

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-269, 50-270, 50-287

License Nos: DPR-38, DPR-47, DPR-55

Report Nos: 50-269/98-15, 50-270/98-15, 50-287/98-15

Licensee: Duke Energy Corporation

Facility: Oconee Nuclear Station, Units 1, 2, and 3

Location: 7812B Rochester Highway
Seneca, SC 29672

Dates: November 2-6, November 16-20, and December 11, 1998

Inspectors: R. Schin, Senior Reactor Inspector
M. King, Resident Inspector Trainee
G. McCoy, Resident Inspector Trainee

Approved by: K. Landis, Chief
Engineering Branch
Division of Reactor Safety

Enclosure 2

9901200368 981223
PDR ADOCK 05000269
G PDR

EXECUTIVE SUMMARY

Oconee Nuclear Station, Units 1, 2, and 3
NRC Inspection Report 50-269/98-15, 50-270/98-15, and 50-287/98-15

This special inspection included follow-up on open items regarding potential design basis issues with the emergency feedwater system and failure to update the Updated Final Safety Analysis Report regarding the emergency feedwater system. The report covers two one-week periods and one additional day of inspection by one region-based inspector. [Applicable template codes and the assessment for items inspected are provided below.]

Operations

- An apparent violation (EEI 50-269,270,287/98-15-02, Inadequate 10 CFR 50.59 Safety Evaluations) was identified for three examples of the failure to perform or inadequate safety evaluations for changes to emergency operating procedures related to providing alternate emergency power to a high pressure injection pump. (Section E8.1; [EEI: 1C, 4B, 4C - Poor])
- An apparent violation (EEI 50-269,270,287/98-15-03, Emergency Procedure Not Adequate to Mitigate Secondary Pipe Break Events) was identified for an inadequate procedure for connecting alternate emergency power to a high pressure injection pump. (Section E8.1; [EEI: 1C - Poor])

Engineering

- A violation (VIO 50-269,270,287/98-15-01, Failure to Update the UFSAR) was identified. This violation involved failures to update the UFSAR sections describing the emergency feedwater system. (Section E8.1; [VIO: 4A, 4C - Poor])
- The licensee's 1998 UFSAR Review Project lacked the necessary thoroughness to identify the above UFSAR update issues. (Section E8.1; [Weakness: 4A, 4C - Poor])

Report Details

I. Engineering

E8 Miscellaneous Engineering Issues

E8.1 (Open) IFI 269,270,287/98-08-05, EFW Potential Design Basis Issues
(Closed) URI 50-269,270,287/98-09-03, Inaccurate EFW System Information in the
UFSAR

a. Inspection Scope (92903, 37550)

Inspector Followup Item (IFI) 269,270,287/98-08-05 remained open for further NRC review of the following emergency feedwater (EFW) potential design vulnerabilities: 1) a single active failure in the open position of valve C-187 coincident with a main feedwater line break causing a loss of EFW; 2) a main feedwater or auxiliary steam line break in the turbine building causing consequential failures of the EFW system and all three trains of safety-related 4160 volt electrical switchgear; 3) the reliance on operator action to throttle EFW flow within three minutes while using non-safety related equipment and while the EFW pumps operate with insufficient NPSH; 4) poor operator access to the handwheel of Unit 3 EFW flow control valve FDW-316; and 5) the licensee's basis for determining that the turbine-driven EFW pumps were operable on September 2, 1998. During this inspection, the inspectors followed up on concern number 2 listed above.

Unresolved Item (URI) 269,270,287/98-09-03 remained open for further NRC review of inspector-identified inaccurate statements in the Updated Final Safety Analysis Report (UFSAR) regarding the EFW system design. The inspectors followed up on this URI.

b. Observations and Findings

Further NRC review of a main feedwater or auxiliary steam line break in the turbine building causing consequential failures of the EFW system and all three trains of safety-related 4160 volt electrical switchgear determined that these events were an approved exception to the EFW system being able to function during a main feedwater or main steam line break. These events and the licensee's mitigation strategy had been described by the licensee in MDS Report No. OS-73.2, Analysis of Effects Resulting from Postulated Piping Breaks Outside Containment for Oconee Nuclear Station Units 1, 2, and 3; dated April 25, 1973, and had been approved by the NRC. MDS Report OS-73.2 was incorporated by reference in the licensee's UFSAR Section 3.6, Protection Against Dynamic Effects Associated with the Postulated Rupture of Piping. The occurrence of these events was judged to be very unlikely and the licensee had a mitigation strategy for the events. That mitigation strategy relied upon starting a high pressure injection (HPI) pump, with power from the station auxiliary service water (ASW) switchgear, within 35 minutes. MDS Report OS-73.2 stated: "One HPI pump which began operation within 35 minutes after the accident can prevent the core from uncovering without the aid of secondary cooling. With start of the HPI pump at 35 minutes, the core will nearly be uncovered at 99 minutes. At this time, the cooling capacity of the HPI is more than adequate to handle the decay heat removal; the makeup rate will exceed the boil-off rate

and coolant level will begin rising." Supplement 1 to MDS Report OS-73.2, dated June 22, 1973, additionally stated that the actions to manually restore power to the HPI pump could easily be accomplished within a 30 minute time period. The mitigation strategy also relied on manually depressurizing a steam generator, then starting the station auxiliary service water pump and using it to pump lake water into the steam generator to cool down the reactor to a cold shutdown condition.

The inspector noted an inaccurate statement in UFSAR Section 10.4.7, Emergency Feedwater. The statement that the EFW system can "perform its safety-related function in the event of a single failure coincident with a secondary pipe break and the loss of normal station auxiliary AC power" was inaccurate. The statement was inaccurate because there were certain approved exceptions to that design criteria, and those exceptions were not stated in the UFSAR. Specifically, the EFW system was not designed to perform its safety-related function in the event of certain secondary pipe breaks (of main feedwater or 300 psig auxiliary steam) in the turbine building that would disable the three trains of safety-related switchgear and the EFW system. These exceptions were described in MDS Report No. OS-73.2, Analysis of Effects Resulting from Postulated Piping Breaks Outside Containment for Oconee Nuclear Station Units 1, 2, and 3, dated April 25, 1973. The inspector concluded that the licensee had failed to update the UFSAR to include the results of that analysis. The inspector noted that this UFSAR inaccuracy had not been identified by the licensee's 1998 UFSAR Review Project. This failure to update the UFSAR as required by 10 CFR 50.71(e) is identified as the first example of VIO 50-269,270,287/98-15-01, Failure to Update the UFSAR.

The inspector noted another inaccuracy in UFSAR Section 10.4.7. The statement that "once started, the EFW pumps will continue to run until manually stopped by the operators" was inaccurate because the turbine-driven EFW pump would be stopped automatically on a low once-through steam generator (OTSG) pressure of 500 psig. The inspector concluded that the UFSAR had not been appropriately updated following modification ON-2873, Main Steam Line Break Modification, which had been installed on units 1, 2, and 3 in 1995, 1996, and 1997 respectively. This UFSAR inaccuracy had also not been identified by the licensee's 1998 UFSAR Review Project. This failure to update the UFSAR as required by 10 CFR 50.71(e) is identified as the second example of VIO 50-269,270,287/98-15-01, Failure to Update the UFSAR.

During this inspection, the licensee responded to this violation by approving a revision to the UFSAR on November 18, 1998. The revision corrected the second example of the violation. However, in addressing the first example of the violation, the revision inappropriately stated: "In the case of a secondary pipe break coincident with a single failure, the emergency feedwater function may be provided by another unit's EFW pumps, the standby shutdown facility (SSF) ASW pump, or the station ASW pump. Manual action is required to align these other sources." By allowing any secondary pipe break (along with a single failure) to fail the EFW system, this revision decreased the required reliability of the EFW system. The NRC had only approved that certain specific and very low probability pipe breaks (that would disable the three trains of 4160 volt switchgear) could disable the EFW system. Therefore, this UFSAR revision appears to have introduced an

unreviewed safety question and the licensee's corrective actions may not be adequate. During an open meeting in Atlanta on December 8, 1998, the licensee described plans to revise their UFSAR Review Project and re-review the entire UFSAR to assure that other inaccuracies are not overlooked. The NRC plans to follow up on the licensee's improved UFSAR review before closing Oconee Recovery Plan Issue DB5, UFSAR Review Project. URI 269,270,287/98-09-03 is closed.

The inspector reviewed the licensee's procedures for mitigating the events for which the EFW system was not designed; specifically, certain secondary pipe breaks (of main feedwater or 300 psig auxiliary steam) in the turbine building that would disable the three trains of safety-related switchgear and the EFW system. MDS Report No. OS-73.2 described a mitigation strategy that relied on electricians manually connecting alternate power cables to an HPI pump within 30 minutes of being directed to do so, to enable operators to start the HPI pump within 35 minutes after the accident. The inspector noted that the current emergency operating procedure AP/1/A/1700/011, Loss of Power, Rev. 19, dated June 30, 1998, did not direct operators to power an HPI pump from the ASW switchgear in the event of a 300 psig auxiliary steam line break as described in MDS Report OS-73.2. Instead, it directed operators to start the SSF reactor coolant (RC) makeup pump within 10 minutes to establish reactor coolant pump (RCP) seal flow. However, the SSF RC makeup pump had a small capacity of about 30 gpm, which was sufficient for RCP seal makeup but much less than the HPI pump capacity of over 300 gpm. This event, involving a steam line break and resultant RCS cooldown, was outside the licensing basis of the SSF RC makeup pump.

The inspector reviewed past changes to the emergency operating procedures (EOPs). Prior to 1981, the EOPs had directed that, on a loss of 4160 volt switchgear TC, TD, and TE, operators would tell electricians to manually connect the alternate power to an HPI pump. However, EP/O/A/1800/16, Loss of Power, Rev. of June 4, 1981, revised the loss of power procedure so that it directed that alternate power be connected to an HPI pump on a loss of the 4160 volt main feeder bus, and not on a loss of the 4160 volt switchgear TC, TD, and TE. As a result of this change, emergency operating procedures no longer directed operators to power an HPI pump from the ASW switchgear to mitigate the 300 psig auxiliary steam line break event described in MDS Report OS-73.2. The safety evaluation for this procedure revision, which was dated March 28, 1981, incorrectly stated that the change may not increase the consequences of an accident or malfunction of equipment important to safety previously evaluated in the safety analysis report. This apparent violation is identified as the first example of EEI 50-269,270,287/98-15-02, Inadequate 10 CFR 50.59 Safety Evaluations.

EP/O/A/1800/16, Loss of Power, Rev. of July 15, 1985, revised the loss of power procedure so that it no longer directed operators to power an HPI pump from the ASW switchgear on a loss of the 4160 volt main feeder bus. Instead, the procedure directed operators to start the SSF RC makeup pump. However, this event was outside of the licensing basis of the SSF RC makeup pump. The safety evaluation, dated June 19, 1985, incorrectly stated that the change did not increase the consequences of an accident or malfunction of equipment important to safety previously evaluated in the safety analysis

report. At the time, the licensee had no analysis to demonstrate that this change would not increase the consequences of an accident. This apparent violation is identified as the second example of EEI 50-269,270,287/98-15-02, Inadequate 10 CFR 50.59 Safety Evaluations.

IP/O/A/0050/001, Procedure to Provide Emergency Power To An HPI Pump Motor From The ASW Switchgear, Rev. 7, dated September 8, 1998, was the written procedure to manually connect temporary cables to power an HPI pump from the ASW switchgear. However, the procedure required first racking out the 4160-volt breaker to the HPI pump at the safety-related 4160-volt switchgear. In the event of a 300 psig auxiliary steam line or main feedwater line break as described in MDS Report OS-73.2, the safety-related 4160-volt switchgear would be inaccessible because it would be in a steam environment. Further, licensee personnel estimated that the EOPs would not direct operators to get the auxiliary steam line break isolated until about 20 to 30 minutes into the event. Instructions in the procedure were not appropriate and would not have enabled plant electricians to connect alternate power cables to an HPI pump within 30 minutes of being directed to do so, and consequently would not have enabled operators to start the HPI pump within 35 minutes of the accident. The procedure was not adequate to accomplish the event mitigation as described in MDS Report OS-73.2. This apparent violation is identified as EEI 50-269,270,287/98-15-03, Emergency Procedure Not Adequate to Mitigate Secondary Pipe Break Events.

The inspector noted that the installation of several modifications during 1974 - 1985 substantially improved the licensee's ability to mitigate these events. The EFW cross-ties between units were installed in about 1974, which enabled the licensee to provide EFW from one of the other units' EFW pumps. The EFW piping was rerouted away from the main feedwater line in about 1974, which protected the EFW piping from a main feedwater line break and enabled locally starting and using the turbine-driven EFW pump during these events. The SSF diesel generator and SSF ASW pump, and the SSF RC Makeup Pump were installed in about 1985, which provided additional sources of water to the steam generators. The SSF RC Makeup pump and the SSF ASW pump were designed to provide sufficient decay heat removal and RCS makeup to maintain a unit in hot standby indefinitely. The 30 gpm SSF RC Makeup Pump was to be started within 10 minutes of a loss of reactor coolant pump (RCP) seal water and cooling water, to prevent an RCP seal loss of coolant accident (LOCA).

The inspector noted that the potential for an RCP seal LOCA had not been recognized in 1973 and had not been accounted for in the mitigation strategy described in MDS Report OS-73.2. MDS Report OS-73.2 had assumed that either the station ASW pump (started within 15 minutes) or one HPI pump (started within 35 minutes) would be sufficient to mitigate these events and maintain the unit in hot standby for an extensive period of time. However, the inspector observed that the station ASW pump alone could not have mitigated this event along with a potential RCP seal LOCA for very long. Also, one HPI pump alone may not have been able to mitigate the event along with a potential RCP seal LOCA. To assess the current ability to mitigate these events, along with a potential RCP seal LOCA, the licensee performed an analysis; OSC-7299, dated November 18, 1998.

That analysis concluded that starting an HPI pump within one hour, or starting the SSF RC makeup pump within 10 minutes, in addition to providing secondary cooling water to an OTSG within 15 minutes (from another unit, the SSF ASW pump, the turbine-driven EFW pump, or the station ASW pump) would be sufficient to prevent reactor core uncover or damage. The inspector noted that the analysis confirmed the licensee's past ability (during 1973 - 1998) to mitigate the high energy line break events described in MDS Report OS-73.2 by using both the station ASW pump (or other source of secondary cooling water) and either an HPI pump or the SSF RC Makeup pump. However, the inspector noted that mitigation of the auxiliary steam line break event described in MDS Report OS-73.2 (and resultant RCS cooldown) was outside of the current approved licensing basis of the SSF RC Makeup pump.

In response to this issue, the licensee promptly revised the EOPs so that, in the event of a high energy line break as described in MDS Report OS-73.2, operators would both start the SSF RC Makeup pump and direct electricians to connect alternate power to an HPI pump, and also would provide secondary cooling water to a steam generator. The inspector noted that the licensee's new analysis indicated that the revised EOPs now included a strategy for mitigating these events that was able to withstand a single failure.

In response to this issue, the licensee also revised procedure IP/O/A/0050/001 on November 20, 1998. The revised procedure (Rev. 8) directed that, if the 4160 volt switchgear were inaccessible, then the electrician should go to the blockhouse. In the blockhouse, the electrician should remove two close coil fuses and rack out six breakers. The inspector noted that the licensee previously had difficulty accomplishing the old procedure within the required time, and that the added steps could take more time to perform. In response to inspector questions, the licensee stated that they had not done a verification or validation of the new procedure to assure the ability to accomplish it within the required time. The licensee subsequently performed such a validation and was not able to accomplish the new procedure within the required time. The procedure took 37 minutes, which exceeded the time of 30 minutes that was described in Supplement 1 to the MDS Report OS-73.2. The inspector noted that the 10 CFR 50.59 Evaluation Screening for Rev. 8 listed sections of the UFSAR that were reviewed. However, that list did not include Section 3.6, which incorporated by reference the MDS Report OS-73.2. The inspector also noted that the screening incorrectly concluded that there were no unreviewed safety concerns. Question 4 of the screening, "Could the activity adversely affect any system, structure, or component necessary to operate the plant in accordance with the SAR?" was answered incorrectly. The licensee's answer to question 4 was: "No. The change would allow timely connection of the HPI pump motor to the ASW switchgear." This answer was inappropriately made without validation that the revised procedure could be accomplished within the time stated in MDS Report OS-73.2. While the licensee had an analysis that concluded that the reactor core would be protected as long as the HPI pump was started within one hour and secondary cooling water was provided to an OTSG within 15 minutes, that analysis had not been reviewed or approved by the NRC as a change to the license basis. Consequently, the loss of the ability to connect alternate power to an HPI pump within 30 minutes in this event represented a potential nonconformance with the licensing basis and a potential unreviewed safety question. The licensee's failure to perform a

required 50.59 safety evaluation for this procedure change is identified as the third example of EEI 50-269,270,287/98-15-02, Inadequate 10 CFR 50.59 Safety Evaluations.

c. Conclusions

An apparent violation (EEI 50-269,270,287/98-15-02, Inadequate 10 CFR 50.59 Safety Evaluations) was identified for three examples of failure to perform or inadequate safety evaluations for changes to emergency operating procedures related to providing alternate emergency power to a high pressure injection pump.

An apparent violation (EEI 50-269,270,287/98-15-03, Emergency Procedure Not Adequate to Mitigate Secondary Pipe Break Events) was identified for an inadequate procedure for connecting alternate emergency power to a high pressure injection pump.

A violation (VIO 50-269,270,287/98-15-01, Failure to Update the UFSAR) was identified for inaccurate information in the Updated Final Safety Analysis Report (UFSAR) describing the emergency feedwater system. This violation involved failures to update the UFSAR as required and failure to identify and correct the inaccuracies during your 1998 UFSAR Review Project.

II. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on December 11, 1998. The licensee acknowledged the findings presented, and had no dissenting comments. No proprietary information was identified to the inspectors,

Partial List of Persons Contacted

Licensee

L. Azzarello, Design Basis Engineering Manager
 E. Burchfield, Regulatory Compliance Manager
 J. Forbes, Station Manager
 W. Foster, Safety Assurance Manager
 W. McCollum, Site Vice President
 M. Nazar, Manager of Engineering

Other licensee employees contacted during the inspection included engineers, operators, maintenance personnel, regulatory compliance personnel, and administrative personnel.

Inspection Procedures Used

IP 37550: Engineering
 IP 92903: Followup - Engineering

Items Opened, Closed, and Discussed

Opened

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
VIO	50-269,270,287/98-15-01	Open	Failure to Update the UFSAR (Section E8.1)
EEl	50-269,270,287/98-15-02	Open	Inadequate 10 CFR 50.59 Safety Evaluations (Section E8.1)
EEl	50-269,270,287/98-15-03	Open	Emergency Procedure Not Adequate to Mitigate Secondary Pipe Break Events (Section E8.1)

Closed

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
URI	50-269,270,287/98-09-03	Closed	Inaccurate EFW System Information in the UFSAR (Section E8.1)

Discussed

<u>Type</u>	<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
IFI	269,270,287/98-08-05	Open	EFW Potential Design Basis Issues (Section E8.1)

List of Acronyms

AC	- Alternating Current
ASW	- Auxiliary Service Water
EFW	- Emergency Feedwater
FSAR	- Final Safety Analysis Report
HPI	- High Pressure Injection
LOCA	- Loss of Coolant Accident
NPSH	- Net Positive Suction Head
OTSG	- Once-Through Steam Generator
psig	- pounds per square inch
RC	- Reactor Coolant
RCP	- Reactor Coolant Pump
RCS	- Reactor Coolant System
SSF	- Standby Shutdown Facility
UFSAR	- Updated Final Safety Analysis Report
URI	- Unresolved Item

V. Predecisional Enforcement Conferences

Whenever the NRC has learned of the existence of a potential violation for which escalated enforcement action appears to be warranted, or recurring nonconformance on the part of a vendor, the NRC may provide an opportunity for a predecisional enforcement conference with the licensee, vendor, or other person before taking enforcement action. The purpose of the conference is to obtain information that will assist the NRC in determining the appropriate enforcement action, such as: (1) a common understanding of facts, root causes and missed opportunities associated with the apparent violations, (2) a common understanding of corrective actions taken or planned, and (3) a common understanding of the significance of issues and the need for lasting comprehensive corrective action.

If the NRC concludes that it has sufficient information to make an informed enforcement decision, a conference will not normally be held. However, an opportunity for a conference will normally be provided before issuing an order based on a violation of the rule on Deliberate Misconduct or a civil penalty to an unlicensed person. If a conference is not held, the licensee may be requested to provide a written response to an inspection report, if issued, as to the licensee's views on the apparent violations and their root causes and a description of planned or implemented corrective actions. However, if the NRC has sufficient information to conclude that a civil penalty is not warranted, it may proceed to issue an enforcement action without first obtaining the licensee's response to the inspection report.

During the predecisional enforcement conference, the licensee, vendor, or other persons will be given an opportunity to provide information consistent with the purpose of the conference, including an explanation to the NRC of the immediate corrective actions (if any) that were taken following identification of the potential violation or nonconformance and the long-term comprehensive actions that were taken or will be taken to prevent recurrence. Licensees, vendors, or other persons will be told when a meeting is a predecisional enforcement conference.

A predecisional enforcement conference is a meeting between the NRC and the licensee. Conferences are normally held in the regional offices and are normally open to public observation. Conferences will not normally be open to the public if the enforcement action being contemplated:

- (1) Would be taken against an individual, or if the action, though not taken against an individual, turns on whether an individual has committed wrongdoing;
- (2) Involves significant personnel failures where the NRC has requested that the individual(s) involved be present at the conference;
- (3) Is based on the findings of an NRC Office of Investigations report that has not been publicly disclosed; or
- (4) Involves safeguards information, Privacy Act information, or information which could be considered proprietary;

In addition, conferences will not normally be open to the public if:

- (5) The conference involves medical misadministrations or overexposures and the conference cannot be conducted without disclosing the exposed individual's name; or
- (6) The conference will be conducted by telephone or the conference will be conducted at a relatively small licensee's facility.

Notwithstanding meeting any of these criteria, a conference may still be open if the conference involves issues related to an ongoing adjudicatory proceeding with one or more intervenors or where the evidentiary basis for the conference is a matter of public record, such as an adjudicatory decision by the Department of Labor. In addition, notwithstanding the above normal criteria for opening or closing conferences, with the approval of the Executive Director for Operations, conferences may either be open or closed to the public after balancing the benefit of the public's observation against the potential impact on the agency's decision-making process in a particular case.

The NRC will notify the licensee that the conference will be open to public observation. Consistent with the agency's policy on open meetings, "Staff Meetings Open to Public," published September 20, 1994 (59 FR 48340), the NRC intends to announce open conferences normally at least 10 working days in advance of conferences through (1) notices posted in the Public Document Room, (2) a toll-free telephone recording at 800-952-9674, (3) a toll-free electronic bulletin board at 800-952-9676, and on the World Wide Web at the NRC Office of Enforcement homepage (www.nrc.gov/OE). In addition, the NRC will also issue a press release and notify appropriate State liaison officers that a predecisional enforcement conference has been scheduled and that it is open to public observation.

The public attending open conferences may observe but may not participate in the conference. It is noted that the purpose of conducting open conferences is not to maximize public attendance, but rather to provide the public with opportunities to be informed of NRC activities consistent with the NRC's ability to exercise its regulatory and safety responsibilities. Therefore, members of the public will be allowed access to the NRC regional offices to attend open enforcement conferences in accordance with the "Standard Operating Procedures For Providing Security Support For NRC Hearings and Meetings," published November 1, 1991 (56 FR 56251). These procedures provide that visitors may be subject to personnel screening, that signs, banners, posters, etc., not larger than 18" be permitted, and that disruptive persons may be removed. The open conference will be terminated if disruption interferes with a successful conference. NRC's Predecisional Enforcement Conferences (whether open or closed) normally will be held at the NRC's regional offices or in NRC Headquarters Offices and not in the vicinity of the licensee's facility.

For a case in which an NRC Office of Investigations (OI) report finds that discrimination as defined under 10 CFR 50.7 (or similar provisions in Parts 30, 40, 60, 70, or 72) has occurred, the OI report may be made public, subject to withholding certain information (i.e., after appropriate redaction), in which case the associated predecisional enforcement conference will normally be open to public observation. In a conference where a particular individual is being considered potentially responsible for the discrimination, the conference will remain closed. In either case (i.e., whether the conference is open or closed), the employee or former employee who was the subject of the alleged discrimination (hereafter referred to as "complainant") will normally be provided an opportunity to participate in the predecisional enforcement conference with the licensee/employer. This participation will normally be in the form of a complainant statement and comment on the licensee's presentation, followed in turn by an opportunity for the licensee to respond to the complainant's presentation. In cases where the complainant is unable to attend in person, arrangements will be made for the complainant's participation by telephone or an opportunity given for the complainant to submit a written response to the licensee's presentation. If the licensee chooses to forego an enforcement conference and, instead, responds to the NRC's findings in writing, the complainant will be provided the opportunity to submit written comments on the licensee's response. For cases involving potential discrimination by a contractor or vendor to the licensee, any associated predecisional enforcement conference with the contractor or vendor would be handled similarly. These arrangements for complainant participation in the predecisional enforcement conference are not to be conducted or viewed in any respect as an adjudicatory hearing. The purpose of the complainant's participation is to provide information to the NRC to assist it in its enforcement deliberations.

A predecisional enforcement conference may not need to be held in cases where there is a full adjudicatory record before the Department of Labor. If a conference is held in such cases, generally the conference will focus on the licensee's corrective action. As with discrimination cases based on OI investigations, the complainant may be allowed to participate.

Members of the public attending open conferences will be reminded that (1) the apparent violations discussed at predecisional enforcement conferences are subject to further review and may be subject to change prior to any resulting enforcement action and (2) the statements of views or expressions of opinion made by NRC employees at predecisional enforcement conferences, or the lack thereof, are not intended to represent final determinations or beliefs.

When needed to protect the public health and safety or common defense and security, escalated enforcement action, such as the issuance of an immediately effective order, will be taken before the conference. In these cases, a conference may be held after the escalated enforcement action is taken.