REQUEST REPLY BY 3/19/97

COMMISSIONER

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555

COMNJD-97-001

March 5, 1997

MEMORANDUM TO: Chairman Jackson
Commissioner Rogers
Commissioner Dicus
Commissioner McGaffigan

FROM: Commissioner Diaz

SUBJECT: CLARITY OF PUBLIC COMMUNICATIONS

During my brief tenure as a Nuclear Regulatory Commission (NRC) Commissioner, two facts have been articulated repeatedly and fully supported by the Commission: we have an excellent staff and we have an obligation to clearly inform the public on regulatory issues, actions, and activities. The clarity, transparency, and objectivity of communications are indispensable to earn public "respect for and confidence in the NRC". [1] The Commission and the staff have consistently recognized the importance of accurate and objective communications, without speculative, inflammatory, or vague messages that find their way to the public domain. Thus, we seek to make full and complete information on our activities available to the public, and we do our job best when we accurately explain in plain language the safety significance of the information. Our public messages should not engender fear where no danger or hazards exist; they should clearly communicate the issue and action to be taken.

However, I keep reviewing NRC letters, documents, reports, and press releases which by their very nature do not serve the people of this country. Many subjective and confusing statements have become our tools of communication. I am troubled by the use of phrases like "the worst nuclear plant in this region" and a full spectrum of "weak," "insensitive," "below expectations," "questionable," or even "no danger...." As a specific example, in a story published by the Chicago Sun Times (2/25/97) on the Zion control rod movement incident at about zero power level (2/21/97) an NRC spokesman is reported to have said :

> The main reason restart procedures are carefully supervised is that if the graphite control rods, which slow the nuclear chain reaction, are withdrawn too quickly or unevenly, "a hot spot in the reactor core" could develop that might damage some fuel rods.

This statement is inaccurate and totally inappropriate. There is no significant safety issue in this incident. This is a serious procedural error that probably involves lack of conformance by the operating crew with a plant specific requirement on core and plant configuration. It is not

[1]From the draft Strategic Plan, December 1996, page 2, "Our Vision"

possible for the core to develop "hot spots that might damage some fuel rods" at this power level or even at much higher power levels. In fact, "hot spots" per se are only a concern near full power; certainly not existent at any rod configuration when subcritical at less than 1% full power.

The press article is then closed by a phrase attributed to the NRC's spokesman:

> That could allow nuclear fuel to leak into the cooling water circulating through the core and expose plant workers and equipment to excessive radiation levels

The above sentence is speculative and alarming. It does a great disservice to the people in the vicinity of the plant who could easily conclude that they were in danger. In contrast, the PNO-III-97-010 (copy attached), which the general public may not see, used language that is factual and correct. Public communications is different and often more crucial than public disclosure and it requires special expertise, attention, care, and finally, accountability.

I strongly recommend that immediate steps be taken to assure we provide correct and clear information to the public, especially in cases of incidents that could generate anxiety or fear. Steps should be taken to ensure full coordination between the Office of Public Affairs spokesperson or any NRC person communicating externally and the appropriate technical staff. Likewise, the technical staff, whether in headquarters or in the regions, should implement procedures whereby sound and complete technical guidance is provided to the NRC spokesperson. This action will bring our best asset - the staff - to bear and solve one of NRC's critical areas - public communications. Accountability for public communications must be continuous and quality assured.

In summary, we must improve our performance in this area of public communications, even if resources, training, and management directives need to be redefined or updated. It is imperative that we employ coordinated NRC efforts dedicated to our obligation to inform the public clearly. The public deserves the best joint technical and public relations efforts of the NRC; anything less is not adequate.

I would appreciate your review and any comments you may have on this matter by COB Wednesday, March 19, 1997.

SEC. please track

cc: SEC.
EDO
OPA

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-97-010

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region III staff (Lisle, Illinois) on this date.

Facility	Licensee Emergency Classification
Commonwealth Edison Co.	Notification of Unusual Event
Zion 1	Alert
Zion, Illinois	Site Area Emergency
Dockets: 50-295	General Emergency
	X Not Applicable

Subject: AIT TO REVIEW IMPROPER CONTROL ROD MOVEMENT DURING REACTOR SHUTDOWN

On February 21, 1997, the Unit 1 reactor was at low power (about 7 percent), approaching shutdown because a diesel-driven containment spray pump was found to be inoperable during a routine surveillance test on February 19. The Technical Specifications required the plant be shut down by 2:20 p.m. if the pump was not restored.

At about 2 p.m. a reactor operator was inserting control rods to take the reactor to a very low power level, though still critical. He inserted two groups of control rods continuously for a total of about 200 steps which resulted in reducing power well below the intended power level. Normally, control rods would be inserted incrementally in a series of movements to reach the intended power level.

The control rod group insertion took the reactor subcritical (i.e. shut down). The reactor operator realized that he had moved the rods further than he should have. Without clear direction from shift management, the operator withdrew one of the rod groups approximately 80 steps, leaving the reactor in a subcritical condition.

The actual safety significance of the error was minimal. The operator's actions, however, are of concern because the act of adding a significant amount of positive reactivity with the plant in hot shutdown was non-conservative decision making. Additionally, the operator's failure to clearly communicate plant conditions and the failure of shift management to provide proper oversight during this phase of the shutdown indicated a breakdown of command and control.

As a result of this incident, licensee management plans to conduct training for the control room operating staff. The unit will remain shut down in a maintenance outage which the licensee had previously planned to begin in early May. The licensee is investigating the incident further and, based on the results of this investigation, licensee management will determine what additional actions are required.

An NRC Augmented Inspection Team (AIT) will be sent to the site to review the circumstances surrounding the control rod movement incident and the licensee's response to it. The team will be led by a Region III (Chicago) branch chief and include personnel from the regional office and the Headquarters staff.

Region III will also issue a Confirmatory Action Letter to the licensee documenting the licensee's plans to evaluate the incident and to perform appropriate training of licensed operators and other corrective actions. There has been news media interest in the incident. Region III will issue a news release on the formation of the AIT.

The State of Illinois will be notified. The information in this Preliminary Notification has been reviewed with licensee management. Region III was notified of this incident at 11:00 a.m. on February 22, 1997 by the Senior Resident Inspector. This information is current as of 3 p.m. on February 24, 1997.

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