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FINAL REPLY:

David A. Lochbaum
Union of Concerned Scientists

TO:

Comm. Nils Diaz

FOR SIGNATURE OF : ** GRN ** CRC NO: 00-0373

DESC:

Example of a 2.206 Petition that Failed to Address the Concerns raised in the Petition (Indian Point 2)

DATE: 06/09/00

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Union of Concerned Scientists
Citizens and Scientists for Environmental Solutions

June 1, 2000

Commissioner Nils Diaz
United States Nuclear Regulatory Commission
Washington, DC 20555-0001

Dear Commissioner Diaz:

During the Commission briefing on the 2.206 petition process held on May 25, 2000, you asked me to provide one example of a Director's Decision that failed to address the concerns raised in the petition. I selected the most recent Director's Decision because it was in response to a petition submitted after Management Directive 8.11 was revised to include purported "enhancements" like the petitioner's pre-PRB contact. Attachment 1 to this letter details the issues raised in our petition and why I feel the staff's response failed to address them.

I am also providing a recent example of the NRC staff rejecting a petition at the PRB stage on what I believe are totally bogus grounds. Attachment 2 to this letter details the issues raised in this petition and why I feel the staff's rejection was unwarranted.

Thank you for your interest in this matter.

Sincerely,

David A. Lochbaum
Nuclear Safety Engineer
Washington Office

cc: Chairman Richard A. Meserve
Commissioner Greta Joy Dicus
Commissioner Edward McGaffigan, Jr.
Commissioner Jeffrey Merrifield

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Attachment 1: Contested Response to Indian Point 2 Petition

On September 15, 1999, UCS submitted a 2.206 petition to the NRC. Our petition raised five (5) issues following the August 31, 1999, event at Indian Point 2 in which an emergency was declared due to complications from a reactor trip. These five issues are presented below along with the NRC staff's response and UCS's reasons for considering the staff's response to be non-responsive.

Issue No. 1, Apparent Violation of Station Battery Design and Licensing Bases: The staff's response to this issue consists of 384 words including dates and numbers. Of that response, 133 words (or approximately 35 percent) dealt exclusively with the repairs and retesting of the depleted station batteries. We never contended that the station batteries could not be repaired and retested. Thus, this sizeable portion of the staff's response is not relevant.

In our petition, we subdivided Issue 1 into four potential problems. The first potential problem dealt with the time to restore power to the safety-related 480-volt electrical bus being longer than the duration assumed in the station blackout coping duration. The staff responded by pointing out that the August 31, 1999, event was not a station blackout event and that the licensee had not invoked its station blackout procedures. (The staff pointed out that the licensee did not even have any procedures for the event that happened on August 31, 1999.) During the Petition Review Board telecon, I clarified that we recognized the event was not a station blackout event, but that the long duration of the bus outage raised questions about whether the 8-hour coping duration would have been satisfied had a station blackout occurred. Given the potential problem statement in our petition and our clarification during the PRB telecon, I fully expected the staff's response to include some examination of the adequacy of the station blackout procedures at Indian Point 2. But the staff's response did not describe any investigation into the adequacy of the licensee's station blackout procedures. Thus, our first potential problem under Issue 1 remains unaddressed.

The second potential problem under Issue 1 dealt with a design and licensing requirement from the Updated Final Safety Analysis Report (UFSAR) for the alternate ac (AAC) source being available to prevent excessive discharge of the station batteries. The staff's response stated that minimum battery voltage (105 volts) was maintained for awhile, but that voltage dropped to as low as 35 volts 9i.e., excessive discharge of the battery did indeed occur). The staff did not mention in any manner the availability of the alternate ac (AAC) source or why it was not used to prevent excessive discharge of the battery.[1] Thus, our second potential problem under Issue 1 remains unaddressed.

The third potential problem under Issue 1 dealt with the failure to prevent 24 DC Battery from excessive discharge. We cited a commitment made by the IP2 licensee in 1980 "...of maintaining all engineered safeguards equipment operational following the loss of a D.C. feed." This letter also stated that "at least two (2) of the four (4) batteries would have to fail before we would lose a single diesel generator or 480 VAC switchgear." The staff responded with the following: "Station Battery 24 supplied its shutdown load for more than 11 hours. For approximately seven and one-half hours of the 11 hours voltage was maintained above 105 volts." Our point was not that 24 DC Battery failed to met its two-hour load carrying requirement. Our point was that the licensee had an obligation to prevent excessive discharge of the battery. In other words, AC power was supposed to have been restored (either via normal or diesel generator or alternate AC means) before the bus voltage dropped below 105 volts. That licensee failed. The staff responded with "the staff does believe the absence of a procedure to recover from the loss of a single 480-volt safety bus did contribute to the inordinate recovery time associated with this event." So, the staff explained why the licensee failed to prevent excessive discharge. But the staff did not 'pull the sting' on the root cause. Was this procedure the only one missing? Does the licensee have procedures in place to handle all required actions specified in the UFSAR? The staff's response is silent on these obvious questions. Thus, our third potential problem under Issue 1 remains only partially addressed.

[1] The staff did state, in its response to Issue No. 5, that "the licensee did not start the gas turbine generators since they are not called for by procedure."

The fourth potential problem under Issue 1 dealt with the loss of engineering safeguards equipment. It is essentially a restatement of second and third potential problems.

Issue No. 2, Apparent Failure to Adequately Correct Circuit Breaker Problems: In our petition, we detailed a long history of breaker problems at Indian Point 2, including the imposition of a $110,000 civil penalty in July 1998. The staff responded by agreeing with our assertions and by pointing out other breaker problems that we had not known about. The staff also mentioned that a $88,000 civil penalty had been imposed on February 25, 2000 (after restart of the plant following the August 31, 1999, emergency and after the February 15, 2000, emergency caused by a steam generator tube rupture.) Given a longer list of breaker problems than we had developed, we cannot accept the staff's optimism that a smaller civil penalty will now get this licensee to do the right thing. After all, this licensee's responses to the prior LERs, inspection report findings, and larger civil penalty for breaker-related problems each contained promises of actions to prevent recurrence. Those promises had been repeatedly unfulfilled. Thus, Issue 2 was not fully addressed.

Issue No. 3, Apparent Unreliability of the EDGs: In our petition, we detailed a long history of emergency diesel generator problems at Indian Point 2. The staff responded by essentially agreeing with our assertions. In addition, the staff pointed out that the August 31, 1999, event "caused the Maintenance Rule (MR) performance criteria for the 480 Vac switchgear system to be exceeded" and that the "PI [performance indicator] for the IP2 EDGs is in the increased regulatory response band." Thus, Issue 3 was addressed. The EDGs at Indian Point 2 ARE less reliable than NRC desires.

Issue No. 4, Potentially Unjustified License Amendment for Undervoltage and Degraded Voltage Relay Surveillance Intervals: In our petition, we stated that the primary cause of the August 31, 1999, event at IP2 was the failure of the licensee to place the tap changer on the station auxiliary transformer in automatic as required by the plant's licensing basis. We expressed the concern that a surveillance interval extension granted by the staff in 1994 may have contributed to the misplaced tap changer remaining undetected. The staff responded by letter dated October 8, 1999, explaining that the surveillance test in question did not, and was not required to, verify the configuration of the tap changer. Thus, Issue 4 was addressed.

Issue No. 5, Apparent Errors and Non-Conservatisms in Individual Plant Examination: In our petition, we detailed eight potential problems between statements in the Indian Point 2 (IPE) and reality as demonstrated by the August 31, 1999, event. In its response, the staff corrected the equipment demand failure probabilities that I had mis-stated in the petition.

The staff also stated, "If the conditions of the tap changer in manual control (and its inability to maintain voltage on the emergency buses), coupled with the EDG 23 output breaker problem, had existed or continues to exist for a long time, these conditions could represent a significant increase in the core damage frequency reported in the IPE." However, the staff concluded, "the August 31 event did not appear to invalidate the IPE."

I know that the Commission has been striving to make regulatory decisions more transparent. The staff response needs to be opaque in this case because I cannot see how "a significant increase in the core damage frequency reported in the IPE" can be reconciled with "the August 31 event did not appear to invalidate the IPE." If a licensee's inability to prevent a series of pre-existing degraded conditions from adding up to a significantly higher chance of core damage, as in fact occurred at Indian Point 2 on August 31, 1999, does not invalidate an IPE, what could possibly invalidate an IPE? Had the licensee's ineptitude grown to the point where the Indian Point 2 core actually melted down on August 31, 1999, would the staff determine that regrettable occurrence not to invalidate the IPE because, after all, the IPE did not report a zero change of core damage? Thus, Issue 5 still remains unaddressed.

Attachment 2: Unwarranted Rejection of Diablo Canyon Petition

On November 24, 1999, UCS petitioned the NRC on behalf of San Luis Obispo Mothers for Peace and the Project on Liberty and the Workplace. The petitioners sought to suspend the operating license of Diablo Canyon Units 1 and 2 until its owner complied with the terms/conditions of a Department of Labor ruling involving the unlawful discrimination against Neil Aiken, a senior reactor operator at the facility. By letter dated December 22, 1999, the NRC staff rejected our petition on the grounds that our "request does not meet the threshold criteria for treating your request as a 2.206 petition in that the issues you raised were previously the subject of NRC staff review and evaluation, for which a resolution has been achieved by an earlier Director's Decision (DD-99-05)."

The earlier Director's Decision was issued in response to a petition submitted November 24, 1998, by the same petitioners. This petition also involved Neil Aiken's situation. Our first petition sought to have the NRC issue an order requiring an independent assessment of the safety culture at Diablo Canyon. That petition was based, in large part, on a letter of support signed by more than three dozen of Mr. Aiken's co-workers. Many of those endorsements expressed sentiments along the lines of Mr. Aiken being right and the plant owner being wrong to punish him for speaking out on safety. The petitioners felt then, and still feel today, that the actions taken against Mr. Aiken -- whether legal or not -- caused a chilling effect at Diablo Canyon because so many of his co-workers felt he was in the right and the company was in the wrong.

The second petition, filed exactly one year later, came as the plant owner was moving to terminate Mr. Aiken. Although the guilty plant and the victim named in the second petition were identical to the guilty plant and victim named in the first petition, the actions requested were distinctly different. We know all too well that the public cannot 're-litigate' an issue in 2.206 petition space, no matter how absurd or unfounded the prior Director's Decision. So, we carefully crafted the second petition to stake out new ground. That new ground was intended to prevent the plant's owner from benefiting from the virtual interminable delays associated with the appeal process for DOL rulings. We asked the NRC to suspend the operating licenses for Units 1 and 2 at Diablo Canyon until Mr. Aiken's DOL case was resolved. If granted, this request would subject both Mr. Aiken and the plant's owner to financial consequences from delaying the proceedings. Otherwise, only Mr. Aiken suffered ill effects from delays.

Instead of even entertaining the merits of our request, the staff proclaimed "no do-overs" and rejected the petition. I was informed of the rejection on Friday, December 17, 1999, by a phone call from the Diablo Canyon project manager. This individual reassured me that despite the rejection of our petition, the NRC staff was monitoring Mr. Aiken's status very closely. I asked the individual about Mr. Aiken's current status. The individual hesitated. I asked if he knew that Mr. Aiken had been terminated on Monday, December 13, 1999. The individual admitted that it was news to him. So much for closely monitoring the situation!