

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION  
OFFICE OF NUCLEAR REACTOR REGULATION

Thomas E. Murley, Director

In the matter of	)	
	)	
TU ELECTRIC COMPANY	)	Docket Nos. 50-445
	)	and 50-446
(Comanche Peak Steam Electric	)	10 CFR § 2.206
Station, Units 1 and 2)	)	

DIRECTOR'S DECISION UNDER 10 CFR 2.206

I. INTRODUCTION

On May 19, 1992, Ms. Sandra Long Dow, Disposable Workers of Comanche Peak Steam Electric Station, and Mr. R. Micky Dow (the Petitioners) filed a request (the Petition) with the Director, Office of Nuclear Reactor Regulation, requesting that the U.S. Nuclear Regulatory Commission (NRC) take action regarding the Comanche Peak Steam Electric Station (CPSES), Units 1 and 2.

Petitioners requested that the Commission order the immediate shutdown of Unit 1 of the Comanche Peak Steam Electric Station and institute a proceeding to modify, suspend, or revoke the license held by the Texas Utilities Electric Company (licensee) for Unit 1. They also requested that the NRC suspend considering whether to extend or modify the construction permit for Unit 2 of the facility until resolving any proceeding regarding the license for Unit 1. Petitioners allege, as a basis for this request, that the licensee has failed to demonstrate the necessary character and capability that are the primary factors to be

considered in granting a license, and has shown a "downward spiral" in violations, reportable incidents, and NRC staff concerns. Petitioners allege that the NRC staff failed to respond to requests for information about several of these incidents. Petitioners also offered, as they have previously, to give the Commission transcripts of 16 reels of audio tapes that contain conversations between the licensee and certain individuals that allegedly indicate duplicity between Region IV and the licensee.

Previously, on February 20, 1992, Petitioners filed a motion for late intervention to reopen the CPSES operating license proceeding (Docket Number 50-445) and the construction permit amendment proceedings (Docket Number 50-446). On April 4, 1992, Petitioners filed a motion seeking to present oral argument before the Commission on their February 20, 1992 motions. On August 12, 1992, the Commission denied these requests. Texas Utilities Electric Company (Comanche Peak Steam Electric Station, Units 1 and 2), CLI-92-12. Additionally, Petitioners' request to reopen the proceedings for the operating license for Units 1 and 2 because of alleged deficiencies in the labeling of pressure valves and limit switches was referred to the staff for consideration as a Petition submitted pursuant to 10 CFR 2.205. That issue will also be addressed herein.

In my letter of June 10, 1992, I acknowledged receipt of the May 19, 1992, Petition and stated that the NRC would take action on Petitioners'

request within a reasonable time.<sup>1</sup> In an Order dated July 28, 1992, the staff extended the construction completion date for CPSES Unit 2 to August 1995. This action constituted a partial denial of the Petition, specifically the request to suspend consideration of extension or modification of the construction permit for Unit 2. In a letter of July 28, 1992, I informed Petitioners of the partial denial. The staff based its decision on 10 CFR 50.55(b), which states that the construction completion date may be extended for a reasonable period of time upon a showing of good cause. In its request dated February 3, 1992, the licensee demonstrated that the delay in construction of Unit 2 was necessary to concentrate resources on the completion of Unit 1. The NRC agreed that a period of three years is necessary for construction and testing, plus a period for unanticipated delays.

I have evaluated the Petition and have determined, for the reasons set forth below, that no adequate basis exists to take action against the licensee for CPSES, Units 1 and 2. Accordingly, the Petition is denied.

## II. DISCUSSION

Petitioners support their request with several incidents that occurred since November 1991. Petitioners allege that the following matters demonstrate the inadequate character and capability of the licensee to hold licenses:

---

<sup>1</sup> Because Petitioners assert wrongdoing by the NRC Region IV staff, the Petition was also referred to the Office of the Inspector General on June 10, 1992, for such action as it may deem appropriate.

1. A leak in a pressure tank caused 100 mile-per-hour winds in the access tunnel between Units 1 and 2, which resulted in a female employee being blown into a radiation area.
2. Resin spilled into the core because of personnel error and misaligned valves.
3. A "hot" valve in Unit 1 was cut in two, causing a radiation release and exposure to several individuals.
4. Sample lists of NRC documents available in the public document room were submitted with the Petition. The lists contain 26 documented "reportable incidents", numerous areas showing direct concern by Region IV, and at least six reactor trips.
5. The NRC proposed fines for violations by the licensee totaling close to \$100,000 for 1992.
6. An additional reactor trip occurred, after which the spent fuel pool for Unit 1 was without cooling water for approximately 20 hours causing an abnormal rise in temperature. Petitioners submit this incident as evidence of a continuing problem involving the use of improperly trained control room personnel.
7. The Petitioners submitted, as an attachment to the petition, a photograph which they assert shows Comanche Peak control room staff to be asleep, which they state is known to be the "common manner" for control room personnel.



8. Petitioners allege that the licensee has failed to label and mislabeled pressure valves and limit switches on both units.

Petitioners submitted several written statements from Texas Utilities employees and local citizens expressing concern about safety of the plant in support of the Petition. The statements of Ron Jones and Dobie Hatley allege specific safety concerns, which the NRC previously evaluated when it considered the February 20, 1992, motion of Petitioners to reopen the record. The Commission found that these statements did not raise substantial safety concerns. Texas Utilities Electric Company (Comanche Peak Steam Electric Station, Units 1 and 2), CLI-92-12, (August 12, 1992). The remaining statements express a general concern for the safety of the plant or the treatment of employees but present no facts or evidence to support Petitioners' request. Sixteen signed statements express support for Petitioners' Motion to Reopen the Record but do not address issues raised by the Petition herein. Five affidavits or letters, addressed to whom it may concern, express general concern about the operation of Comanche Peak and about the presence of waste disposal sites containing toxic and radiation contaminated materials. The NRC previously determined that waste disposal sites at Comanche Peak do not raise a substantial safety concern and denied a request for enforcement action under 10 CFR 2.206. Texas Utilities Electric Co. (Comanche Peak Steam Electric Station, Units 1 and 2), DD-91-04, 34 NRC 2011 (1991).

Each of the issues raised in the Petition is summarized and evaluated below.

A. Employee injured in airlock

Petitioners claim that a leak in a pressure tank caused 100 mph winds in the access tunnel between Units 1 and 2 and resulted in a woman employee being injured when she was blown into a radiation area so hard that she bent welded piping.

In its review of this allegation, the NRC staff found that the licensee had informed the resident inspector of the incident and provided him with copies of a written report, Operations Notification Evaluation Form FX-91-1102. The incident occurred on October 6, 1991, in the personnel airlock between Unit 1 containment and the safeguards building. The airlock consists of two air-tight doors which are only allowed to be opened individually during operation to preserve containment integrity. At the time of the incident, Unit 1 was shut down in preparation for a refueling outage. Under these conditions, both doors of the airlock are allowed to be open since the containment atmosphere has very low radiation levels. The operators were in the process of opening the airlock to provide access to containment. The outer door was open and the differential pressure across the inner door was measured to be 0.2 psil. A negative pressure in containment is desirable for containment integrity. The operators did not recognize this as a high pressure differential that could be dangerous. The operators also did not close the containment purge supply and exhaust dampers prior to defeating the door interlocks, contrary to operating procedures. When the inner door was unlatched, the force swept the employee into containment. The actual speed of the wind is not known. The employee hit a 3-inch insulated pipe.

with her forearm and was then pulled around a corner where she struck more piping. There was no report of an overexposure of radiation to the employee. The employee was examined on site and returned to work when no injuries were found. Examinations and x-rays taken later by the employee's doctor revealed no broken bones or deformities.

The licensee evaluated the incident to determine root causes. The licensee took corrective action by informing all employees of the event, emphasizing the failure to close the purge dampers before opening the doors, and the failure to recognize the danger of opening a door against a differential pressure. The licensee added this incident to the training program and revised the training to cover the potential danger of a differential pressure. The licensee also changed the procedure for opening airlock doors to address these concerns.

Petitioners are concerned that Region IV treated this incident as unreportable. The NRC requires employee injuries to be reported only when a radioactively contaminated person is transported to an offsite medical facility for treatment. 10 CFR § 50.72. The employee in this incident was treated at the site. The event did not result in damage to any safety equipment, did not change plant conditions, and did not affect the safety of the plant. Because it was not in any of the categories mentioned, the event is not required by regulations to be reported to the NRC. Moreover, the licensee informed the resident inspector of the event and provided him with copies of the internal report containing several written statements by eye witnesses, a thorough review of the root causes, and copies of documents which implemented the corrective actions.

Although the event was not reportable, the NRC was informed of the event by the licensee at the time of occurrence. The NRC staff followed up to ensure that the licensee took appropriate actions to correct deficiencies in its training and procedures. Petitioners provide no new information and no basis to conclude that the licensee is unable or unwilling to operate CPSES in a safe manner. Accordingly, I conclude that the incident does not present a substantial public health or safety concern that justifies the requested action.

B. Resin in the core

Petitioners contend that resin was spilled into the core as a result of personnel error. In its review of the incident, the NRC staff found that on November 5, 1991, some fine particles of resin and three resin beads bypassed the resin traps on a demineralizer filter for the spent fuel pool. The demineralizer is part of the spent fuel pool cooling and purification system which has two redundant trains, each consisting of two cooling pumps, two coolers, two purification pumps, two demineralizers, and several filters and skimmers. At the time of the incident, both trains of the purification system were running. When resin particles were discovered in a routine sample taken at the outlet of demineralizer 2, the licensee shut down that train of the purification system and isolated it to avoid releasing any more resin into the spent fuel pool, the refueling cavity, and ultimately into the reactor coolant system. Train 1 continued to purify the refueling cavity. The cause of the resin release was a failed resin trap and not operator error as



alleged by Petitioners. Shortly after the event, the licensee informed the resident inspector and gave him a copy of the written report of this incident, Operations Notification Evaluation Form FX-91-1455.

As a short term corrective action to maximize cleanup of the spent fuel pool and reactor coolant system, the operators increased the amount of reactor coolant sent through the chemical and volume control system and placed three temporary filters in service.

Westinghouse Electric Corporation evaluated the effect of resin in the reactor coolant system in a letter to the licensee dated November 19, 1991. Westinghouse stated that the resin products are not considered to be corrosive to primary system piping and that normal use of the chemical and volume control system is adequate for control of system cleanup. Based on the small quantity of resin released, Westinghouse concluded that the material could have had no adverse consequences on fuel assembly integrity or operations. Upon review of the letter, the NRC staff came to the same conclusion.

At the time of the incident, the NRC staff determined that the licensee took appropriate corrective actions and that the incident was not detrimental to the safety of the plant. Petitioners provide no facts to contradict these findings. Therefore, I conclude that Petitioners have not raised a substantial health or safety concern.

C. "Hot" valve cut in two

Petitioners claim that a "hot" valve in Unit 1 was cut open, causing a radiation release and exposure to several individuals.

On March 17, 1992, a work request was written to have work performed on valve 2CS-7048A, a valve located in Unit 2. However, personnel disassembled and reassembled valve 1CS-7048A, in Unit 1, a valve similar to the Unit 2 valve which was the subject of the work request. Upon reviewing the work logs after maintenance was completed, a radiation protection technician thought the contamination levels appeared excessively high for what should have been a Unit 2 valve. The contamination levels were consistent with the normal levels in that area of Unit 1. Before the maintenance work was performed, a radiation protection technician had established a radiological barrier around the Unit 1 valve. Because of the barrier, personnel working on the valve took appropriate precautions and did not receive an overexposure of radiation. After discovering the mistake, personnel performed the required maintenance on the Unit 2 valve.

On August 23, 1992, the NRC issued a Severity Level IV violation for failure to follow authorized work instructions, citing both this incident and a similar incident that occurred on February 23, 1992 in Unit 1. The NRC documented the incident in Inspection Report Nos. 50-445/92-08 and 50-446/92-08, April 23, 1992.

The NRC staff found the licensee's corrective action to be suitable. After the event, Unit 2 management suspended all activities to disassemble or reassemble components within the operations controlled

area for permanent plant equipment in Unit 2 until the licensee reviewed the incident. After reviewing the incident, the licensee took short-term actions requiring double verification of component identification before beginning work. A Unit 1 task team had been formed previously in response to the February 23, 1992, incident. The team was exploring a number of corrective actions regarding procedural compliance to be implemented in Unit 1. The staff found no reason to conclude that the licensee could not or would not operate CPSES safely. Petitioners provide no facts to conclude otherwise. Therefore, I conclude that the event does not present a substantial health or safety concern.

D. Reportable incidents and reactor trips

Petitioners submitted a sample of weekly reports which they claim contain reports of 26 reportable incidents and at least 6 reactor trips, which Petitioners find excessive. The weekly reports cover the period from January 19 to April 18, 1992, and consist of the Local Public Document Room list of correspondence between the NRC and TU Electric, such as inspection reports, licensee event reports (LERs), periodic operating reports, and general correspondence.

Upon reviewing these documents and NRC records, the NRC staff found that the licensee submitted 10 LERs during this period. These 10 LERs are written reports of nonemergency incidents that occurred at CPSES. NRC regulations require that licensees report shutdowns, deviations from technical specifications, and events that result in degradation of safety barriers or place the plant in a condition outside of its design basis. The licensee is also required to include in the report an assessment of

the safety consequences and a description of all corrective actions. 10 CFR § 50.73. This reporting process ensures that the plant is in a safe condition after the event and that steps are being taken to avoid repeating the problem.

The 16 other documents that Petitioners cite were updates or revisions to LERs of events that occurred several months (or years) earlier, and 10 CFR Part 21 reports of defects in components that could affect performance.

The monthly operating reports for the period between January 19 and April 18, 1992 show that no reactor trips occurred during this period. The licensee reduced power four times to make repairs but did not shut down the reactor. During the 19 months between January 1991 and July 1992, Unit 1 was shut down 11 times. The licensee manually shut down the reactor four times for maintenance; once the unit was shut down for a refueling outage; twice the reactor automatically tripped because equipment failed; and four trips were caused by operator error. Therefore, nearly half of the shutdowns were initiated by the licensee to improve plant performance or comply with regulations. The two automatic reactor trips that resulted from equipment failure were the result of problems with the main turbine and did not affect the nuclear or safety-related portion of the plant. In each case of operator error-related trip, the licensee evaluated the causes of the event and implemented appropriate corrective actions. Each event and corrective action was reviewed by the NRC resident inspectors and was found to have no safety significance. In each reactor trip, all systems functioned as expected



to bring the plant to a safe shutdown condition.

The 10 reportable incidents which occurred during the time period specified by Petitioners did not place the plant in an unsafe condition and the reactor did not trip during this period. The six automatic trips which occurred between January 1991 and July 1992 did not affect the safety of the plant. Petitioners have not provided any information to contradict this conclusion. The NRC was informed of each of the events at the time of occurrence and determined that the licensee took appropriate corrective actions. Accordingly, I conclude that Petitioners have not raised a substantial safety concern.

E. Fines of \$100,000

Petitioners claim that civil penalties of approximately \$100,000 imposed for violations by the licensee during 1992 demonstrate that the licensee cannot safely operate the plant.

In evaluating violations to determine the appropriate enforcement action, the NRC staff assesses the safety and regulatory significance of the violations, the licensee's corrective actions to prevent future occurrences, and other relevant factors. During its review, the NRC considers whether a violation warrants shutting down a plant. In neither of these cases did the NRC staff conclude that the licensee was unable or unwilling to safely operate the facility, or that shutdown of the plant was warranted.

On December 4, 1991, the NRC proposed imposition of a civil penalty of \$25,000 on the licensee. Texas Utilities Electric Company (Comanche Peak Steam Electric Station, Units 1 and 2), EA 91-189 (December 27,

1991). This incident is documented in NRC Inspection Report Nos. 50-445/91-62 and 50-446/91-62, December 27, 1992. The violation involved a misalignment of the residual heat removal system which would have prevented the system from actuating automatically in an emergency. The system was misaligned for 53 hours while the plant was in hot standby mode. No events occurred during this time that would have required the use of the residual heat removal system, and if this had been necessary, the system could have been properly aligned by opening two crosstie valves. Therefore, while this was a violation of the operating license, the misalignment did not pose a serious safety concern. The NRC staff concluded that the licensee identified the misalignment, promptly corrected the lineup, and took appropriate actions to avoid recurrence and assure proper control of plant configurations.

In July 1992, the NRC proposed imposition of a civil penalty of \$125,000 on the licensee. Texas Utilities Electric Company (Comanche Peak Steam Electric Station, Units 1 and 2), EA-92-107 (July 23, 1992). The violation resulted from a loss of cooling to the spent fuel pool. The plant was never in an unsafe condition. This event is discussed in detail below in Section II.F.

The NRC staff reviewed the licensee's corrective actions for both of these violations and concluded that the licensee's management adequately implemented its commitments and demonstrated the proper concern for safety to operate CPSES. Petitioners present no new information and no basis to change these conclusions. Therefore, I find that Petitioner's contention is without merit and does not present a substantial health or

safety concern.

F. Loss of cooling to spent fuel pool

Petitioners claim that the spent fuel pool was without cooling for 20 hours, resulting in an abnormal rise in temperature which would have caused a meltdown if not detected by the resident inspector. Both the licensee and the NRC evaluated this incident in great detail. The NRC proposed imposition of a civil penalty of \$125,000. Texas Utilities Electric Company (Comanche Peak Steam Electric Station, Units 1 and 2), EA-92-107 (July 23, 1992). This incident is documented in NRC Inspection Report Nos. 50-445/92-20 and 50-446/92-20, June 9, 1992.

The spent fuel pool is a large pool of water located outside the containment. Fuel bundles that are depleted of most of their uranium are stored in the pool after being removed from the core. The fuel emits a small amount of decay heat (less than 0.001 percent of the heat generated during operation) into the water of the spent fuel pool. The water is cooled by passing through heat exchangers that are cooled by the component cooling water system. At the time of this event, the pool contained only 64 fuel assemblies. The pool has a capacity of 554 fuel assemblies and therefore, the heat in the pool was only a fraction of the design heat load.

On May 12, 1992, the spent fuel pool was without cooling for 17 hours because the component cooling water system was misaligned. This allowed the temperature to rise 5 degrees from 80 to 85°F. The maximum fuel pool temperature allowed in the Final Safety Analysis Report is 152°F. Therefore, the pool was never in danger of overheating. Since

the spent fuel pool water is part of a system completely separate from the reactor coolant system, the fuel in the core was never in danger of a meltdown. The resident inspector discovered the problem upon finding a discrepancy in the alignment of valves on the control board, not by noticing a temperature rise as alleged by Petitioners. If the alignment discrepancy had not been discovered, the operators would have become aware of the problem when the temperature reached 139°F by an alarm in the control room.

Upon learning of the problem, the operators corrected it by aligning the Unit 2 cooling water to the heat exchanger. This action was a violation of the Unit 1 operating license since the Unit 2 cooling system was not under full control of the operations department and was not incorporated into the licensing basis for Unit 1.

The NRC assessed a civil penalty of \$125,000 for this violation, primarily because the event demonstrated that managers were not exercising proper control of licensed actions, not because of the safety significance of the event.

Petitioners also claim that the incident was caused by using undertrained operators and that this has been a continuing problem of concern to the NRC as evidenced by an NRC letter of December 15, 1989. This letter was a request for additional information about the operating experience of the control room staff. A request for additional information is the standard means of obtaining information needed for the NRC to complete reviews and does not imply that the NRC has a safety concern or that the licensee has withheld information. The licensee's



response of December 28, 1989, demonstrated that the licensee had satisfied all requirements for training and experience.

In reviewing this event, the NRC identified minor training deficiencies related to operator knowledge of design modifications and procedural changes. NRC Inspection Report Nos. 50-445/92-20 and 50-446/92-20, June 9, 1992. The licensee took corrective actions that included developing more effective methods of informing operators of design changes, and providing operators with a list of systems that could be cross-tied.

Petitioners also refer to a reactor trip that occurred 4 days before the loss of cooling to the spent fuel pool and which Petitioners allege was caused by undertrained personnel. This trip was not related to the loss of cooling event as implied by Petitioners. The trip on May 8, 1992, was caused by an inadvertent actuation of the reactor protection system when technicians opened an incorrect power supply breaker while calibrating the power monitor module. LER 92-009, June 4, 1992; NRC Inspection Report Nos. 50-445/92-14 and 50-446/92-14, July 1, 1992. The licensee determined that the root cause was using personnel who were inexperienced in this type of calibration. To correct this problem, the licensee now requires that an experienced technician supervise all sensitive tasks being performed for the first time. This event generated no safety consequences since all systems responded as expected.

The July 23, 1992, enforcement action prompted the licensee to evaluate the loss of cooling to the spent fuel pool thoroughly. The

licensee and the NRC found no substantial health or safety concern. Petitioners have presented no facts or basis to reach a different conclusion.

G. Photo of sleeping operators

Petitioners submitted a copy of a photograph allegedly showing a member of the CPSES control room staff asleep. Petitioners state that the photograph is the subject of in-plant humor, since sleeping is known to be the "common manner" for control room personnel. It cannot be ascertained from this poor quality copy either whether the person is sleeping or whether the room shown is in fact the Comanche Peak control room.

The NRC considers inattentiveness by control room operators a very serious offense. The NRC requires control room operators to be fully attentive at the controls to monitor plant safety status and to take corrective action if abnormal circumstances arise. Random control room observations by the resident inspectors allow the NRC to check the adequacy of the licensee's programs for enforcing this requirement. The senior resident inspector at CPSES confirmed that the four resident inspectors normally make control room observations several times during normal working hours and several times a month during night and weekend hours. The residents have never found an operator asleep or inattentive in the control room at CPSES.

I find that Petitioners have failed to demonstrate any merit to their contention and have not substantiated a health or safety concern.

H. Labeling deficiencies

Petitioners allege that an employee of CPSES testified that the licensee failed to label components and mislabeled pressure valves and limit switches on both units.

While conducting an inspection in October 1989, the NRC found minor labeling deficiencies. NRC Inspection Report Nos. 50-445/89-200 and 50-446/89-200, February 14, 1990. The inspectors found a number of valves without identification labels, unofficial hand-written tags used to label rooms, and small metal label tags on some components which were difficult to read. The inspectors believed that this could cause operator errors. The licensee had identified the missing labels earlier and was in the process of installing temporary tags. The licensee had initiated a program to improve labeling in 1988 but had delayed implementation. This inspection prompted the licensee to implement the program sooner than planned. The licensee also audited the labeling program and revised administrative procedures to give guidance to personnel on performing independent verification of labeling.

The licensee labeled each of the rooms in Unit 1, and equipment containing both Unit 1 and Unit 2 components, before the licensing of Unit 1. The licensee scheduled to complete the upgrade program during the first refueling outage in December 1991. The NRC inspected the labels four more times and found that the program was on schedule and was being implemented effectively. The NRC documented its findings in

Inspection Report Nos. 50-445/90-20 and 50-446/90-20, July 23, 1990; 50-445/91-32 and 50-446/91-32, August 22, 1991; 50-445/91-41 and 50-446/91-41, October 9, 1991; and 50-445/91-70 and 50-446/91-70, February 12, 1992. During the last inspection, documented in Report Nos. 50-445/91-70 and 50-446/91-70, the staff found that the licensee had completed 95 percent of the label upgrade in Unit 1 with the remaining labels to be handled by the ongoing label maintenance program.

The NRC considers this to be a closed item because the licensee's labeling program exceeds NRC requirements. The components and systems in Unit 1 have been labeled with clear and informative labels which assist the plant operators and maintenance personnel to accurately identify equipment. On March 24, 1992, William D. Johnson, senior Resident Inspector at Comanche Peak Unit 1, submitted an affidavit in support of the staff's response to the Petitioners' February 21, 1992, motion to reopen the record. The affidavit summarizes the NRC staff's evaluation of and conclusions about the effectiveness of labeling in the plant.

Therefore, I conclude that the Petitioners have presented no basis to change the NRC staff's conclusion that the licensee's labeling program meets NRC requirements. Petitioners have failed to raise a substantial safety concern.

### III. CONCLUSIONS

The NRC staff has reviewed the allegations in the Petition that the licensee does not demonstrate the appropriate character or capability to operate a nuclear plant. The incidents described in the Petition, as

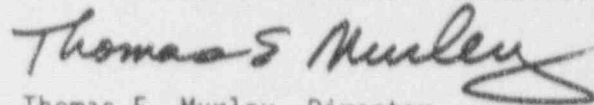


examples of the licensee's inability to operate the plant, are either events which had been evaluated and resolved by the NRC staff or are unfounded accusations with no technical merit, and provide no basis for the requested action. The staff assessed the inspections, enforcement actions, NRC documents, and evaluations conducted by both the licensee and the staff, related to Petitioners' concerns. The staff evaluated the 10 exhibits attached to the Petition. Most of these documents are NRC inspection reports or letters and therefore do not present any new information. The remaining exhibits consist of statements written by 10 employees or members of the public which either do not address safety issues or discuss events that do not relate to the issues of this petition. Petitioners have presented neither any information nor any reason to question the continued safe operation of CPSES.

The institution of proceedings in response to a request in accordance with 10 CFR 2.206 is appropriate only when substantial health and safety issues have been raised. See Consolidated Edison Co. of New York (Indian Point, Units 1, 2, and 3), CLI-75-8, 2 NRC 173, 176 (1975) and Washington Public Power Supply System (WPPSS Nuclear Project No. 2), DD-84-7, 19 NRC 899, 923 (1984). I have applied this standard to determine if any action is warranted in response to the Petition. For the reasons discussed above, I find no basis for taking any action in response to the Petition as no substantial health or safety issues have been raised by the Petition. Accordingly, the NRC is taking no action pursuant to 10 CFR 2.206 in this matter.

A copy of this Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR 2.206(c).

FOR THE NUCLEAR REGULATORY COMMISSION

A handwritten signature in dark ink, appearing to read "Thomas E. Murley", with a stylized flourish at the end.

Thomas E. Murley, Director  
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland  
this 19th day of November 1992