causes for motor load alarms. The inspectors concluded the certificatee's actions to address **Violation 70-7002/98018-01** were reasonable and consider this violation closed.

However, on November 15, 1999, during a tour of Building X-333 the inspectors identified that the motor load alarm low set point was not correctly adjusted for two stages on Cell 33-2-2. The inspectors reviewed the certificatee's interim corrective actions in response to this procedure non-compliance. Problem Report PTS-99-06769 identified that the actions taken were to adjust set points to within acceptable limits.

However, no root cause evaluation was performed to determine why the corrective actions imposed by Violation 70-7002/98018-01 were not effectively implemented until the issue was again identified by the inspectors on January 4.

On January 4, the Cascade Operation Manager requested each process building manager to personally ensure that load alarms were adjusted as required by the procedure and review records from December 1, 1999, for non-compliance. The certificatee found that Buildings X-326 and X-330 were in compliance but 24 of the 70 shift surveillance records for Building X-333 were not available.

10 CFR, Part 76.93, "Quality Assurance," requires, in part, that the Corporation shall establish, implement, and maintain a Quality Assurance Program. Section 2.16, of the Quality Assurance Program, "Corrective Action," requires, in part, that conditions adverse to quality shall be corrected as soon as practical. Appendix A of Procedure XP4-BM-CI1002, "Problem Report Screening Process," defines a condition adverse to quality to include failure to execute a procedure. Contrary to the above, between November 15, 1999, and January 4, 2000, plant staff did not correct a condition adverse to quality as soon as practical. Specifically, the plant staff failed to implement adequate corrective actions to ensure that the motor load alarms were adjusted each shift as required by XP4-CO-CN2106B, Normal Cell Operations in X-333," Rev. 0, dated February 10, 1997. This is a Violation (**VIO 70-7002/99017-001**).

c. Conclusion

The inspectors concluded that plant staff failed to implement adequate corrective actions to ensure that process motor load alarms were properly adjusted. The inspectors identified that the certificatee updated the normal cell operations procedure to clearly address the motor load alarm adjustment requirements and developed a comprehensive alarm response procedure in response to a previous violation but failed to effectively implement the actions. One corrective action violation was identified.

O1.3 Response To Solid Cylinder Railcar Event

a. Inspection Scope (88100)

The inspectors reviewed the circumstances leading to three railcars loaded with solid uranium hexafluoride (UF₆) cylinders rolling unattended through a security gate.

b. Observations and Findings

On January 12, at approximately 12:30 p.m., three railcars loaded with nine full 14-ton cylinders containing uranium tails were moved from Building X-343 to the north end of the plant within the secured area and uncoupled from the trackmobile. At approximately 2:40 p.m., site security force observed the railcars moving westward on the rail and then through the east security gate to the H-Lot unattended. The three railcars came to a stop on the access drive for the H-Lot.

The security force notified the Plant Shift Superintendent (PSS) office and the PSS responded. The system engineer requested Building X-343 operators check the brake system for air pressure. No residual pressure was noted in the lead car; however, the other two cars had some residual pressure. The operators moved the cars to a staging

area southwest of Building X-343. The PSS required all railcars to be tagged out of service pending functional brake tests and a root cause investigation.

As an immediate follow-up, the inspectors observed the three railcars which had been moved to Building X-343 and verified only superficial damage to a railcar and cylinder. During discussions with the PSS, the inspectors noted that the railcar wheels had not been chocked nor were the manual brakes set. The inspectors verified that railcars loaded with liquid UF6 cylinders at the Tails area were adequately chocked.

On January 13, the certificatee performed a functional test of the railcar emergency brake system and completed a root cause investigation. The certificatee identified that the railcars passed the emergency brake system functional test. However, inspectors noted that the emergency brake system required compressed air to actuate and would only stay engaged under pressure. The emergency brakes were only designed to slow or stop a moving railcar and were not intended as parking brakes. The railcars were equipped with a manual parking brake. The certificatee identified the root cause of the event was a failure to follow Procedures XP2-TE-TE2240, "Operations of Railcar Mover," which required operators to set the parking brake and chock a set of wheels. As corrective action, shift briefings were conducted to review the requirements of Procedure XP2-TE-TE2240 before rail operations were commenced. The inspectors noted that the certificatee's immediate response was timely and the corrective actions to prevent recurrence appeared adequate.

Failure to chock the wheels and set the parking brakes on the rail cars as required by Procedure XP2-TE-TE2240 was a violation. However, the certificatee took immediate and effective corrective actions to address the issue. Therefore, this non-repetitive, self-revealing violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.

c. Conclusions

The inspectors noted that a failure to follow a procedure resulted in a minor railcar event. The certificatee took appropriate action to address the issue.

08 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.

<u>Number</u>	<u>Date</u>	<u>Status</u>	<u>Title</u>
36529	12/20/99	Closed*	Other governmental agency notification; minor out gassing occurred due to a cracked bonnet nut on a cylinder valve while sampling a Department of Energy tails cylinder in Building X-343.

36605	1/19/00	Open	Safety System Failure, Building X-330, High Pressure Fire Water Systems were not capable of meeting operability requirements due to corrosion problems identified on adjacent sprinkler heads.
-------	---------	------	--

*The inspectors observed the emergency response and reviewed the root cause investigation and corrective actions and identified no issues. No 30-day report to the NRC is required.

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 (NCS) 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 or in future inspection reports.

<u>Number</u>	<u>Date</u>	<u>Title</u>
36540	12/26/99	24-Hour Report - NCS violation, Building X-333 was evacuated due to a see and flee which resulted in unattended open cell piping flanges during ongoing cell maintenance.
36617	01/22/00	4-Hour Report - NCS violation, Building X-344A, cylinder storage area not covered by nuclear criticality safety approval as required.

II. Maintenance

M1 Conduct of Maintenance Activities

M1.1 Unauthorized Marking of Procedure Step "Non Applicable"

a. Inspection Scope (88103)

The inspectors reviewed the circumstances involving the marking of a maintenance procedure step "Not Applicable (N/A)."

b. Observations and Findings

On January 5, while observing maintenance personnel cutting converters for removal from Cell 25-7-6 in Building X-326, the inspectors reviewed the work packages and noted that a procedure step had been lined out and marked "N/A." Step 6.5 of Procedure XP4-OM-MM4307, "Removal And Installation Of Uncomplicated Handling Converters In X-326," requires that a technetium (Tc-99) negative be obtained as a prerequisite to removing the converters from the purge cascade. The basis for making this step "NA", as documented, was that it was not feasible, as the cell could not be operated to obtain the negative.

Upon further review and discussion with plant staff, the inspectors noted that the staff's basis was supported by a recent change to SAR Section 3.1.2.3.1. The change required a Tc negative using "hot-air" treatments only when operationally feasible. Otherwise, the SAR states that the cell's Tc negative could be assured by gas-bulb sampling or other engineering controls and the use of protective equipment to keep personnel exposure to Tc at acceptable levels. The inspectors verified that adequate controls to minimize personnel exposure were in place.

However, the inspectors determined that plant staff were not in compliance with the criteria for marking a procedure step "N/A" as stated in Step 6.1.12 of Procedure UE2-PS-PS1034, "Use of Procedures." The criteria that was violated was the purpose that the procedure was changed, and could have resulted in a failure to establish a regulatory requirement because the requirement was SAR-related, and was used as a temporary procedure change.

As corrective action, plant management issued a daily operating instruction to the staff emphasizing the requirements for when the use of "N/A" was allowed. Plant management also committed to perform a self-assessment to determine whether or not the problem was an isolated case. The non-compliance with Procedure UE2-PS-PS1034 was a violation of Technical Safety Requirement (TSR) 3.9.1. However, the safety significance was minimal as the SAR requirement to minimize personnel exposure was in place. Therefore, the issue constituted a violation of minor safety significance and is not subject to formal enforcement action.

c. Conclusion

The inspectors identified a non-compliance with the criteria for marking a procedure step "N/A," as the purpose of the procedure was changed and should have been processed as a temporary procedure change. The violation was of minor safety significance as the SAR requirement to minimize exposure to Tc was maintained.

M8 Miscellaneous Maintenance Issues

M8.1 (Closed) Compliance Plan Issue 24, "Maintenance Program": The description of the noncompliance for this issue identified that the maintenance program needed upgrading to increase the formality to levels specified in the application commitments and to document the maintenance of quality, augmented quality-NCS, and other augmented quality structures, systems, and components. Affected activities included corrective and preventive maintenance, work control, calibration and testing, control of measuring and test equipment, material control, and scheduled surveillance testing.

The inspectors reviewed the certificatee's closure package and verified that the required program activities have been developed or upgraded and that the appropriate personnel were trained. However, the inspectors identified weaknesses in the implementation of some activities including the failure analysis and trending program (VIO 70-7002/99006-03), calibration program (70-7002/99001-02), and the development of approved procedures for complex safety-related maintenance activities (VIO 70-7002/97005-02). The inspectors will use those items to track the corrective actions for these deficiencies. This item is closed.

- M8.2 (Closed) Event Reports 98-16, 98-18 and 98-19: Failure of electrical circuits during manual shutdown of operating cells in Building X-326. Plant staff determined that root cause of the local trip circuit to de-energize the cell motors in each case was the lack of lubrication on the breaker linkage. The vendor manual did not describe the type of lubrication to use nor the lubrication frequency. After consulting with the vendor, plant staff revised the applicable procedures which provided guidance for lubricating the breaker linkage. The safety significance of the failures was minimal due to the diverse means of de-energizing the cell motors, as described in the applicable TSR basis statements. The inspectors did not note any further failures and these items are closed
- M8.3 (Closed) VIO 70-7002/98011-03: Failure to take effective corrective action to prevent recurrence of spurious autoclave safety system actuations. Plant staff determined that the primary root cause of the repeated actuations was the failure to conduct routine preventive maintenance (PM) on the system's programmable logic controllers. The failure to perform the PM resulted in spurious electronic transients caused by corrosion, dirt, vibration, and thermal cycling. As a corrective action, the plant staff established a PM activity for these components and reviewed the adequacy of PM on similar electronic equipment. The inspectors did not identify any issues regarding the actions taken and this item is closed.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.2 Battery Surveillance Review

a. Inspection Scope (88103)

The inspectors observed maintenance and surveillance activities associated with the emergency backup batteries and reviewed vendor technical information.

b. Observation and Findings

The inspectors toured the emergency battery rooms in the electrical switchyard and the process buildings to observe the condition of the batteries and components. The accident analysis described that shutting down cell motors would mitigate or terminate a large UF₆ release. The emergency batteries supply backup DC power to disconnect cascade breakers if normal AC power was lost and also supplied emergency lighting power as well.

The inspectors observed that the electrolyte levels in the batteries were within specification; batteries and terminals were clean; there was no indication of electrolyte leakage from the batteries; general housekeeping of the battery rooms was adequate; and the exhaust fans were operating as required. However, the inspectors observed that several of the flame arrestor vent caps had deteriorated and were cracked. The inspectors noted that the defective caps had minimal operability significance but could be a pathway for debris to contaminate the battery electrolyte. In response, plant staff will revise Procedure XP4-OM-EM6507, "Preventive Maintenance of Switchyard and Cascade Storage Batteries," to check for cap defects and replaced as required.

The inspectors reviewed biweekly, quarterly, and annual surveillance records for selected battery rooms and observed instrument mechanics performing the surveillance activities. The inspectors noted the selected surveillances were performed within the required frequencies and addressed the surveillance requirements of TSR Section 2.7.3.13, "Cascade DC Control Power." The instrument mechanics used the guidance in Procedure XP4-OM-EM6507 to perform battery surveillances. During review of the procedure, the inspectors noted that no guidance for performing the specific gravity surveillance was included. On January 12, the inspectors observed instrument mechanics measuring the specific gravity from an electrolyte sample extracted from the frame arrestor vent cap which was contrary to the battery vendor manual. Specifically, the vendor manual recommended that a test port be used and that a second, more representative sample be drawn to measure the specific gravity.

The inspectors discussed the issue with engineering personnel, who were not aware of the vendor recommendations. After discussions with the vendor, engineering explained that measuring the first sample could result in a nonrepresentative specific gravity reading but would result in a lower, more conservative value. The certificatee issued Engineering Evaluation EVAL-PS-2000-0015, "Battery Specific Gravity Sampling Techniques," that concluded the test method was acceptable because it would result in a conservative error of the specific gravity if stratification of the electrolyte occurred. Plant staff also intended on revising the procedure to provide the instructions for drawing and reading the specific gravity.

c. Conclusions

The inspectors concluded that the certificatee was performing required battery surveillances as required by the TSRs to ensure operability. The inspectors identified that the specific gravity surveillance was not performed in accordance with the vendor manual recommendations. In response, plant staff performed an engineering evaluation which concluded that the operability of the batteries was not impacted.

III. Plant Support

P8 Miscellaneous Emergency Preparedness Issues

- P8.1 (Closed) Compliance Plan Issue 34, "Training for Emergency Preparedness": The description of the noncompliance for this issue identified that tenant organizations had not been required to attend site specific emergency preparedness training nor had a formal training model been developed for tenant organizations. In addition, on-site and off-site emergency response personnel required additional training due to the revisions of the emergency plan and the new implementing procedures.

The inspectors reviewed the certificatee's closure package for this item. Training Model 05.01.01 (00), "Safety and Emergency Preparedness," addressed significant elements of the Emergency Plan to ensure that appropriate protective actions were taken if an emergency occurred. Specifically, enabling objectives required the tenant to define the emergency philosophy, list methods for reporting an emergency, recognize plant alarm signals, etc. Procedure XP2-EP-EP1045, "Emergency Management Training," required that contractors, subcontractors, and tenant organizations, and offsite emergency support organizations receive site specific biennial emergency preparedness training. The inspectors noted that the enabling objective topics of Training Model 05.01.01 (00)

were required in Procedure XP2-EP-EP1045 for the biennial training and selected tenant training records for this training were current. This item is closed.

- P8.2 (Closed) Compliance Plan Issue 33, "Emergency Plan Support Documents": The description of the noncompliance for this issue identified that the emergency plan support documents needed to be upgraded to include hazardous chemical emergency documents. Specifically, two documents were identified. The first was a public document that explained the capability to respond to and mitigate a release of a hazardous material, and the second was a hazardous assessment document that included an evaluation of the chemical hazards associated with facility operations.

The inspectors noted that the certificatee developed both required documents. In June 1995, "PORTS Superfund Amendments and Reauthorization Act, Title III, Hazardous Material Facility Emergency Plan," was issued and approved by the cognizant local county director and chairman. This document included site response information, hazard identification, and response coordinators. The other requirement, the Hazardous Assessment Document, included site specific background information, facility hazard assessments, and consequence assessment. The consequence assessment addressed the emergency action level, event classification, anticipated consequences and protective actions. The inspectors noted that the information specified in the Hazardous Assessment Document was in accordance with Procedure XP2-EP-EP1050, "Emergency Classification," with a current copy located in the emergency response vehicle. Selected information reviewed was accurate, informative, and conclusive. This item is closed.

- P8.3 (Closed) VIO 70-7002/99006-03b: The violation addressed the certificatee's failure to correct inconsistencies in the classification levels and to initiate conditions for severe wind and security emergencies that existed between the Emergency Plan and Emergency Plan Implementing Procedure (EPIP) XP2-EP-EP1050, "Emergency Classification," following the December 9, 1998, Building X-326 fire. Specifically, corrective actions following the fire included the appropriate emergency action levels (EALs) for other emergency conditions, consistent with the information presented in NRC Regulatory Guide 3.67, "Standard Format and Content for Emergency Plans for Fuel Cycle and Material Licensees." The inspectors identified that EPIP XP2-EP-EP1050 had not been updated to include the emergency action level for severe natural phenomena addressed in NRC Regulatory Guide 3.67.

As corrective action, Procedure XP2-EP-EP1050 was updated to specify the actions required to address natural phenomenon and security events. Specifically, the inspectors noted that the natural phenomenon section included the event classification, anticipated consequences, and anticipated responses and protective actions required for earthquake, tornado, high winds, failure of an earthen dam on-site, and addressed appropriate actions for numerous security events. Selected PSSs demonstrated appropriate knowledge on the actions required to respond to several EALs. Selected PSSs were cognizant that Procedure XP2-EP-EP1050 addressed event response and identified the location of the procedure in the PSS emergency response vehicle and Plant Control Facility. In addition, the inspectors noted that the emergency management group had enhanced emergency response training for individuals of the emergency response organization. This item is closed.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of the facility management on January 24, 2000. The facility staff acknowledged the findings presented and indicated concurrence with the facts, as stated. The inspectors asked the plant staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

United States Enrichment Corporation

- *J. Anzelmo, Work Control Manager
- *M. Brown, General Manager
- *D. Couser, Training Manager
- *J. Cox, Site & Facility Support Manager
- L. Fink, Commitment Management Manger
- *S. Fout, Operations Manager
- *R. Helme, Engineering Manager
- R. Lawton, Safety, Safeguards & Quality Manager
- *P. Miner, Regulatory Affairs Manager
- *P. Musser, Enrichment Plant Manager
- *R. Smith, Production Support Manager
- K. Tomko, Environmental, Safety & Health Manager
- *M. Wayland, Maintenance Manager

*Denotes those present at the exit meeting on January 24, 2000.

INSPECTION PROCEDURES USED

- IP 88100: Plant Operations
- IP 88102: Surveillance
- IP 88103: Maintenance
- IP 90712: In-office Reviews of Written Reports on Non-routine Events

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

- 070-7002/2000001-01 VIO Failure to implement corrective actions for setting motor load alarm as discussed in Safety Analysis Report.
- 36605 CER Safety System Failure, Building X-330, High Pressure Fire Water systems No. 284 and No. 365 were not capable of meeting operability requirements due to corrosion problems identified on adjacent sprinkler heads.

Closed

- 070-7002/98011-03 VIO Failure to take action to prevent challenge to safety system.
- 070-7002/98018-01 VIO Motor load alarms not adjusted as required by procedure.
- 070-7002/99006-03b VIO Failure to implement corrective actions for conditions adverse to quality associated the emergency plan implementing procedures.

36529	CER	Other governmental agency notification; minor out gassing occurred due to a cracked bonnet nut on a cylinder valve while sampling a DOE tails cylinder.
35101 (CER 98-16)		Safety System Failure, Building X-326, electrical circuit required by SAR to shutdown operating cell.
35139 (CER 98-18)		Safety System Failure, Building X-330, electrical circuit required by SAR to shutdown operating cell.
35147 (CER 98-19)		Safety System Failure, Building X-326, electrical circuit required by SAR to shutdown operation cell.
Compliance Plan Issue 24		Maintenance Program
Compliance Plan Issue 34		Training for Emergency Preparedness
Compliance Plan Issue 33		Emergency Plan Support Documents

Discussed

None

LIST OF ACRONYMS USED

CER	Certificate Event Report
CFR	Code of Federal Regulations
DNMS	Division of Nuclear Material Safety
DOE	Department of Energy
EAL	Emergency Action Level
EPIP	Emergency Plan Implementing Procedures
FLM	First Line Manager
GDP	Gaseous Diffusion Plant
N/A	Not Applicable
NCS	Nuclear Criticality Safety
NRC	Nuclear Regulatory Commission
PDR	Public Document Room
PM	Preventive Maintenance
PSS	Plant Shift Superintendent
SAR	Safety Analysis Report
Tc	Technetium
TSR	Technical Safety Requirements
UF ₆	Uranium Hexafluoride
USEC	United States Enrichment Corporation
VIO	Violation
Y2K	Year 2000