



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION II  
SAM NUNN ATLANTA FEDERAL CENTER  
61 FORSYTH STREET, SW, SUITE 23T85  
ATLANTA, GEORGIA 30303-8931

[REDACTED]

July 3, 2006

EA-06-141

Mr. Dwight B. Ferguson, Jr.  
President, Chief Executive Officer  
Nuclear Fuel Services, Inc.  
P. O. Box 337, MS 123  
Erwin, TN 37650

SUBJECT: CONFIRMATION OF CLOSED PRE-DECISIONAL ENFORCEMENT  
CONFERENCE (NRC INSPECTION REPORT NO. 70-143/2005-004  
AND NRC OFFICE OF INVESTIGATIONS REPORT NO. 02-2005-27)

Dear Mr. Ferguson:

This letter refers to the apparent violation that occurred on May 31, 2005, when a Nuclear Fuel Services, Inc., (NFS) acting building manager transferred raffinate [REDACTED] waste into [REDACTED] without procedural authorization. This event occurred in the BLEU Preparation Facility [REDACTED]. This action was determined by the NRC to be an apparent violation of Section 2.7 of the License Application, "Procedures," which states that, "SNM operations and safety function activities are conducted in accordance with written procedures as defined in Sections 1.7.4 and 1.7.5." This issue was first documented as an unresolved item ((URI) 70-143/2005-04-01) in Nuclear Regulatory Commission (NRC) Inspection Report No. 70-143/2005-004 dated August 5, 2005.


This letter also refers to an investigation completed by the NRC's Office of Investigations (OI) on March 29, 2006. The purpose of the OI investigation was to determine whether the above apparent violation occurred as the result of willful actions on the part of an NFS supervisor. Based on the evidence developed during the investigation, the NRC concluded that the supervisor's actions were willful. A factual summary that provides relevant details of the OI investigation and subsequent apparent violation is included as Enclosure 1.

Based on these findings, this apparent violation is being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's website at [www.nrc.gov/OE](http://www.nrc.gov/OE).


A closed, pre-decisional enforcement conference (PEC) to discuss the apparent violation will be scheduled for a future date, to be conducted in the NRC's Region II Office, located at the Sam Nunn Atlanta Federal Center, 61 Forsyth Street SW, Suite 23T85, Atlanta, GA 30303. Representatives of my staff will contact you to reach a mutually acceptable date and time for

[REDACTED]

the conference. The conference will be closed to the public because the preliminary conclusions are based on an NRC OI investigation that has not been publicly released. In addition, the conference will be transcribed. A proposed agenda for the conference is included as Enclosure 2.

The evidence obtained by OI revealed that the acting building manager involved in the transfer of  raffinate waste solution to the condensate waste storage area has been involved in several previous examples of procedural non-compliance at NFS. The NRC is concerned that this individual may not possess the appropriate sensitivity to procedural requirements and the need to adhere to them. Such a sensitivity is imperative for continued participation in activities that can affect nuclear safety at NFS in the future. In addition, the NRC is concerned that NFS management has been ineffective in communicating proper safety and procedural compliance expectations to all members of its management team and staff. Based on these concerns, the NRC requests that NFS be prepared to discuss the corrective actions that have been taken or are planned to ensure that: (1) this individual can be entrusted with the responsibility to supervise or conduct activities that affect nuclear safety at NFS, and (2) expectations concerning safety and procedural compliance have been communicated to and are being embraced by all members of its management team and staff. Because of the NRC's specific concerns in this matter, we also request that NFS consider ensuring that the individual involved in the procedural non-compliance described above personally attends the conference.

The decision to hold a pre-decisional enforcement conference does not mean that the NRC has determined that violations have occurred or that enforcement action will be taken. This conference is being held to obtain information to assist the NRC in making an enforcement decision. This may include information to determine whether violations occurred, information to determine the significance of the violations, information related to the identification of the violations, and information related to any corrective actions taken or planned. The conference will provide an opportunity for you to provide your perspectives on these matters and any other information you believe the NRC should take into consideration in making an enforcement decision. In presenting your corrective actions, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in the enclosed excerpt from NRC Information Notice 96-28, "SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION," may be helpful.

Instead of a PEC, you may also request alternative dispute resolution (ADR) with the NRC in an attempt to resolve this issue. ADR is a general term encompassing various techniques for resolving conflicts outside of court using a neutral third party. The technique that the NRC has decided to employ during a pilot program, which is now in effect, is mediation. Additional information concerning the NRC's pilot program is described in the enclosed brochure (NUREG/BR-0317) and can be obtained at <http://www.nrc.gov/what-we-do/regulatory/enforcement/adr.html>. The Institute on Conflict Resolution (ICR) at Cornell  


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University has agreed to facilitate the NRC's program as an intake neutral. Please contact ICR at 877-733-9415 within 10 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

Since the NRC has not made a final determination in this matter, no Notice of Violation is being issued for these inspection and investigative findings at this time. In addition, please be advised that the number and characterization of apparent violations may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding the apparent violation is required at this time.

[REDACTED]

Should you have any questions concerning this letter, please contact Mr. David Ayres at 404-562-4711.

Sincerely,

*/RA/*

Douglas M. Collins, Director  
Division of Fuel Facility Inspection

Docket No. 70-143  
License No. SNM-124

Enclosures:

1. Factual Summary
2. Closed Pre-decisional Enforcement Conference Agenda
3. Information Notice 96-28

cc w/encls: (See page 4)

[REDACTED]

D. B. Ferguson



cc w/encls:

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ADAMS: XYes      ACCESSION NUMBER: \_\_\_\_\_

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NAME	SBurris*	WGloersen*	DAyres*	CEvans*			
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## FACTUAL SUMMARY

On March 29, 2006, the U.S. Nuclear Regulatory Commission's (NRC), Office of Investigations (OI), Region II (RII), completed an investigation to determine whether a Nuclear Fuel Services, Inc., (NFS) acting building manager willfully transferred raffinate [REDACTED] waste into a [REDACTED] without procedural authorization.

Safety Condition S-1 of Special Nuclear Materials License No. SNM-124 authorizes the use of licensed materials in accordance with the statements, representations, and conditions in the License Application and Supplements.

Section 2.7 of the License Application, "Procedures," states that, "SNM operations and safety function activities are conducted in accordance with written procedures as defined in Sections 1.7.4 and 1.7.5."

Standard Operating Procedure (SOP) 409, Caustic and Condensate Discard Tank, Revision 2, May 14, 2005, Section 3.2, Safety Hazards and Precautions, specifies that nothing may be added to [REDACTED] except as described in SOP-409, without the approval of Building Supervision, Industrial Safety, and NCS through work instructions.

On May 31, 2005, an acting building manager transferred [REDACTED] raffinate waste solution to the condensate waste storage area, [REDACTED], without the approval of Building Supervision, Industrial Safety or NCS through work instructions. In this case, the NRC concluded that the actions of the building manager were willful given that, 1) this individual had received training on the procedure at issue and had previously used procedure SOP-409 without incident; 2) this individual failed to determine if the transfer of [REDACTED] raffinate waste solution to the condensate storage area was addressed by procedure SOP-409 or any other procedures; and 3) the individual was aware that approval had not been granted by Building Supervision, Industrial Safety, and Nuclear Criticality Safety through work instructions to transfer [REDACTED] raffinate waste solution to the condensate storage area. Nonetheless, the individual proceeded with the transfer of [REDACTED] raffinate waste solution to the condensate storage area. This activity was determined to be in apparent violation of Special Nuclear Materials License No. SNM-124, Section 2.7 of the License Application, and SOP-409, in that solution was added to [REDACTED] without the approval of Building Supervision, Industrial Safety, and Nuclear Criticality Safety through work instructions.

Enclosure 1

[REDACTED]

[REDACTED]

PROPOSED CLOSED PREDECISIONAL ENFORCEMENT CONFERENCE AGENDA

NUCLEAR FUEL SERVICES, INC.

ATLANTA, GEORGIA

I. OPENING REMARKS AND INTRODUCTIONS

W. Travers, Regional Administrator

II. NRC ENFORCEMENT POLICY

C. Evans, Enforcement Officer and Regional Counsel

III. SUMMARY OF THE ISSUES AND DISCUSSION OF THE APPARENT VIOLATIONS

D. Collins, Director  
Division of Fuel Facility Inspection

IV. LICENSEE PRESENTATION

V. BREAK/NRC CAUCUS

VI. NRC FOLLOW UP QUESTIONS

VII. CLOSING REMARKS

W. Travers, Regional Administrator

[REDACTED]

Enclosure 2

[REDACTED]

NOTE: The following information is an updated excerpt from an NRC Information Notice (96-28) issued in 1996.

## NRC INFORMATION NOTICE 96-28

UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
OFFICE OF NUCLEAR MATERIAL SAFETY AND SAFEGUARDS  
WASHINGTON, D.C. 20555

May 1, 1996

### NRC INFORMATION NOTICE 96-28: SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION

#### Addressees

All material and fuel cycle licensees.

#### Purpose

The U.S. Nuclear Regulatory Commission (NRC) is issuing this information notice to provide addressees with guidance relating to development and implementation of corrective actions that should be considered after identification of violation(s) of NRC requirements. It is expected that recipients will review this information for applicability to their facilities and consider actions, as appropriate, to avoid similar problems. However, suggestions contained in this information notice are not new NRC requirements; therefore, no specific action nor written response is required.

#### Background

On June 30, 1995, NRC revised its Enforcement Policy (NUREG-1600)<sup>1</sup> 60 FR 34381, to clarify the enforcement program's focus by, in part, emphasizing the importance of identifying problems before events occur, and of taking prompt, comprehensive corrective action when problems are identified. Consistent with the revised Enforcement Policy, NRC encourages and expects identification and prompt, comprehensive correction of violations.

In many cases, licensees who identify and promptly correct non-recurring Severity Level IV violations, without NRC involvement, will not be subject to formal enforcement action. Such violations will be characterized as "non-cited" violations as provided in Section VI.A of the Enforcement Policy. Minor violations are not subject to formal enforcement action. Nevertheless, the root cause(s) of minor violations must be identified and appropriate corrective action must be taken to prevent recurrence.

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<sup>1</sup>Copies of NUREG-1600 can be obtained by calling the contacts listed at the end of the Information Notice.

If violations of more than a minor concern are identified by the NRC during an inspection, licensees will be subject to a Notice of Violation and may need to provide a written response, as required by 10 CFR 2.201, addressing the causes of the violations and corrective actions taken to prevent recurrence. In some cases, such violations are documented on Form 591 (for materials licensees) which constitutes a notice of violation that requires corrective action but does not require a written response. If a significant violation is involved, a predecisional enforcement conference may be held to discuss those actions.

The quality of a licensee's root cause analysis and plans for corrective actions may affect the NRC's decision regarding both the need to hold a predecisional enforcement conference with the licensee and the level of sanction proposed or imposed.

### Discussion

Comprehensive corrective action is required for all violations. In most cases, NRC does not propose imposition of a civil penalty where the licensee promptly identifies and comprehensively corrects violations. However, a Severity Level III violation will almost always result in a civil penalty if a licensee does not take prompt and comprehensive corrective actions to address the violation.

It is important for licensees, upon identification of a violation, to take the necessary corrective action to address the noncompliant condition and to prevent recurrence of the violation and the occurrence of similar violations. Prompt comprehensive action to improve safety is not only in the public interest, but is also in the interest of licensees and their employees. In addition, it will lessen the likelihood of receiving a civil penalty. Comprehensive corrective action cannot be developed without a full understanding of the root causes of the violation.

Therefore, to assist licensees, the NRC staff has prepared the following guidance, that may be used for developing and implementing corrective action. Corrective action should be appropriately comprehensive to not only prevent recurrence of the violation at issue, but also to prevent occurrence of similar violations. The guidance should help in focusing corrective actions broadly to the general area of concern rather than narrowly to the specific violations. The actions that need to be taken are dependent on the facts and circumstances of the particular case.

The corrective action process should involve the following three steps:

1. Conduct a complete and thorough review of the circumstances that led to the violation.

Typically, such reviews include:

- Interviews with individuals who are either directly or indirectly involved in the violation, including management personnel and those responsible for training or procedure development/guidance. Particular attention should be paid to lines of communication between supervisors and workers.
- Tours and observations of the area where the violation occurred, particularly when those reviewing the incident do not have day-to-day contact with the operation under review. During the tour, individuals should look for items that may have contributed to the violation as well as those items that may result in future violations. Reenactments



(without use of radiation sources, if they were involved in the original incident) may be warranted to better understand what actually occurred.

- Review of programs, procedures, audits, and records that relate directly or indirectly to the violation. The program should be reviewed to ensure that its overall objectives and requirements are clearly stated and implemented. Procedures should be reviewed to determine whether they are complete, logical, understandable, and meet their objectives (i.e., they should ensure compliance with **the current** requirements). Records should be reviewed to determine whether there is sufficient documentation of necessary tasks to provide an auditable record and to determine whether similar violations have occurred previously. Particular attention should be paid to training and qualification records of individuals involved with the violation.

2. Identify the root cause of the violation.

Corrective action is not comprehensive unless it addresses the root cause(s) of the violation. It is essential, therefore, that the root cause(s) of a violation be identified so that appropriate action can be taken to prevent further noncompliance in this area, as well as other potentially affected areas. Violations typically have direct and indirect cause(s). As each cause is identified, ask what other factors could have contributed to the cause. When it is no longer possible to identify other contributing factors, the root causes probably have been identified. For example, the direct cause of a violation may be a failure to follow procedures; the indirect causes may be inadequate training, lack of attention to detail, and inadequate time to carry out an activity. These factors may have been caused by a lack of staff resources that, in turn, are indicative of lack of management support. Each of these factors must be addressed before corrective action is considered to be comprehensive.

3. Take prompt and comprehensive corrective action that will address the immediate concerns and prevent recurrence of the violation.

It is important to take immediate corrective action to address the specific findings of the violation. For example, if the violation was issued because radioactive material was found in an unrestricted area, **immediate** corrective action must be taken to place the material under licensee control in authorized locations. After the immediate safety concerns have been addressed, timely action must be taken to prevent future recurrence of the violation. Corrective action is sufficiently comprehensive when corrective action is broad enough to reasonably prevent recurrence of the specific violation as well as prevent similar violations.

In evaluating the root causes of a violation and developing effective corrective action, consider the following:

1. Has management been informed of the violation(s)?
2. Have the programmatic implications of the cited violation(s) and the potential presence of similar weaknesses in other program areas been considered in formulating corrective actions so that both areas are adequately addressed?

3. Have precursor events been considered and factored into the corrective actions?
4. In the event of loss of radioactive material, should security of radioactive material be enhanced?
5. Has your staff been adequately trained on the applicable requirements?
6. Should personnel be re-tested to determine whether re-training should be emphasized for a given area? Is testing adequate to ensure understanding of requirements and procedures?
7. Has your staff been notified of the violation and of the applicable corrective action?
8. Are audits sufficiently detailed and frequently performed? Should the frequency of periodic audits be increased?
9. Is there a need for retaining an independent technical consultant to audit the area of concern or revise your procedures?
10. Are the procedures consistent with current NRC requirements, should they be clarified, or should new procedures be developed?
11. Is a system in place for keeping abreast of new or modified NRC requirements?
12. Does your staff appreciate the need to consider safety in approaching daily assignments?
13. Are resources adequate to perform, and maintain control over, the licensed activities? Has the radiation safety officer been provided sufficient time and resources to perform his or her oversight duties?
14. Have work hours affected the employees' ability to safely perform the job?
15. Should organizational changes be made (e.g., changing the reporting relationship of the radiation safety officer to provide increased independence)?
16. Are management and the radiation safety officer adequately involved in oversight and implementation of the licensed activities? Do supervisors adequately observe new employees and difficult, unique, or new operations?
17. Has management established a work environment that encourages employees to raise safety and compliance concerns?
18. Has management placed a premium on production over compliance and safety? Does management demonstrate a commitment to compliance and safety?
19. Has management communicated its expectations for safety and compliance?

20. Is there a published discipline policy for safety violations, and are employees aware of it? Is it being followed?

This information notice requires no specific action nor written response. If you have any questions about the information in this notice, please contact one of the technical contacts listed below.

Michael F. Weber, Director  
Division of Fuel Cycle Safety and Safeguards  
Office of Nuclear Material Safety  
and Safeguards

Donald A. Cool, Director  
Division of Industrial and Medical Nuclear Safety  
Office of Nuclear Material Safety  
and Safeguards

Technical contacts: (Updated as of September 30, 2002)

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