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WITH SELECTED ORDERS

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**ATOMIC SAFETY AND LICENSING BOARD PANEL**

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**Chief Administrative Law Judge**

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PREFACE

This is the fortieth volume of issuances (1 – 387) of the Nuclear Regulatory Commission and its Atomic Safety and Licensing Boards, Administrative Law Judges, and Office Directors. It covers the period from July 1, 1994 – December 31, 1994.

Atomic Safety and Licensing Boards are authorized by Section 191 of the Atomic Energy Act of 1954. These Boards, comprised of three members conduct adjudicatory hearings on applications to construct and operate nuclear power plants and related facilities and issue initial decisions which, subject to internal review and appellate procedures, become the final Commission action with respect to those applications. Boards are drawn from the Atomic Safety and Licensing Board Panel, comprised of lawyers, nuclear physicists and engineers, environmentalists, chemists, and economists. The Atomic Energy Commission first established Licensing Boards in 1962 and the Panel in 1967.

Beginning in 1969, the Atomic Energy Commission authorized Atomic Safety and Licensing Appeal Boards to exercise the authority and perform the review functions which would otherwise have been exercised and performed by the Commission in facility licensing proceedings. In 1972, that Commission created an Appeal Panel, from which are drawn the Appeal Boards assigned to each licensing proceeding. The functions performed by both Appeal Boards and Licensing Boards were transferred to the Nuclear Regulatory Commission by the Energy Reorganization Act of 1974. Appeal Boards represent the final level in the administrative adjudicatory process to which parties may appeal. Parties, however, are permitted to seek discretionary Commission review of certain board rulings. The Commission also may decide to review, on its own motion, various decisions or actions of Appeal Boards.


The Commission also has Administrative Law Judges appointed pursuant to the Administrative Procedure Act, who preside over proceedings as directed by the Commission.

The hardbound edition of the Nuclear Regulatory Commission Issuances is a final compilation of the monthly issuances. It includes all of the legal precedents for the agency within a six-month period. Any opinions, decisions, denials, memoranda and orders of the Commission inadvertently omitted from the monthly softbounds and any corrections submitted by the NRC legal staff to the printed softbound issuances are contained in the hardbound edition. Cross references in the text and indexes are to the NRCl page numbers which are the same as the page numbers in this publication.

Issuances are referred to as follows: Commission--CLI, Atomic Safety and Licensing Boards--LBP, Administrative Law Judges--ALJ, Directors’ Decisions--DD, and Denial of Petitions for Rulemaking--DPRM.

The summaries and headnotes preceding the opinions reported herein are not to be deemed a part of those opinions or to have any independent legal significance.
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The Commission denies General Atomics' motion seeking to stay discovery in this proceeding until (1) the Commission determines whether it will grant General Atomics' Petition for Review of LBP-94-17 and/or Motion for Directed Certification; and (2) assuming that the Commission grants the Petition/Motion, the Commission determines with finality the jurisdictional issues raised in General Atomics' previously filed Motion for Summary Disposition or for an Order of Dismissal.

RULES OF PRACTICE: STAY PENDING APPEAL

Where a party files a stay motion with the Commission pursuant to 10 C.F.R. § 2.730 (which contains no standards by which to decide stay motions), the Commission will turn for guidance to the general stay standards in section 2.788.

RULES OF PRACTICE: STAY OF DISCOVERY; STAY PENDING APPEAL

Interlocutory appeals or petitions to the Commission are not devices for delaying or halting licensing board proceedings. The stringent four-part standard
set forth in section 2.788(e) makes it difficult for a party to obtain a stay of any aspect of a licensing board proceeding. Therefore, only in unusual cases should the normal discovery and other processes be delayed pending the outcome of an appeal or petition to the Commission. Cf. 10 C.F.R. § 2.730(g).

RULES OF PRACTICE: STAY PENDING APPEAL (IRREPARABLE INJURY)


RULES OF PRACTICE: DISCOVERY

LICENSING BOARD: AUTHORITY

Were a party subjected to overly burdensome discovery, the licensing board has full authority to prevent or modify unreasonable discovery demands. 10 C.F.R. § 2.740(c).

RULES OF PRACTICE: STAY OF DISCOVERY

Under normal circumstances, motions for a stay of discovery should be filed with the licensing board rather than the Commission. See 10 C.F.R. § 2.730(a).

RULES OF PRACTICE: STAY OF DISCOVERY; STAY PENDING APPEAL

The Commission has the authority to exercise its "inherent supervisory powers over adjudicatory proceedings" and to address the stay motion itself, rather than either dismiss it or refer it to the licensing board. Ohio Edison Co. (Perry Nuclear Power Plant, Unit 1), CLI-91-15, 34 NRC 269, 271 (1991), reconsideration denied, CLI-92-6, 35 NRC 86 (1992).
RULES OF PRACTICE: STAY PENDING APPEAL (LIKELIHOOD OF SUCCESS ON THE MERITS)

Irreparable injury is the most important of the four factors set forth in section 2.788(e). *Public Service Co. of New Hampshire* (Seabrook Station, Units 1 and 2), CL1-90-3, 31 NRC 219, 258 (1990), *aff’d on other grounds sub nom. Massachusetts v. NRC*, 924 F.2d 311 (D.C. Cir.), *cert. denied*, 112 S. Ct. 275 (1991). Consequently, where a movant (as here) fails to show irreparable harm, then it must make an overwhelming showing that it is likely to succeed on the merits. *See, e.g., Kerr-McGee Chemical Corp.* (West Chicago Rare Earths Facility), ALAB-928, 31 NRC 263, 269 (1990) (absent a showing of irreparable harm, movant must demonstrate that the reversal of the licensing board is a "virtual certainty").

RULES OF PRACTICE: STAY PENDING APPEAL

The importance and novelty of significant jurisdictional issues of first impression are, in and of themselves, insufficient to justify a stay. *Cf. Kerr-McGee Chemical Corp.* (West Chicago Rare Earths Facility), ALAB-928, 31 NRC 263, 270 (1990).

RULES OF PRACTICE: STAY PENDING APPEAL (HARM TO OTHER PARTIES; PUBLIC INTEREST)

Where the party seeking a stay has failed to meet its burden on the two most important factors (irreparable injury and likelihood of success on the merits), the Commission need not give lengthy consideration to the other two factors (public interest and harm to other parties). *Kerr-McGee Chemical Corp.* (West Chicago Rare Earths Facility), ALAB-928, 31 NRC 263, 270 (1990).

RULES OF PRACTICE: STAY PENDING APPEAL (HARM TO OTHER PARTIES)

The mere possibility that a stay would save other parties from incurring significant litigation expenses is insufficient to offset the movant’s failure to demonstrate irreparable injury and a strong likelihood of success on the merits.
ORDER

Pursuant to 10 C.F.R. § 2.730, General Atomics filed a motion with the Commission on July 6, 1994, seeking to stay discovery in this proceeding until (1) the Commission determines whether it will grant General Atomics' June 24, 1994 Petition for Review of LBP-94-17 and/or Motion for Directed Certification; and (2) assuming that the Commission grants the June 24th Petition/Motion, the Commission determines with finality the issues raised in General Atomics' February 17, 1994 Motion for Summary Disposition or for an Order of Dismissal. Sequoyah Fuels Corporation ("Sequoyah Fuels") supports General Atomics' motion, while Native Americans for a Clean Environment (NACE), the Cherokee Nation and the NRC Staff all oppose the motion. For the reasons set forth below, we deny General Atomics' motion for stay.

BACKGROUND

NRC Staff initiated this proceeding on October 15, 1993, by issuing an order ("Staff Order") holding both Sequoyah Fuels and its parent company, General Atomics, jointly and severally liable for providing (1) the necessary "funding to continue remediation" of the contamination at Sequoyah's facility in Gore, Oklahoma; (2) "financial assurance for decommissioning" of that facility; and (3) "an updated detailed cost estimate for decommissioning and a plan for assuring the availability of adequate funds for completion of decommissioning." Staff Order at 23-24.

On February 17, 1994, General Atomics filed with the Licensing Board a motion for an order granting summary disposition in its favor regarding all issues in this proceeding or, in the alternative, for an order of dismissal. In that motion, General Atomics asserted that the statutes relied upon in the Staff Order do not authorize the Staff either to assert jurisdiction over General Atomics in this proceeding or to impose upon General Atomics the non-civil-penalty financial liability set forth in the Staff Order.

On April 28, 1994, the Licensing Board denied General Atomics' February 17th Motion, and set forth its reasons in a Memorandum issued June 8, 1994 (LBP-94-17, 39 NRC 359). On June 24, 1994, General Atomics filed a Petition for Review of LBP-94-17 and/or Motion for Directed Certification ("June 24th Petition/Motion") — a pleading which is currently pending before the Commission.
POsITIONS OF THE PARTIES

General Atomics asserts in its stay motion that discovery in this proceeding is expected to be both lengthy (at least 6 months) and expensive, and that a Commission decision accepting General Atomics' jurisdictional arguments would render such expenses unnecessary. According to General Atomics, a delay of 1 to 2 months (within which the Commission purportedly could resolve the jurisdictional issue) would not have a significant detrimental impact on the length of this proceeding. General Atomics also points out that the Staff Order was not issued "effective immediately" and is not urgently required to protect the public interest or the public health and safety. General Atomics further asserts that the continuation of discovery would impose substantial unrecoverable litigation expenses on all parties and would also result in an unrecoverable diversion of Sequoyah Fuel's assets away from decommissioning activities. Stay Motion at 4-5.

Sequoyah Fuels supports General Atomics' position and briefly reiterates its parent company's arguments regarding the minimization of litigation costs and the diversion of Sequoyah Fuels' assets. Sequoyah Fuels' Reply to General Atomics' Motion to Stay Discovery (July 15, 1994).

NRC Staff opposes General Atomics' motion on the grounds that such a stay may delay discovery well beyond the "1 or 2 months" asserted by General Atomics. Staff also asserts that it does not intend to serve further discovery requests on Sequoyah Fuels or General Atomics until Staff completes its review of those two parties' responses to Staff's first round of discovery, and that the delay inherent in this review may render unwarranted the concerns of General Atomics regarding substantial litigation costs. NRC Staff's Answer in Opposition to General Atomics' Motion to Stay Discovery at 2 (July 15, 1994).

NACE and the Cherokee Nation oppose General Atomics' motion on two grounds. First, they argue that the Commission looks with disfavor upon motions for stay pending the outcome of a Motion for Directed Certification. In support of this position, they point to section 2.730(g) of our regulations, which provides that "[u]nless otherwise ordered, neither the filing of a motion nor the certification of a question to the Commission shall stay the proceeding or extend the time for the performance of any act." NACE/Cherokee Nations' Opposition to General Atomics' Motion to Stay Proceeding at 1 (July 15, 1994), quoting 10 C.F.R. § 2.730(g). Second, these intervenors argue that General Atomics meets none of the standards for a stay set forth in 10 C.F.R. § 2.788(e), and enumerated immediately below. NACE/Cherokee Nation's Opposition at 2-4.
General Atomics appropriately cites 10 C.F.R. § 2.730 ("Motions") as the authority under which it filed its stay motion. However, because section 2.730 contains no standards by which to decide stay motions, we turn instead for guidance to the general stay standards in section 2.788 ("Stays of decisions of presiding officers pending review"), subsection (e) of which provides that:

In determining whether to grant or deny an application for a stay, the Commission or presiding officer will consider:

1. Whether the moving party has made a strong showing that it is likely to prevail on the merits;
2. Whether the party will be irreparably injured unless a stay is granted;
3. Whether the granting of a stay would harm other parties; and
4. Where the public interest lies.

Interlocutory appeals or petitions to the Commission are not devices for delaying or halting licensing board proceedings. The stringent four-part standard set forth in section 2.788(e) makes it difficult for a party to obtain a stay of any aspect of a Licensing Board proceeding. Therefore, only in unusual cases should the normal discovery and other processes be delayed pending the outcome of an appeal or petition to the Commission. Cf. 10 C.F.R. § 2.730(g) (quoted supra at p. 5).

1. Irreparable Injury to Movant if Stay Request Is Denied

General Atomics' principal assertion regarding irreparable injury is that the "substantial" and "unrecoverable" litigation expenses that General Atomics would incur due to the continuation of discovery in this proceeding might ultimately prove unnecessary were the Commission to rule that it lacks jurisdiction over General Atomics. Stay Motion at 5. We disagree with General Atomics that the incurrence of such costs constitutes "irreparable injury."

The Commission does not consider the incurrence of litigation expenses to constitute irreparable injury in the context of a stay decision. As we have previously held, "[m]ere litigation expense, even substantial and unrecoverable cost, does not constitute irreparable injury." Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit 1), CLI-84-17, 20 NRC 801, 804 (1984), quoting Consumers Power Co. (Midland Plant, Units 1 and 2), ALAB-395, 5 NRC 772, 779 (1977), in turn quoting Renegotiation Board v. Bannercraft Co., 415 U.S. 1, 24 (1974). "[I]njuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough" to render an injury irreparable. Virginia Petroleum Jobbers Ass'n v. Federal Power Commission, 259 F.2d 921, 925 (D.C. Cir. 1958). Accord
Toledo Edison Co. (Davis-Besse Nuclear Power Station, Units 1, 2, and 3), ALAB-385, 5 NRC 621 (1977). Finally, were General Atomics subjected to overly burdensome discovery, the Licensing Board has full authority to prevent or modify unreasonable discovery demands. 10 C.F.R. § 2.740(c).\(^1\)

General Atomics also proffers a second argument that could be construed as an “irreparable injury” contention — that the continuation of discovery would result in the “unrecoverable diversion of the licensee’s [i.e., Sequoyah Fuel’s] assets from decommissioning activities.” Stay Motion at 5. See also Sequoyah Fuels’ Reply at 2. This argument at least implies that the denial of a stay would render Sequoyah Fuels less able to meet its decommissioning obligations, and that this would result in an irreparable injury to Sequoyah Fuels. We reject this argument on the ground that General Atomics fails to provide any tangible evidence to support its argument.

Indeed, the current record suggests a contrary conclusion. NRC Staff represents that it does not intend to serve further discovery requests upon General Atomics and Sequoyah Fuels until Staff has completed its review of those two parties’ responses to its first round of discovery (NRC Staff’s Answer at 2), and the two intervenors have not yet even sought a first round of discovery (see NACE/Cherokee Nation’s Opposition at 4 n.4). Consequently, the record does not support the conclusion that, during the pendency of General Atomics’ June 24th Petition/Motion to the Commission, Sequoyah Fuels will potentially be burdened with such heavy discovery expenses that its decontamination funds would be meaningfully diluted.

2. Strong Showing That It Is Likely to Prevail on the Merits

Irreparable injury is the most important of the four factors set forth in section 2.788(e). Public Service Co. of New Hampshire (Seabrook Station, Units 1 and 2), CLI-90-3, 31 NRC 219, 258 (1990), aff’d on other grounds sub nom. Massachusetts v. NRC, 924 F.2d 311 (D.C. Cir.), cert. denied, 112 S. Ct. 275 (1991). Consequently, where a movant (as here) fails to show irreparable harm, then it must make an overwhelming showing that it is likely to succeed on the merits. See, e.g., Kerr-McGee Chemical Corp. (West Chicago Rare Earths Facility), ALAB-928, 31 NRC 263, 269 (1990) (absent a showing of irreparable harm, movant must demonstrate that the reversal of the licensing board is a “virtual certainty”). General Atomics has made no such showing here.

\(^1\)Under normal circumstances, motions for a stay of discovery should be filed with the Licensing Board rather than the Commission. See 10 C.F.R. § 2.730(a) (“All motions shall be addressed to the Commission or, when a proceeding is pending before a presiding officer, to the presiding officer” (emphasis added)). However, we will exercise “our inherent supervisory powers over adjudicatory proceedings” and will address the stay motion ourselves, rather than either dismiss it or refer it to the Licensing Board. Ohio Edison Co. (Perry Nuclear Power Plant, Unit 1), CLI-91-15, 34 NRC 269, 271 (1991), reconsideration denied, CLI-92-6, 35 NRC 86 (1992).
General Atomics’ June 24th Petition/Motion may well raise significant jurisdictional issues of first impression. Nevertheless, the importance and novelty of those issues are, in and of themselves, insufficient to justify a stay. Cf. id. at 270. General Atomics has simply failed to demonstrate a sufficiently high probability of success on the merits so as to justify the grant of a stay.

3. Other Factors

Given that the movant has failed to meet its burden on the two most important factors, we need not give lengthy consideration to the other two factors. Id.

We do not believe that a grant of the requested stay would harm other parties to this proceeding. In fact, we agree with General Atomics that a stay might even benefit the other parties by saving them unnecessary litigation costs in the event that the Commission rules in favor of General Atomics on the jurisdiction issue. However, this mere possibility is insufficient to offset General Atomics’ failure to demonstrate irreparable injury and a strong likelihood of success on the merits. Moreover, the NRC Staff, NACE, and the Cherokee Nation all oppose the stay request, despite their potential cost savings.

Finally, we see no “public interest” factors that would mitigate either for or against a grant of the requested stay. Although General Atomics is correct that the Staff Order was not issued “effective immediately” and is not urgently required to protect the public interest or the public health and safety, these facts merely support the conclusion that the requested stay would not actually contravene the public interest. They do not demonstrate that such a stay would be in the public interest.

CONCLUSION

For the reasons set forth above, General Atomics’ motion for stay is denied. It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland, this 21st day of July 1994.
In this proceeding concerning an NRC Staff enforcement order issued in accordance with 10 C.F.R. § 2.202, the Licensing Board concludes that a Native American tribe wishing to participate in the proceeding to support the Staff’s enforcement order has established its standing and presented two litigable contentions.

RULES OF PRACTICE: STANDING TO INTERVENE (INJURY IN FACT; ZONE OF INTERESTS)

In order to grant an intervenor party status in a proceeding, the presiding officer must find that the petitioner meets the contemporaneous judicial concepts of standing. This requires that the intervenor establish that it will suffer injury
in fact relative to its interests in the proceeding and that those alleged interests are within the zone of interests protected by the statutes and regulations under which the petitioner seeks to participate in the proceeding. See, e.g., Cleveland Electric Illuminating Co. (Perry Nuclear Power Plant, Unit 1), CLI-93-21, 38 NRC 87, 92 (1993).

RULES OF PRACTICE: STANDING (REPRESENTATIONAL); STANDING TO INTERVENE (AUTHORIZATION)

To represent the interests of its members, a Native American tribe must identify at least one member who will be injured and obtain authorization to represent that individual. See, e.g., Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-535, 9 NRC 377, 390-96 (1979).

RULES OF PRACTICE: CONTENTIONS (PLEADING IMPERFECTIONS)

Longstanding Commission practice suggests that the benefit of the doubt should be given to the potential intervenor in order to obviate dismissal of an intervention petition because of inarticulate draftsmanship or procedural pleading defects. See, e.g., Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), ALAB-146, 6 AEC 631, 633-34 (1973). See also LBP-94-8, 39 NRC 116, 120 & n.7 (1994), appeals pending.

MEMORANDUM AND ORDER
(Granting Intervention Motion)

This Memorandum and Order addresses the intervention petition filed by the Cherokee Nation in this ongoing proceeding regarding the NRC Staff's October 15, 1993 enforcement order imposing decommissioning funding requirements for Sequoyah Fuels Corporation's (SFC) facility near Gore, Oklahoma. In our prior decisions in LBP-94-5 and LBP-94-8,1 we found that petitioner Native Americans for a Clean Environment (NACE) had established its standing to intervene in this proceeding pursuant to 10 C.F.R. § 2.714(a) and had presented

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litigable contentions so as to sanction its admission as a party to this proceeding.² We now conclude that Petitioner Cherokee Nation has established the requisite standing to intervene in support of the Staff’s enforcement order and has presented litigable contentions, thereby warranting its admission as a party as well.

I. BACKGROUND

Pursuant to our ruling in LBP-94-5, the background for which is fully detailed in that decision and will not be repeated here,³ on March 29, 1994, we issued a notice of hearing in this proceeding that subsequently was published in the Federal Register.⁴ The notice informed the public that NACE had been allowed to intervene in this proceeding and further invited any person whose interest may be affected by the proceeding to petition for leave to intervene. Acting on this notice, on April 20, 1994, the Cherokee Nation filed a timely application for intervention that set forth several concerns regarding environmental contamination of tribal lands adjacent to the SFC facility.⁵ On May 5 and May 10, respectively, SFC and the Staff filed their initial responses to the Cherokee Nation petition.⁶

In its first filing, SFC opposed the Cherokee Nation’s application, arguing that the tribe had not met the legal standards for intervention set forth in 10 C.F.R. § 2.714(a)(1) because it failed to establish a cognizable “organizational” or “representational” interest in the proceeding; failed to show how its interest

² SFC and its parent corporation, General Atomics (GA), sought this hearing to contest the Staff’s October 1993 enforcement order pursuant to 10 C.F.R. § 2.202, which provides that “the licensee or any other person adversely affected” by an enforcement order can request a hearing regarding the order. In LBP-94-5, 39 NRC at 63-66, we ruled that under the terms of 10 C.F.R. § 2.714(a)(1), petitioner NACE can intervene in support of an enforcement order in a proceeding instituted by the licensee under section 2.202. We also referred that ruling to the Commission. See 39 NRC at 75-76. Thereafter, with the issuance of LBP-94-8 admitting NACE’s two contentions, see 39 NRC at 118-20, pursuant to 10 C.F.R. § 2.714a, SFC and GA took an appeal of our determination that NACE could intervene in support of the order (along with our ruling that NACE had established its standing to intervene). See [SFC’s] Brief on Appeal of LBP-94-5 and LBP-94-8 (Apr. 7, 1994) at 7-28; [GA’s] Notice of Appeal (Apr. 7, 1994) (adopting arguments in SFC’s appeal brief). The Board’s referred ruling and the SFC and GA appeals currently are pending with the Commission.

With the Cherokee Nation in the same litigative posture as NACE, see Supplement to Cherokee Nation’s Combined Response to [SFC’s] Answer in Opposition and N.R.C. Staff’s Response to Cherokee Nation’s Application for Order Allowing Intervention (June 3, 1994) at 2 [hereinafter Cherokee Nation Combined Response Supplement], we need not revisit our ruling in LBP-94-5 regarding intervention by interested persons seeking to support a Staff enforcement order.

³ See LBP-94-5, 39 NRC at 73 n.21.


⁵ See Application for Order Allowing Intervention (Apr. 20, 1994).

⁶ See [SFC’s] Answer in Opposition to Cherokee Nation’s Application for Order Allowing Intervention (May 5, 1994) [hereinafter SFC Initial Answer]; NRC Staff’s Response to the Cherokee Nation’s Application for Order Allowing Intervention (May 10, 1994) [hereinafter Staff Initial Response]. In addition, GA filed a pleading stating that it adopted the arguments against permitting intervention set forth in SFC’s answer. See [GA’s] Answer in Opposition to the Application of the Cherokee Nation for an Order Permitting Intervention (May 5, 1994).
would be affected by the proceeding; and failed to identify the specific aspect or aspects of the subject matter of the proceeding as to which it wishes to intervene.\(^7\)

In its response, the Staff likewise found the Cherokee Nation petition deficient for failing to address adequately the tribe’s “injury in fact” and the adverse impact the proceeding could visit on the Cherokee Nation’s interest. The Staff also asserted that it was unclear whether the Cherokee Nation was seeking intervention on its own behalf as an organization or on behalf of its members. While concluding that the Petitioner had not submitted enough information to demonstrate its standing to intervene, the Staff nonetheless suggested that the Cherokee Nation be given the opportunity to amend its petition to correct the identified pleading deficiencies and to submit a valid contention.\(^8\)

On May 19, while the Board was considering the parties’ initial filings, the Cherokee Nation filed a combined response to the SFC and Staff responses.\(^9\)

That response outlines the Cherokee Nation’s claim of ownership to the north bed and banks of the Arkansas River, which is approximately one-half mile to the southwest of the SFC facility, and included a letter from the Cherokee Nation Office of Environmental Services (OES) outlining the results of United States Environmental Protection Agency (EPA) groundwater tests conducted on riverbed property.\(^10\)

Asserting that the natural groundwater flow is to the west toward the tribal riverbank property, the combined response declares that if SFC “does not do an adequate clean-up of the site and nearby tribal property,” tribal property would remain contaminated and would continue to be contaminated by water runoff from the SFC property.\(^11\)

The response concludes by adopting the contentions previously filed by NACE and admitted by the Board.\(^12\)

On May 23, prior to receiving the Cherokee Nation May 19 combined response, we issued an order allowing the Cherokee Nation the opportunity to amend its intervention petition by providing any additional information it

\(^7\) See SFC Initial Answer at 10-18. In addition to its argument addressing the intervention factors in 10 C.F.R. § 2.714(a)(1), SFC asserted that section 189a(1) of the Atomic Energy Act (AEA), 42 U.S.C. §2239(a)(1), the AEA’s principal provision affording hearing rights to intervenors, does not provide for intervention by the Cherokee Nation as it seeks to support the Staff’s October 1993 enforcement order because the order does not grant, suspend, revoke, or amend a license. See id. at 8-10.

\(^8\) See Staff Initial Response at 3-8.

\(^9\) Cherokee Nation’s Combined Response to [SFC’s] Answer in Opposition and N.R.C. Staff’s Response to Cherokee Nation’s Application for Order Allowing Intervention (May 19, 1994) [hereinafter Cherokee Nation Combined Response]. Although the pages in this filing are not numbered, we refer to them in their numerical order.

\(^10\) See id. at 2. The OES letter declared that heavy metals contamination levels met “EPA Superfund criteria” for contamination. Id., attached Letter from Curtis Canard, Cherokee Nation OES, to James Wilcoxen (Sept. 24, 1992). The Cherokee Nation, however, does not explain how this seemingly nonradiological contamination is under the jurisdiction of the NRC rather than the EPA.

\(^11\) Id. at 3.

\(^12\) See id. at 4. See also LBP-94-8, 39 NRC at 118-20.
believed appropriate relative to its standing in this proceeding. The order also requested that the Cherokee Nation supplement its petition by listing those contentions and supporting bases it wished to litigate. The other parties were given the opportunity to respond to that amended petition within 14 days after service.

Because the Cherokee Nation's May 19 combined response literally crossed paths in the mail with our May 23 order, on June 3 the tribe provided a further supplement to its combined response. In that supplement, the tribe declines to submit any additional information regarding the basis for its standing and declares that it should be permitted to appear as a party in support of the Staff's October 1993 enforcement order. In its response to the tribe's May 19 combined response and June 3 supplement, SFC does not address the Commission's standing requirements; instead, SFC repeats the arguments it makes to the Commission in appealing LBP-94-5 by denying categorically that any petitioner can intervene in support of a Staff enforcement order. The Staff, however, does not oppose granting the Cherokee Nation intervention request so long as the tribe is limited to representing its own organizational interests.

II. ANALYSIS

A. The Cherokee Nation's Particularized Injury

As it has often been stated, in order to grant an intervenor party status in a proceeding, we must find that the petitioner meets the contemporaneous judicial concepts of standing. This requires that the intervenor establish that it will suffer injury in fact relative to its interests in the proceeding and that those alleged

13 See Order (Establishing Filing Schedules for Cherokee Nation Amended Intervention Application and Contentions Supplement and for Party Responses Thereto) (May 23, 1994) at 1 (unpublished). This order had the effect of granting the Cherokee Nation's May 19, 1994 motion for leave to file that accompanied the tribe's May 19 combined response to the initial SFC and Staff responses.

14 See id. at 1-2.

15 See Cherokee Nation Combined Response Supplement at 1-2.

16 See [SFC's] Response in Opposition to the Cherokee Nation's Amended Intervention Application (June 22, 1994) at 2-3. In its filings regarding our referral to the Commission of certain rulings in LBP-94-5 and its pending appeal from LBP-94-5 and LBP-94-8, SFC has put before the Commission the question of whether our determination in LBP-94-5 allowing NACE to intervene in this proceeding should be sustained. See supra note 2; [SFC's] Initial Brief in Opposition to the Ruling in Section I.A of LBP-94-5 (Mar. 11, 1994); [SFC's] Reply Brief in Opposition to the Ruling in Section I.A of LBP-94-5 (Mar. 17, 1994). In both instances, SFC (joined by GA) argues that persons seeking to support a Staff enforcement order cannot intervene in an adjudicatory proceeding convened pursuant to 10 C.F.R. 2.202 to contest the order.

17 See NRC Staff's Response to the Cherokee Nation's Combined Response of May 19, 1994, and Supplement of June 3, 1994 (June 22, 1994) at 4-6 & n.6 [hereinafter Staff Response to Combined Response/Supplement].
interests are within the zone of interests protected by the statutes and regulations under which the petitioner seeks to participate in the proceeding.\textsuperscript{18}

As noted above, in its May 19 combined response the Cherokee Nation provides confirmation that it holds title to the banks and the riverbed of the Arkansas River adjacent to the SFC facility.\textsuperscript{19} The Cherokee Nation further states that the natural flow of the groundwater in the area of the SFC facility is westward toward the Arkansas River and declares that SFC is in agreement with this assertion.\textsuperscript{20} In its combined response, the Cherokee Nation also alleges that groundwater runoff will continue to contaminate tribal property in the future, affecting the health and safety of tribal members who use the river and the tribe's economic interests in developing the property.\textsuperscript{21}

The Cherokee Nation's allegations of environmental damage are proffered in the same factual context as those presented by NACE earlier in this proceeding. As we noted there, "[w]e have no trouble concluding that the interest of [the Petitioner] in seeing that the Staff's decommissioning funding order is sustained falls within the zone of interests protected by the [Atomic Energy Act (AEA)]."\textsuperscript{22} Moreover, as we stated in ruling on NACE's petition, "the Staff's October 1993 enforcement order makes clear [that] there is uranium contamination of the soil and groundwater on the SFC main processing facility and the nearby pond areas with sufficient safety significance to warrant remediation before the property can be released for unrestricted use."\textsuperscript{23} This contamination on the SFC site, in conjunction with the proximity of the Cherokee Nation's property to the SFC facility and the direction of groundwater flow from that facility, establishes that there is a real potential for decommissioning-related activities to have an impact on the Cherokee Nation's riverbank property.

Thus, based on the record before us, we are unable to conclude that there is "no potential for offsite consequences" relative to the Cherokee Nation property from SFC site contamination and its decommissioning operations.\textsuperscript{24} As a

\textsuperscript{18} See, e.g., Cleveland Electric Illuminating Co. (Perry Nuclear Power Plant, Unit 1), CLI-93-21, 38 NRC 87, 92 (1993).

\textsuperscript{19} The Cherokee Nation cites several cases in support of its claim of ownership to the affected riverbank and riverbed along the Arkansas River less than a mile to the southwest of the SFC facility. See Cherokee Nation Combined Response at 1-2. Neither SFC nor the Staff has disputed this claim. Our review of those cases does not give us any reason to doubt it either. See Choctaw Nation v. Cherokee Nation, 393 F. Supp. 224, 246 (E.D. Okla. 1975) (three-judge court) (finding that the north portion of the Arkansas River bed from the Canadian River fork to the Arkansas-Oklahoma border belongs to the Cherokee Nation in fee simple).

\textsuperscript{20} See Cherokee Nation Combined Response at 3 & n.1. See also LBP-94-5, 39 NRC at 68-71, for a discussion of the groundwater patterns surrounding the SFC facility.

\textsuperscript{21} The Staff points out in its June 22 response that the National Environmental Policy Act of 1969 (NEPA) protects some economic interests injured by environmental damage. See Staff Response to Combined Response/Supplement at 4 (citing Sacramento Municipal Utility District (Rancho Seco Nuclear Generating Station), CLI-92-2, 35 NRC 47, 56 (1992)).

\textsuperscript{22} LBP-94-5, 39 NRC at 67.

\textsuperscript{23} Id. at 68-69 (citing 58 Fed. Reg. 55,087, 55,087 (1993)).

\textsuperscript{24} Perry, CLI-93-21, 38 NRC at 95.
consequence, we find that the Cherokee Nation has sufficiently demonstrated injury in fact to provide the tribe, as an organization, with standing to intervene as of right in this proceeding.

B. The Cherokee Nation’s Contentions

In our May 23, 1994 order, we allowed the Cherokee Nation to amend its intervention application and instructed that the tribe list those contentions, with supporting bases, it desired to litigate in this proceeding. In its May 19 combined response that was submitted prior to the tribe's receipt of the Board’s May 23 order, the Cherokee Nation restates and adopts the contentions of NACE, albeit without providing any supporting bases for those contentions.

Longstanding Commission practice suggests that the benefit of the doubt should be given to the potential intervenor in order to obviate dismissal of an intervention petition because of inarticulate draftsmanship or procedural pleading defects. Because we have already found the NACE bases sufficient to warrant admission of the contentions they support, in this instance we conclude that no real purpose would be served by requiring that the tribe file a further supplemental response adopting those bases as well. Accordingly, we admit the Cherokee Nation’s two contentions.

III. CONCLUSION

The Cherokee Nation seeks to ensure that the Staff enforcement order contested in this proceeding is sustained, alleging that without the enforcement of that order there is the potential for continued radiological contamination

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25 The Cherokee Nation’s intervention application and its later supplements are less than articulate in explaining whether the tribe is seeking to intervene to protect its own organizational interests or those of its members. Of course, to represent the interests of its members, the tribe must identify at least one member who will be injured and obtain authorization to represent that individual. See, e.g., Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-535, 9 NRC 377, 390-96 (1976). The Cherokee Nation has not done this. Nonetheless, because the tribe has made a sufficient showing to establish its standing as an organization, we need not reach the question of whether its petition is sufficient to provide it with representational standing to protect the interests of its individual members.

26 See Cherokee Nation Combined Response at 4. As restated by the tribe, those contentions are:
1. The NRC has enforcement authority over General Atomics.
2. Guaranteed decommissioning financing by General Atomics is required by NRC regulations and is necessary to provide adequate protection to public health and safety, including the tribe’s members, as well as the property interest of the tribe.

See id.

27 See, e.g., Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), ALAB-146, 6 AEC 631, 633-34 (1973). See also LBP-94-8, 39 NRC at 120 & n.7.

28 Because NACE and the Cherokee Nation have proffered essentially identical contentions, at a future juncture the Board will consider whether and to what degree consolidation of their litigation presentations is appropriate. See 10 C.F.R. § 2.714(f).
of tribal property from groundwater migration. This continuing potential for contamination of tribal property from groundwater flow provides a cognizable injury to an interest within the zone of interests protected by the AEA. The alleged injury also appears to be sufficiently concrete and particularized. We thus find that the Cherokee Nation has established its standing as of right in this proceeding. Further, in adopting the already-admitted contentions of intervenor NACE, the tribe has presented litigable contentions. Accordingly, having fulfilled the requirements of 10 C.F.R. § 2.714, the Cherokee Nation is admitted as a party to this proceeding.

For the foregoing reasons, it is, this 7th day of July 1994, ORDERED that
1. The Cherokee Nation's April 20, 1994 intervention application is granted.
2. Contentions 1 and 2 set forth in the Cherokee Nation's May 19, 1994 combined response are admitted.
3. In accordance with the provisions of 10 C.F.R. § 2.714a(a), as this Memorandum and Order grants an intervention petition, it may be appealed to the Commission within 10 days after it is served.
MEMORANDUM AND ORDER
(Request for Hearing)

This informal adjudicatory proceeding, convened under 10 C.F.R. Part 2, Subpart L, involves an application by the Chemetron Corporation (Licensee) for a license amendment. The proposed amendment concerns the decommissioning of the Licensee’s Bert Avenue site in Newburgh Heights, Ohio, and its Harvard Avenue site and associated buildings at the McGean-Rohco property in Cuyahoga Heights, Ohio.

A request for hearing on the application has been submitted by Chris Trepal on behalf of the Earth Day Coalition (Coalition), which is referred to as a nonprofit environmental organization serving northeast Ohio. Responses in
opposition to the Coalition's hearing request have been filed by the Staff and the Chemetron Corporation.¹

BACKGROUND

The amendment at issue here authorizes the Licensee to decommission the sites listed above in accordance with a remediation plan submitted to the NRC. Notice of an opportunity for a hearing on the amendment application, for any person whose interest may be affected by the proceeding, was published in the Federal Register. See 59 Fed. Reg. 17,124 (Apr. 11, 1994).

Under informal hearing procedures authorized by the Commission's rules, a petitioner for a materials license amendment hearing is called upon to describe areas of concern about the proposed licensing action and how the petitioner's interest may be affected by the results thereof. The presiding officer is required to determine that the concerns listed are germane to the subject matter and that the petition is filed on a timely basis. Finally, the requestor must meet the Agency's judicial requirements for standing. See 10 C.F.R. § 2.1205(d)(g). These standing requirements, identical to contemporaneous standards in other judicial proceedings, require some demonstration that the challenged action could cause an injury-in-fact and that such injury is within the zone of interests protected by statute. See Sacramento Municipal Utility District (Rancho Seco Nuclear Generating Station), CLI-92-2, 35 NRC 47, 56 (1992).

There are several flaws to be noted in the requestor's petition which may, or may not, prove fatal to its request for a hearing on Licensee's amendment application. First, the hearing request does not make clear whom the petitioner represents. An organization may meet the injury-in-fact standing test by demonstrating an effect upon its organizational interest or injury to its members. See Houston Lighting and Power Co. (South Texas Project, Units 1 and 2), ALAB-549, 9 NRC 644, 646 (1979). Or it can represent a member of the organization who has a threatened interest if the representation is authorized by the member. See Florida Power and Light Co. (Turkey Point Nuclear Generating Plant, Units 3 and 4), ALAB-952, 33 NRC 521, 530 (1991).

Based on the petition's recital, the Coalition purports to involve itself in this proceeding as a focal point for residents of the area to raise concerns about the proceeding on their behalf. In this context, it does not appear to be an authorized representative of those residents; nor does it allege any potential injury to its own organizational interests. As pointed out in responses filed by both the Staff

¹ Staff Notice of Participation and Response to Petitioner's Request for Hearing (June 10, 1994) (Staff Response); Licensee Chemetron Corporation's Answer to Request for Hearing by Earth Day Coalition (June 9, 1994) (Licensee Answer).
and Licensee, an institutional interest in providing information to the public is insufficient for standing; and for representational purposes, the petitioner fails to identify at least one resident who could suffer injury from the challenged action and who has provided authorization for representation to the Coalition. Accordingly, Petitioner fails herein to cite any injury, actual or threatened, to either its organizational interests or those of its members. And with respect to acting for the area‘s residents generally, nothing in the Commission’s regulations authorizes requestors to undertake to represent the general public as if they were private attorneys general. See Babcock and Wilcox Co. (Pennsylvania Nuclear Services Operations, Parks Township, Pennsylvania), LBP-94-4, 39 NRC 47, 50 (1994). Also see Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), LBP-77-11, 5 NRC 481, 484 (1977).

The petitioner sets forth ten areas of concern about the proposed license amendment but herein, the second flaw in the Coalition’s request for a hearing makes its appearance. Under the Commission’s informal proceeding rules in Subpart L, the Presiding Officer is charged with determining whether the areas of concern submitted by the petitioner are germane to the proceeding’s subject matter. To exercise this responsibility, the basis for the Presiding Officer’s determination can only originate from information supplied by the requestor in its hearing petition. The Petitioner’s enumerated areas of concern, however, fail to demonstrate the connection existing between such areas and the license amendment in this proceeding. This is not to conclude that such connections do not exist, but merely that they are not manifest from the Coalition’s filing. It would serve no purpose to review the ten concerns individually at this time since most, if not all, suffer from the same deficiency — inadequate information to ground a determination that the Coalition’s concerns are germane to the subject matter of the proceeding. It is not necessary in the proceeding for a petitioner to set forth at this point all of the concerns it has about the proceeding, as the Commission recognizes that such a requirement would be inequitable without access to a hearing file. However, as indicated, there exists the necessity for linking the concerns registered in its hearing petition to the matter under consideration.

As a result of the foregoing, therefore, the petition presented does not provide sufficient information for a determination that standing requirements have been met or that the concerns submitted are germane to the proceeding. The Coalition petition does reveal, however, a background of concern by the organization in the subject matter — it alleges a “substantial interest in the site(s),” a “history of work and public interest advocacy on radioactive waste issues” and also a past participation “on behalf of residents” concerning the site. This familiarity,
interest, and involvement in the activities concerning the site combine to create a reflection that, provided the opportunity, the potential exists for the Coalition to clarify its petition and to establish standing as well as the relevancy of its concerns. Contemplation also needs to be given to the consideration that a civic organization like the Coalition, which does not appear to be represented by counsel, may not be aware of all of the Agency's informal hearing procedural requirements. Accordingly, it would appear to be inappropriate to deny its hearing request at this point. The Presiding Officer's action on this petition will therefore be deferred to permit the Coalition to supplement its petition to provide further information to remedy the deficiencies outlined above. The Petitioner is granted a 3-week period, dating from the receipt of this Order to provide any additional information it cares to provide in support of its hearing request. And the Staff and Licensee will have a 2-week period thereafter to respond.

The Licensee, but not the Staff, raises lateness objections to the Coalition's petition on grounds that the petition was filed 1 to 3 days late and the grant of the hearing request would cause undue prejudice and injury to the Chemetron Corporation. Based on the papers filed, it is not clear when the requestor's petition was filed. It is dated May 9, 1994, one day prior to the expiration of the 30 days allowed by the Federal Register notice, supra. NRC's practice reflects that filing is deemed complete as of the time it is deposited in the mail — not postmarked. 10 C.F.R. § 2.701(c). Due to the uncertainty concerning the actual filing date, which does not in any event involve an inordinate amount of time, and with the ruling herein granting additional time to supplement its hearing request in mind, it does not appear pertinent to dwell on whether the petitioner's request meets the Agency's lateness criteria. The Licensee's own response to the hearing request was substantially late in meeting filing requirements and any small delay encountered here should not, in light of the present circumstances of the case, be represented as constituting an untimely filing.

ORDER

1. Action is deferred on the Earth Day Coalition request for a hearing.
2. A supplement to the Coalition's request may be filed within a period of 3 weeks after receipt of this Order.

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3 As the Appeal Board has pointed out, reasonable opportunities to cure defects in petitions should be provided. See Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), ALAB-146, 6 AEC 631, 634 (1973).
3. The Staff and the Chemetron Corporation may file a response within a 2-week period after service of any supplement.

FOR THE ATOMIC SAFETY AND LICENSING BOARD

James P. Gleason, Presiding Officer
ADMINISTRATIVE JUDGE

Bethesda, Maryland
July 7, 1994
In this license suspension and modification enforcement proceeding, the Licensing Board rules on prediscovery dispositive motions regarding ten issues specified by the parties for litigation.

ENFORCEMENT ACTIONS: LEGAL BASIS

Under Atomic Energy Act provisions such as subsections (b) and (i) of section 161, 42 U.S.C. § 2201(b), (i), the agency’s authority to protect the public health and safety is uniquely wide-ranging. That, however, is not the same as saying that it is unlimited. In exercising that authority, including its prerogative to bring enforcement actions, the agency is subject to some restraints. See, e.g., Hurley Medical Center (One Hurley Plaza, Flint, Michigan), ALJ-87-2, 25 NRC 219, 236-37 & n.5 (1987) (NRC Staff cannot apply a comparative-performance standard in civil penalty proceedings absent fair notice to licensees about the
parameters of that standard). One of those constraints is the requirement of constitutional due process.

ENFORCEMENT ACTIONS: CONSTITUTIONAL DUE PROCESS REQUIREMENTS (NOTICE OF CHARGES; OPPORTUNITY FOR RESPONSE)

DUE PROCESS: ENFORCEMENT ACTIONS (NOTICE OF CHARGES; OPPORTUNITY FOR RESPONSE)

A party responding to an agency enforcement complaint has been accorded due process so long as the charges against it are understandable and it is afforded a full and fair opportunity to meet those charges. See Citizens State Bank v. FDIC, 751 F.2d 209, 213 (8th Cir. 1984). Put somewhat differently, "'[p]leadings in administrative proceedings are not judged by standards applied to an indictment at common law,' but are treated more like civil pleadings where the concern is with notice . . . ." Id. (quoting Aloha Airlines, Inc. v. CAB, 598 F.2d 250, 262 (D.C. Cir. 1979)).

ENFORCEMENT ACTIONS: CONSTITUTIONAL DUE PROCESS REQUIREMENTS (NOTICE OF CHARGES; OPPORTUNITY FOR RESPONSE)

DUE PROCESS: ENFORCEMENT ACTIONS (NOTICE OF CHARGES; OPPORTUNITY FOR RESPONSE)

When there is no claim of a lack of understanding regarding the nature of the charges in an NRC Staff enforcement order, the fact that the validity of the Staff’s assertions have not been litigated is no reason to preclude the Staff from utilizing those charges as a basis for the order. The adjudicatory proceeding instituted pursuant to 10 C.F.R. § 2.202 affords those who are adversely affected by the order with an opportunity to contest each of the charges that make up the Staff’s enforcement determination, an opportunity intended to protect their due process rights. The “unlitigated” nature of the Staff’s allegations in an enforcement order thus is not a constitutional due process deficiency that bars Staff reliance on those allegations as a component of the enforcement order.

RULES OF PRACTICE: COLLATERAL ESTOPPEL; RES JUDICATA

Issue and claim preclusion principles (i.e., res judicata and collateral estoppel) are applicable in NRC adjudicatory proceedings. See, e.g., Ohio Edison Co.
ENFORCEMENT ACTIONS: SUFFICIENCY OF CHARGES (HEARSAY)

EVIDENCE: HEARSAY

RULES OF PRACTICE: HEARSAY EVIDENCE

The fact that the NRC Staff’s charges in support of an enforcement order may be “hearsay” allegations does not provide sufficient reason to dismiss those claims ab initio. See Oncology Services Corp., LBP-93-20, 38 NRC 130, 135 n.2 (1993) (hearsay evidence generally admissible in administrative hearing if reliable, relevant, and material). Rather, so long as those allegations are in dispute, the validity and sufficiency of any “hearsay” information upon which they are based generally is a matter to be tested in the context of an evidentiary hearing in which the Staff must provide adequate probative evidence to carry its burden of proof.

ENFORCEMENT ACTIONS: SUFFICIENCY OF CHARGES

One or more of the bases put forth by the NRC Staff as support for an enforcement order may be subject to dismissal if it is established they lack a sufficient nexus to the regulated activities that are the focus of the Staff’s enforcement action.

LICENSING BOARDS: AUTHORITY TO DISMISS ISSUES IN ENFORCEMENT PROCEEDING

RULES OF PRACTICE: DISMISSAL OF ISSUES IN ENFORCEMENT PROCEEDING

In a proceeding regarding an NRC Staff enforcement order, consistent with the analogous agency rules regarding contentions filed by intervenors, see 10 C.F.R. § 2.714(d)(2)(ii), if it can be established that there is no set of facts that would entitle a party to relief relative to a proposed issue, then dismissal of that issue is appropriate. See Oncology Services Corp., LBP-94-2, 39 NRC 11, 23 n.8 (1994).
ENFORCEMENT ACTIONS: SCOPE OF PROCEEDINGS

As is evident from the Commission's enforcement policy statement, regulatory requirements— including license conditions— have varying degrees of public health and safety significance. See 10 C.F.R. Part 2, App. C, § IV & n.5. Consequently, as part of the enforcement process, the relative importance of each purported violation is evaluated, which includes taking a measure of its technical and regulatory significance, as well as considering whether the violation is repetitive or willful. See id. §§ IV.B, IV.C. Although, in contrast to civil penalty actions, there generally is no specification of a "severity level" for the violations identified in an enforcement order imposing a license termination, suspension, or modification, see id. § VI.C, this evaluative process nonetheless is utilized to determine the type and severity of the corrective action taken in the enforcement order.

ENFORCEMENT ACTIONS: SCOPE OF PROCEEDINGS

In making a determination about whether a license suspension or modification order should be sustained, a presiding officer must undertake an evaluative process that may involve assessing, among other things, whether the bases assigned in the order support it both in terms of the type and duration of the enforcement action. And, just as with the NRC Staff's initial determination about imposition of the enforcement order, a relevant factor may be the public health and safety significance of the bases specified in the order.

ENFORCEMENT ACTIONS: SCOPE OF PROCEEDINGS

As the Commission recently noted, "the choice of sanction is quintessentially a matter of the agency's sound discretion." Advanced Medical Systems, Inc. (One Factory Row, Geneva, Ohio 44041), CLI-94-6, 39 NRC 285, 312 (1994) (footnote omitted). In this regard, a presiding officer's review of an NRC Staff enforcement action would be limited to whether the Staff's choice of sanction constituted an abuse of that discretion.

MEMORANDUM AND ORDER
(Ruling on Prediscovery Dispositive Motions)

In this proceeding, Licensee Indiana Regional Cancer Center (IRCC) and Dr. James E. Bauer, IRCC's Radiation Protection Officer (RSO) and sole authorized user, (collectively IRCC/Dr. Bauer) challenge a November 1993 immediately
effective NRC Staff enforcement order. The order in question suspends and modifies IRCC's byproduct materials license authorizing the use of a strontium-90 source for the treatment of superficial eye conditions. Currently pending before the Licensing Board are dispositive motions filed by IRCC/Dr. Bauer and the Staff. In their motions, the parties address the issue of whether one of the chief grounds for the Staff's order — Dr. Bauer's involvement in a November 1992 incident at IRCC concerning the administration of a high dose rate (HDR) brachytherapy treatment under a different NRC license authorizing the use of iridium-192 — is an appropriate basis for that order. In addition, the Staff asserts that four of the central issues proposed for litigation by IRCC/Dr. Bauer are subject to dismissal from the proceeding.

For the reasons detailed herein, we find that the Staff is not precluded as a matter of law from relying on the November 1992 incident as a basis for its November 1993 enforcement order. We further conclude, as the Staff requests, that an IRCC/Dr. Bauer issue regarding "patient need" for strontium-90 skin lesion treatments should be dismissed. We decline, however, to grant the Staff's petition to dismiss several other issues concerning the medical appropriateness and public health and safety risks of such treatments and whether the licensee's provision of a patient log constituted submitting "complete and accurate information" to the agency as NRC rules require.

I. BACKGROUND

The November 16, 1993 Staff enforcement order at issue in this proceeding suspends IRCC's authority under Byproduct Materials License No. 37-28179-01 to receive or use any strontium-90 and modifies that license to, among other things, prohibit Dr. Bauer from engaging in any activities under the license. See 58 Fed. Reg. 61,932, 61,933 (1993). The order recites three principal bases as support for suspending and modifying IRCC's byproduct materials license: (1) Dr. Bauer's purported performance of activities with the strontium-90 source that were not authorized under the license; (2) Dr. Bauer's alleged failure to provide complete and accurate information to NRC inspectors during a November 11, 1993 inspection of IRCC facilities; and (3) Dr. Bauer's supposed failure to cause an adequate survey of a patient to be made during a November 16, 1992 HDR brachytherapy treatment at IRCC that resulted in a significant radiation exposure to the patient and members of the general public. See id. at 61,932-33. This third matter is also a subject in dispute in a separate enforcement proceeding involving the suspension of an iridium-192 byproduct materials license held by IRCC's parent company, Oncology Services Corporation (OSC). See, e.g., Oncology Services Corp., LBP-94-2, 39 NRC 11, 15 (1994).
Acting pursuant to the Board’s December 17, 1993 initial prehearing order, see Memorandum and Order (Initial Prehearing Order) (Dec. 17, 1993) at 4-5 (unpublished), on January 18, 1994, the parties filed a joint prehearing report in which they specified the central issues for litigation in this proceeding. See Joint Prehearing Report (Jan. 18, 1994) at 1-4 [hereinafter Joint Prehearing Report]. Thereafter, in accordance with the Board’s February 1, 1994 prehearing conference order, see Order (Prehearing Conference Order) (Feb. 1, 1994) at 1-2 (unpublished), on February 28, 1994, both IRCC/Dr. Bauer and the Staff filed dispositive motions relative to several of those issues. See NRC Staff Motion for Summary Disposition and Motion for Dismissal (Feb. 28, 1994) [hereinafter Staff Dispositive Motions]; Motion to Eliminate Basis for Suspension (Feb. 28, 1994) [hereinafter IRCC/Dr. Bauer Dispositive Motion]. The parties also have availed themselves of the opportunity to file a response to these motions and to submit a reply to the opposing party responses. See NRC Staff’s Response to Motion to Eliminate Basis for Suspension (Mar. 31, 1994); Response to NRC Staff Motion for Summary Disposition and Motion for Dismissal (Mar. 31, 1994) [hereinafter IRCC/Dr. Bauer Response to Staff Dispositive Motions]; NRC Staff Reply to IRCC’s Response to NRC Staff Motion for Summary Disposition and Motion for Dismissal (Apr. 15, 1994); Reply to NRC Staff’s Response to Motion to Eliminate Basis for Suspension (Apr. 14, 1994).

In their dispositive motions, both the Staff and IRCC/Dr. Bauer seek a ruling on whether the Staff can rely on Dr. Bauer’s purported involvement in the November 1992 iridium-192 HDR brachytherapy treatment incident as a basis for the November 1993 enforcement order regarding strontium-90 use by IRCC and Dr. Bauer. In addition, the Staff asks that four of the central issues for litigation proposed by IRCC/Dr. Bauer be dismissed from this proceeding. These include whether use of strontium-90 for treating skin lesions on two patients was medically appropriate (IRCC/Dr. Bauer Issue 1); whether use of strontium-90 for skin lesion treatments on two patients posed a risk to the public health, safety, or interest (IRCC/Dr. Bauer Issue 2); whether providing a patient treatment log constitutes providing complete and accurate information to the NRC (IRCC/Dr. Bauer Issue 3); and whether substantial patient need exists for strontium-90 treatments at IRCC (IRCC/Dr. Bauer Issue 14).

II. ANALYSIS

A. IRCC/Dr. Bauer Motion to Eliminate Basis and Staff Motion for Summary Disposition

I. The “Improper Basis” Issue

In their joint prehearing report, the parties mutually identified the following as the fifth central issue for litigation (Joint Issue 5) in this proceeding:
Whether Dr. Bauer's alleged conduct under License No. 37-28540-01 (HDR license), which is subject to pending litigation, can, as a matter of law, be a basis for the suspension of License No. 37-28179-01 (Strontium-90 license)?

Joint Prehearing Report at 2. Both IRCC/Dr. Bauer and the Staff, albeit in somewhat different ways, seek a dispositive ruling on this issue.

In their pleading entitled "Motion to Eliminate Basis," IRCC/Dr. Bauer assert that the Staff's reference to the November 1992 incident as a grounds for the November 1993 enforcement order violates fifth amendment due process guarantees. This is so, they contend, because the Staff's allegations of conduct under the HDR license are unadjudicated, and thus cannot provide a basis for the enforcement order. In addition, they maintain that the Staff's reliance on the November 1992 incident is improper because any allegations regarding Dr. Bauer's conduct relative to that incident are irrelevant and immaterial to this enforcement action. As a result, IRCC/Dr. Bauer conclude, we must prevent the Staff from using the HDR incident as support for its November 1993 order by eliminating it as a basis for the order. See IRCC/Dr. Bauer Dispositive Motion at 4-11.

Asserting that there are no material factual issues relative to Joint Issue 5, the Staff declares that it is entitled to summary disposition regarding that matter. According to the Staff, its authority to utilize the HDR incident as a basis for suspending and modifying the IRCC license arises from (1) the agency's uniquely broad authority under the Atomic Energy Act (AEA), see Siegel v. AEC, 400 F.2d 778, 783 (D.C. Cir. 1968); (2) subsections (b) and (i) of AEA section 161, 42 U.S.C. § 2201(b), (i), which empower the Commission to issue orders to protect health or minimize danger to life or property; (3) AEA section 186a, id. § 2236(a), which permits the Commission to revoke, and by implication suspend, a license for failure to observe any Commission regulation; and (4) 10 C.F.R. § 2.202(a)(1), which provides that in issuing orders the Staff may consider any facts deemed a sufficient ground for a proposed enforcement action. See Staff Dispositive Motions at 8.

The Staff declares that the foundation of the November 1993 order is its conclusion (presumably pursuant to AEA sections 161b and 161i) that it lacked the requisite reasonable assurance that IRCC's operations can be conducted consistent with agency regulations and in a manner that would adequately protect the public health and safety. This Staff conclusion, in turn, is based in significant measure upon a determination that as the RSO and the only authorized user on the IRCC strontium-90 license, Dr. Bauer is unable or unwilling to assure that the Commission's requirements are being and will be followed. And, according to the Staff, the November 1992 incident is pertinent to this finding because it casts doubt upon Dr. Bauer's ability to follow the Commission's regulations and
to conduct licensed activities, including those under the strontium-90 license, in a manner that ensures protection of the public health and safety. See id. at 9.

Relative to its other cited authorities, the Staff asserts that its reliance on the November 1992 incident is consonant with AEA section 186 and with 10 C.F.R. § 35.18, which is a regulation providing that a byproduct materials license will be issued only if an applicant is found to be equipped and committed to observing the Commission's safety standards. The Staff contends that consistent with these provisions it is free to consider any actions by the licensee or those, such as Dr. Bauer, who are named in the license, that bear on the safe conduct of licensed activities. See id. In addition, the Staff maintains that its reliance upon the November 1992 incident — the Staff's allegations about which are as yet unlitigated — is fully in accord with 10 C.F.R. § 2.202 and the Commission's broad authority to protect the public health and safety. See id. at 9-11.

Finally, in its summary disposition motion the Staff claims that of the fourteen other issues proposed for litigation by IRCC/Dr. Bauer, five appear to be closely related to Joint Issue 5. See id. at 7 n.4. Those issues are as follows:

4. Whether allegations regarding Dr. Bauer's conduct on November 12, 1992 are relevant to this proceeding in that they involve a different source, a different license, and an entirely distinguishable factual setting?

5. Whether admission of evidence regarding Dr. Bauer's conduct on November 12, 1992 is improperly prejudicial given the posture of this proceeding and the confusion of issues likely to arise from the admission of that evidence?

6. Whether admission of evidence regarding Dr. Bauer's conduct on November 12, 1992 amounts per se to a denial of the due process rights of Dr. Bauer and the Licensee?

7. Whether admission of evidence into this proceeding regarding Dr. Bauer's conduct on November 12, 1992 amounts to a denial of due process rights of Dr. Bauer and the Licensee because Dr. Bauer and the Licensee have been denied the opportunity to review material in the NRC's possession regarding Dr. Bauer's conduct on November 12, 1992?

8. Whether allegations regarding Dr. Bauer's conduct on November 12, 1992 are admissible in this proceeding in that Dr. Bauer has yet to have the opportunity to contest any implication of fault at a hearing and there has been no finding of fault against him?

Joint Prehearing Report at 3. The Staff asserts that a ruling in its favor regarding Joint Issue 5 compels the dismissal of these issues as well.

2. **The Board's Determination**

The Staff correctly notes that under AEA provisions such as subsections (b) and (i) of section 161, the agency's authority to protect the public health and safety is uniquely wide-ranging. That, however, is not the same as saying that it is unlimited. In exercising that authority, including its prerogative to bring
enforcement actions, the agency is subject to some restraints. See, e.g., Hurley Medical Center (One Hurley Plaza, Flint, Michigan), ALJ-87-2, 25 NRC 219, 236-37 & n.5 (1987) (Staff cannot apply a comparative-performance standard in civil penalty proceedings absent fair notice to licensees about the parameters of that standard).

One of those constraints is the requirement of constitutional due process, which IRCC/Dr. Bauer have invoked in challenging the Staff’s use of the November 1992 incident. See IRCC/Dr. Bauer Dispositive Motion at 4-8. It has been observed, however, that a party responding to an agency enforcement complaint has been accorded due process so long as the charges against it are understandable and it is afforded a full and fair opportunity to meet those charges. See Citizens State Bank v. FDIC, 751 F.2d 209, 213 (8th Cir. 1984). Put somewhat differently, "'[p]leadings in administrative proceedings are not judged by standards applied to an indictment at common law,' but are treated more like civil pleadings where the concern is with notice . . . ." Id. (quoting Aloha Airlines, Inc. v. CAB, 598 F.2d 250, 262 (D.C. Cir. 1979)).

Under these standards, the due process complaint posited by IRCC/Dr. Bauer is not persuasive. They do not claim a lack of understanding regarding the nature of the charges; rather, they contend that they should not be required to meet the Staff’s claims because they do not "rise above the level of 'mere allegation.'" IRCC/Dr. Bauer Dispositive Motion at 11. The fact that the validity of the Staff’s assertions regarding the November 1992 incident has not been litigated is no reason to preclude the Staff from utilizing those charges as a basis for the November 1993 order. Indeed, this very proceeding affords IRCC/Dr. Bauer with an opportunity to contest each of the charges that make up the Staff’s enforcement determination, an opportunity intended to protect their due process rights. The “unlitigated” nature of the Staff’s allegations regarding the November 1992 incident thus is not a constitutional due process deficiency that bars Staff reliance on the incident as a component of the enforcement order at issue here.

In addition to their due process concerns, IRCC/Dr. Bauer also contest the Staff’s reliance on the November 1992 incident on the general grounds of “relevance” and “materiality.” Id. at 9-11. Their central contention in this regard — which appears to hark back to their general due process concern, see

1 In fact, taking the IRCC/Dr. Bauer position to its logical conclusion, the Staff would be hard pressed to bring just about any enforcement action because in most instances the bases for those proceedings are the activities of licensees or others that have not been the subject of litigation.

2 As was noted earlier, a challenge to the Staff’s claims about the November 1992 incident also is pending in a separate proceeding. See supra p. 26. Whether the circumstances surrounding that incident are first tried in that case or in this proceeding may have implications in terms of invoking issue or claim preclusion principles (i.e., res judicata or collateral estoppel), which are applicable in NRC adjudicatory proceedings. See, e.g., Ohio Edison Co. (Perry Nuclear Power Plant, Unit I), LBP-92-32, 36 NRC 269, 283 & n.27 (1992) (citing cases), petitions for review pending, Nos. 92-1665, 93-1665, 93-1672, 93-1673 (D.C. Cir.).
id. at 5-6 — is framed in terms of the uncorroborated "hearsay" nature of the allegations involved.

Even accepting their characterization of the Staff’s claims as "hearsay" allegations, this label alone does not provide sufficient reason to dismiss those claims ab initio. See Oncology Services Corp., LBP-93-20, 38 NRC 130, 135 n.2 (1993) (hearsay evidence generally admissible in administrative hearing if reliable, relevant, and material). Rather, so long as those allegations are in dispute, the validity and sufficiency of any "hearsay" information upon which they are based generally is a matter to be tested in the context of an evidentiary hearing in which the Staff must provide adequate probative evidence to carry its burden of proof.

Besides asserting that the Staff’s allegations are "hearsay," IRCC/Dr. Bauer also state that the Staff’s claims do not relate "in any substantive way" to the IRCC strontium-90 license. IRCC/Dr. Bauer Dispositive Motion at 9. Although in their initial motion they do not delineate what this means, in their response to the Staff’s summary disposition request they contend that the November 1992 incident is too remote from the alleged-improper activities under the strontium-90 license given there are different licensees (OSC v. IRCC), different radiation safety officers (OSC corporate RSO Dr. David E. Cunningham v. Dr. Bauer), and different authorized nuclear materials (iridium-192 v. strontium-90). See IRCC/Dr. Bauer Response to Staff Dispositive Motions at 6.

There might well be instances in which one or more of the bases put forth by the Staff as support for an enforcement order would be subject to dismissal as lacking a sufficient nexus to the regulated activities that are the focus of the Staff’s enforcement action. This is not such a case, however.

If, for the purpose of ruling on the IRCC/Dr. Bauer dispositive motion, we accept what has been pled by the Staff in that order as true, the factual circumstances set forth in the order regarding the November 1992 incident and Dr. Bauer’s activities relating to that incident bear a sufficient link to the challenged activities under the strontium-90 license to permit the November 1992 incident to provide a basis for this enforcement action. A central connecting factor is that Dr. Bauer, as an authorized user under both licenses, was substantially involved (either as a supervisor or the administering physician) in providing treatments using licensed materials in a manner that the Staff finds was not in conformance with agency requirements. This question about the ability of Dr. Bauer (and thus IRCC for whom he serves as RSO and sole authorized user) to operate in conformance with Commission regulatory requirements provides the nexus that links the November 1992 incident under the OSC iridium-192 license with events at IRCC under the strontium-90 license and allows the earlier incident to be invoked as support for the November 1993 enforcement order.
We thus deny the IRCC/Dr. Bauer motion to eliminate the November 1992 incident as a basis for the Staff's November 1993 enforcement order. Further, there being no material factual issues in dispute regarding Joint Issue 5, we find in favor of the Staff regarding that issue, concluding that as a matter of law the Staff is not precluded from utilizing Dr. Bauer's alleged conduct regarding the November 1992 incident as a basis for suspending and modifying the IRCC strontium-90 license. This finding, however, is made with the understanding that the Staff continues to bear the burden of demonstrating that the allegations it has put forth in its November 1993 order are sufficient to sustain that order.

Having found in the Staff's favor regarding Joint Issue 5, we must also consider the Staff's assertion that the five additional IRCC/Dr. Bauer issues should be dismissed. We agree with the Staff about four of those issues. IRCC/Dr. Bauer Issues 4, 5, 6, and 8 embody particular arguments as to why they should prevail on the general issue set forth in Joint Issue 5. Having dealt with those assertions in ruling in the Staff's favor on Joint Issue 5, those particular issues are for all practical purposes moot and so can be dismissed from this proceeding.

IRCC/Dr. Bauer Issue 7 is different. Based on the information now before us, we are unable to conclude there are no material factual issues regarding the IRCC/Dr. Bauer assertion that they have been denied the opportunity to review material in the agency's possession regarding Dr. Bauer's conduct in the November 1992 incident. Nor have we been presented with any arguments demonstrating why such a denial would not be a deprivation of due process. Accordingly, we deny the Staff's request that this issue be dismissed, with the caveat that any of the parties is free to file a postdiscovery dispositive motion relative to this issue.

B. Staff Motion to Dismiss

The Staff also seeks dismissal of four additional issues proposed by IRCC/Dr. Bauer for litigation in this proceeding. The four issues are as follows:

1. Whether the use of the strontium-90 as treatment for skin lesions on the two identified patients was medically appropriate treatment?

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3 In support of its summary disposition motion, the Staff put forth two statements of material fact not in issue. The first declares that the November 1993 enforcement order relied upon Dr. Bauer's conduct under the iridium-192 license, while the other states that Dr. Bauer's conduct under the iridium-192 license is subject to another pending adjudicatory proceeding. See Staff Dispositive Motions at 5. Although IRCC/Dr. Bauer agree that the two statements of material fact put forth by the Staff in support of its summary disposition motion are material and relevant, they nonetheless state that they "contest any assertion that there is no genuine issue to be heard with regard to these facts." IRCC/Dr. Bauer Response to Staff Dispositive Motions at 3. They fail, however, to make any showing establishing how there is a dispute over these factual statements, and we can perceive none. See Advanced Medical Systems, Inc. (One Factory Row, Geneva, Ohio 44041), CLI-94-6, 39 NRC 285, 308 (1994) (mere assertions of dispute over material issues of fact do not invalidate grant of summary disposition).
2. Whether there was any risk to the public health, safety or other interest by virtue of the use of the strontium-90 as treatment for skin lesions on the two identified patients?

3. Whether provision of the patient treatment log constitutes provision of complete and accurate information by the Licensee to the NRC?

14. Whether substantial patient need exists for Strontium-90 treatment at IRCC?

Joint Prehearing Report at 3, 4. As we have previously noted in the Oncology Services Corp. proceeding, if it can be established that there is no set of facts that would entitle IRCC/Dr. Bauer to relief relative to these proposed issues, then dismissal is appropriate. See LBP-94-2, 39 NRC at 23 & n.8.4

1. IRCC/Dr. Bauer Issues 1 and 2

Regarding IRCC/Dr. Bauer Issue 1 — the medical appropriateness of the strontium-90 skin lesion treatments — the Staff correctly points out that whether or not the treatments were medically appropriate would not, in and of itself, be a valid defense to the allegation in the order that Dr. Bauer performed activities that were not authorized under the license. Either Dr. Bauer’s activities were or were not authorized by the license and, if they were not, then Dr. Bauer (as the sole authorized user) was conducting activities in violation of the license. Nonetheless, in conjunction with IRCC/Dr. Bauer Issue 2 concerning the public health and safety risks of the treatments, this “medically appropriate treatment” issue may be relevant to another aspect of our determination about whether the Staff’s order should be sustained. This is the question of the extent or duration of the license suspension and modification imposed by the order.

As is evident from the Commission’s enforcement policy statement, regulatory requirements — including license conditions — have varying degrees of public health and safety significance. See 10 C.F.R. Part 2, App. C, § IV & n.5. Consequently, as part of the enforcement process, the relative importance of each purported violation is evaluated, which includes taking a measure of its technical and regulatory significance, as well as considering whether the violation is repetitive or willful. See id. §§ IV.B, IV.C. Although, in contrast to civil penalty actions, there generally is no specification of a “severity level” for the violations identified in an enforcement order imposing a license termination, suspension, or modification, see id. § VI.C, this evaluative process nonetheless

4 IRCC/Dr. Bauer suggest that the Staff cannot properly seek dismissal of these issues because they are put forth as “defense issues.” See IRCC/Dr. Bauer Response to Staff Dispositive Motions at 7-8. As we have noted previously, consistent with the analogous agency rules regarding contentions filed by intervenors, see 10 C.F.R. § 2.714(d)(2)(ii), these issues are subject to dismissal under the appropriate circumstances. See Oncology Services Corp., LBP-94-2, 39 NRC at 23 n.8.
is utilized to determine the type and severity of the corrective action taken in the enforcement order.

In making a determination about whether a license suspension or modification order should be sustained, we must undertake a similar process in that we must assess, among other things, whether the bases assigned in the order support it both in terms of the type and duration of the enforcement action.\(^5\) And, just as with the Staff's initial determination about imposition of the enforcement order, a relevant factor may be the public health and safety significance of the bases specified in the order.\(^6\)

As a consequence, there may be a set of facts under which IRCC/Dr. Bauer Issue 2 would be relevant to our determination here. Further, the question of whether the treatment involved was "medically appropriate" may be germane to the public health and safety significance of some of the bases of the order. Accordingly, as it relates to IRCC/Dr. Bauer Issue 2, we find IRCC/Dr. Bauer Issue 1 to be an appropriate matter for litigation in this proceeding as well.

2. IRCC/Dr. Bauer Issue 3

With their Issue 3, IRCC/Dr. Bauer apparently call into question the Staff's finding that, contrary to agency regulations, Staff inspectors were not provided with complete and accurate information regarding the use of strontium-90 for purposes other than the treatment of superficial eye conditions as authorized under the IRCC license. The Staff asserts that because the focus of the order is on the alleged initial failure of Dr. Bauer to identify strontium-90 skin lesion treatments when questioned by inspectors, the Licensee's subsequent action in turning over the patient treatment log is irrelevant to the regulatory violations involved. This, the Staff concludes, mandates that the issue be dismissed.

We do not agree with the Staff's analysis regarding this issue. As Joint Issues 2, 3, 4, and 9 indicate, the Staff and IRCC/Dr. Bauer disagree regarding the substance and significance of the conversations between Dr. Bauer and agency inspectors regarding their information requests. Whether or not the patient log has any regulatory significance as "complete and accurate information" seemingly will depend upon how those factual disputes are resolved. Accordingly, we deny the Staff's dismissal request relative to this issue as well.

\(^5\) As the Commission recently noted, "the choice of sanction is quintessentially a matter of the agency's sound discretion." Advanced Medical Systems, Inc., CLI-94-6, 39 NRC at 312 (footnote omitted). In this regard, our review would be limited to whether the Staff's choice constituted an abuse of that discretion.

\(^6\) This, of course, can be contrasted with the Staff's consideration of postenforcement order matters such as the Licensee's efforts to correct alleged deficiencies that are not necessarily appropriate subjects for litigation in a challenge to the enforcement action. See LBP-94-2, 39 NRC at 25-26.
3. IRCC/Dr. Bauer Issue 14

This issue is the same as one we dealt with previously in the Oncology Services Corp. proceeding. As we indicated there, "[w]hatever the patient 'need' for the treatment with licensed materials, the agency cannot authorize their use until it is satisfied that the licensee will act consistent with [the AEA's] statutory mandate [of protecting the public health and safety]." LBP-94-2, 39 NRC at 26. We likewise find this issue to be irrelevant to our consideration of whether the Staff's November 1993 order should be sustained and thus we dismiss it.

III. CONCLUSION

After evaluating the parties' filings, we conclude that there is no legal bar to the Staff utilizing Dr. Bauer's conduct during the November 1992 incident as a basis for the November 1993 enforcement order at issue in this proceeding. We therefore deny the request of IRCC/Dr. Bauer to preclude the Staff from using the incident as a basis for this proceeding and, finding no material issues in dispute, grant the Staff's motion for summary disposition on the same point. This ruling also leads us to dismiss related IRCC/Dr. Bauer Issues 4, 5, 6, and 8 as moot. In addition, we grant the Staff's request to dismiss IRCC/Dr. Bauer Issue 14 as not germane to this proceeding. Finally, because we find IRCC/Dr. Bauer Issues 1, 2, 3, and 7 involve matters for which IRCC/Dr. Bauer might be entitled to some relief, we deny the Staff's request for dismissal of those issues.

For the foregoing reasons, it is, this 12th day of July 1994, ORDERED that:
1. The IRCC/Dr. Bauer February 28, 1994 motion to eliminate basis for suspension is denied.
2. The Staff's February 28, 1994 motion for summary disposition regarding Joint Issue 5 is granted and related IRCC/Dr. Bauer Issues 4, 5, 6, and 8 are dismissed as moot.
3. The Staff's February 28, 1994 motion for summary disposition regarding IRCC/Dr. Bauer Issue 7 is denied.
4. The Staff's February 28, 1994 motion to dismiss regarding IRCC/Dr. Bauer Issues 1, 2, and 3 is denied.
5. The Staff's February 28, 1994 motion to dismiss regarding IRCC/Dr. Bauer Issue 14 is granted.  

THE ATOMIC SAFETY AND LICENSING BOARD

G. Paul Bollwerk, III, Chairman
ADMINISTRATIVE JUDGE

Charles N. Kelber
ADMINISTRATIVE JUDGE

Peter S. Lam
ADMINISTRATIVE JUDGE

Rockville, Maryland
July 12, 1994

7 Copies of this Memorandum and Order are being sent this date to counsel for IRCC/Dr. Bauer by facsimile transmission and to Staff counsel by E-mail transmission through the agency's wide area network system.
The Licensing Board determines that an Intervenor may move to admit into the proceeding a new basis for an already admitted contention. When it does so, the requirements for a late-filed contention are not applicable, but the Intervenor must show that it is timely to consider the new basis, in light of its seriousness and of the timeliness with which it has been raised. The Licensing Board also permitted Intervenor to file a reply to Applicant’s response to his motion to add a new basis to his contention.

RULES OF PRACTICE: NEW BASIS FOR CONTENTION; LATE FILING

Once a contention has been admitted, Intervenor may litigate a new basis for the admitted contention (falling within the scope of the contention) without meeting the five-pronged test for a late-filed contention. The test for admitting
the new basis is whether it is timely to consider the new basis, in light of its seriousness and of the timeliness with which it has been raised. The more serious the safety implications of the proposed new basis, the less important delay in presenting the basis.

RULES OF PRACTICE: BASIS OF CONTENTION; INTERVENOR NEED FILE BASES IT INTENDS TO RELY ON

There is no regulatory requirement that an intervenor supply all the bases known at the time he files a contention. What is required is the filing of bases that the intervenor intends to rely on. 10 C.F.R. § 2.714(b)(2)(ii).

RULES OF PRACTICE: BASIS OF CONTENTION; INTERVENOR MAY REPLY TO APPLICANT'S RESPONSE

Intervenor may reply to Applicant's Response to Intervenors' Motion for a new basis for its contention. In that reply, Intervenor should demonstrate, with particularity: (1) that he understands the answers that have been filed and that (despite those answers) there is an important, genuine issue of fact that Georgia Power has materially misled the Staff of the Commission concerning the public safety and health, and (2) that he did not unnecessarily delay the filing of this new basis for its contention.

MEMORANDUM AND ORDER
(Motion to Accept Additional Factual Basis)

I. MEMORANDUM

Mr. Allen Mosbaugh (Intervenor) moves to admit into this proceeding a new basis for his admitted contention. The new basis he advances is an allegation that Georgia Power misled the Nuclear Regulatory Commission concerning an improper opening of the containment equipment hatch, breaching containment integrity, during the March 20, 1990 site area emergency. 1 Georgia Power has responded to this motion in an extensive factual filing that appears to demonstrate that the new basis is without factual merit. 2 Georgia Power and

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1 Intervenor's Motion to Accept Additional Factual Basis in Support of the Admitted Contention, July 6, 1994 (Intervenor's Motion).
2 Georgia Power Company's "Answer to Intervenors' Motion to Accept Additional Factual Basis in Support of the Admitted Contention," July 21, 1994 (Georgia Power's Answer); Staff of the Nuclear Regulatory Commission, "Response to Intervenor Motion for Admission of Late-Filed Contention Basis," July 26, 1994 (Staff's Response).
the Staff argue that Intervenor’s motion is seeking to raise a new “issue” in an untimely fashion.

We have admitted into this proceeding Intervenor’s following contention:

The license to operate the Vogtle Electric Generating Plant, Units 1 and 2, should not be transferred to Southern Nuclear Operating Company, Inc., because it lacks the requisite character, competence, and integrity, as well as the necessary candor, truthfulness, and willingness to abide by regulatory requirements.

This contention was based on specific allegations about: (1) false or misleading statements about Vogtle’s diesel generators, and (2) illegal transfer of the authority to operate the Vogtle Plant.

A licensing board has the authority to make an appropriate decision about whether the new basis shall be admitted. It has the authority to conduct a fair and impartial hearing and to take appropriate action to avoid delay. We note that a licensing board, in an analogous context, held that an issue that fell within an admitted contention could be litigated. The test that was developed and applied, to determine whether to admit the new issue, was “whether the motion was timely and whether it presents important information regarding a significant issue.” Consumers Power Co. (Midland Plant, Units 1 and 2), LBP-84-20, 19 NRC 1285, 1296 (1984). We accept this test.

Since Intervenor’s new basis falls within the scope of an admitted contention, he is not seeking to raise a new contention; therefore, we have concluded that there is no merit to the joint claim of Georgia Power and the Staff that we should apply the new-contention requirements to the new allegations. There is no regulatory requirement that an intervenor supply all the bases known at the time he files a contention. What is required is the filing of bases that the intervenor intends to rely on.

We note that we had stated, in our unpublished order of June 2, 1994, at 3-4, that we would consider whether or not to admit a new basis as a new contention. After considering the arguments of the parties, we now conclude that it is not necessary to apply new contention requirements to a new basis for an admitted contention. The question before us is whether it is timely to consider the new basis, in light of its seriousness and of the timeliness with which it has been raised.

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4 10 C.F.R. §2.718.
5 10 C.F.R. §2.714(a)(1).
6 Petitioner is required to disclose the bases for his contention that he intended to rely on at the Hearing at the time he filed his case. 10 C.F.R. §2.714(b)(2)(ii). We conclude that Petitioner has given enough explanation in his filing for us to understand why he did not intend to rely on the new allegation at the time he filed his initial contention. Intervenor’s Motion at 3.
7 Our order was cited in the Staff Response at 2-3.
The more serious an issue, the more important it is for this Board to consider it. We can, indeed, always determine that a serious issue that falls within the scope of an admitted contention must be considered in order to assemble an adequate record.8

We have, therefore, chosen to treat Intervenor's filing as a motion to be decided on its merits, in light of the opposing arguments of the parties. In response to that motion, Georgia Power has filed an extensive, carefully documented answer and the Staff also has answered. We invite Intervenor to file a combined reply to Georgia Power and to the Staff. In that response, Intervenor should demonstrate, with particularity: (1) that he understands the answers that have been filed and that (despite those answers) there is an important, genuine issue of fact that Georgia Power has materially misled the Staff of the Commission concerning the public safety and health; and (2) that he did not unnecessarily delay the filing of this new basis for its contention.9

II. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 28th day of July 1994, ORDERED that:

By 6 pm on Friday, August 6, the Licensing Board and the parties shall receive a reply by Allen Mosbaugh (Intervenor) to the answers of Georgia Power,

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8See our unpublished order of June 2, 1994, at 4 (requesting a showing from the parties concerning whether adjudication of a new basis is required in order to compile an adequate record on the admitted contention). See also Pacific Gas and Electric Co. (Diablo Canyon Nuclear Power Plant, Units 1 and 2), LBP-93-1, 37 NRC 5, 20 (1993) (intervenor under the amended contention rule will not be limited to the specific incidents relied on to admit its contention).

9If there is a substantial misstatement involved, we as a Licensing Board could decide that the admission of the new basis is necessary for us to compile an adequate record on the admitted contention. We are unlikely to decide that tardiness in raising an important issue of credibility was reason to omit the issue from our record. We are required to compile an adequate record that covers important relevant issues.
et al., and the Staff of the Nuclear Regulatory Commission to Intervenor's Motion to Accept Additional Factual Basis in Support of the Admitted Contention.

THE ATOMIC SAFETY AND LICENSING BOARD

James H. Carpenter
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
The Commission considers the appeal of a Licensing Board decision, LBP-94-3, 39 NRC 31 (1994), which granted a request for intervention and for hearing on two applications submitted by the Gulf States Utilities Company (GSU). In one application, GSU sought to transfer its operating control over the River Bend nuclear power plant to a new licensee. GSU's second application sought a license amendment to reflect a change in the ownership of GSU. The Commission denies the appeal and affirms the Licensing Board's order, finding that the Petitioner has met the threshold requirements for standing and an admissible contention.

RULES OF PRACTICE: STANDING TO INTERVENE

To determine whether a petitioner has alleged the requisite interest to intervene, the Commission applies judicial concepts of standing.

RULES OF PRACTICE: STANDING TO INTERVENE

For standing, a petitioner must allege a concrete and particularized injury that is fairly traceable to the challenged action and likely to be redressed by a favorable decision.
RULES OF PRACTICE: STANDING TO INTERVENE

In the absence of a clear misapplication of the facts or misunderstanding of law, the Licensing Board's judgment at the pleading stage that a party has crossed the standing threshold is entitled to substantial deference.

RULES OF PRACTICE: STANDING (INJURY IN FACT)

The Atomic Energy Act authorizes the Commission to accord protection from radiological injury to both health and property interests. See AEA, §§ 103b, 161b, 42 U.S.C. §§ 2133(b), 2201(b).

REGULATIONS: INTERPRETATION

Commission regulations recognize that underfunding can affect plant safety. Under 10 C.F.R. § 50.33(f)(2), applicants — with the exception of electric utilities — seeking to operate a facility must demonstrate that they possess or have reasonable assurance of obtaining the funds necessary to cover estimated operation costs for the period of the license. Behind the financial qualifications rule is a safety rationale.

RULES OF PRACTICE: CONTENTIONS

Commission regulations mandate that a contention include a specific statement of the issue of law or fact to be raised or controverted, a brief explanation of the bases of the contention, and a concise statement of the alleged facts or expert opinion, that support the contention, together with references to those specific sources and document on which the petitioner intends to rely to prove the contention. The petitioner must also demonstrate that a genuine dispute exists with the applicant on a material issue of law or fact.

RULES OF PRACTICE: CONTENTIONS

At the contention filing stage the factual support necessary to show that a genuine dispute exists need not be in formal evidentiary form, nor be as strong as that necessary to withstand a summary disposition motion.
MEMORANDUM AND ORDER

I. INTRODUCTION

Pursuant to 10 C.F.R. § 2.714a, the Gulf States Utilities Company (GSU) has appealed the Atomic Safety and Licensing Board's Memorandum and Order LBP-94-3, 39 NRC 31 (1994). The Board found that the Cajun Electric Power Cooperative, Inc. (Cajun) has standing to intervene as a party in this proceeding and that one of Cajun's seven contentions is admissible. On appeal, GSU claims that Cajun lacks both standing and an admissible contention. The Nuclear Regulatory Commission (NRC) Staff concurs with the Licensing Board that Cajun has standing to intervene, but submits that the Board improperly admitted Cajun's contention. The Commission affirms LBP-94-3.

II. BACKGROUND

GSU is a Texas corporation and holds a 70% undivided interest in River Bend Station, Unit 1, located in Feliciana Parish, Louisiana. Cajun is a Louisiana cooperative corporation engaged in the transmission, distribution, and sale of electricity to rural electric distribution cooperatives. Cajun owns the remaining 30% undivided interest in River Bend. Specifically, this proceeding involves two separate applications filed by GSU in January 1993 for changes in the River Bend operating license. In one application, GSU sought to transfer control over River Bend's operations from itself to Entergy Operations, Inc. (EOI), pursuant to 10 C.F.R. § 50.80. GSU's second application was for a license amendment to reflect a change in the ownership of GSU, which through a merger would become a wholly owned subsidiary of Entergy Corporation (Entergy). The merger would not affect River Bend's ownership. The NRC Staff has approved both applications. See 58 Fed. Reg. 68,182 (Dec. 23, 1993).

Cajun and GSU entered into a Joint Ownership, Participation, and Operating Agreement (the JOPOA) in 1979. Under the agreement, Cajun and GSU, proportionate to their ownership interests, share the costs, expenses, and benefits of the River Bend Station. The agreement named GSU as the Licensee responsible for operating River Bend. Now, after the transfer of operating control requested by GSU, and pursuant to a new River Bend Station operating agreement executed by GSU and EOI, EOI is the new operator of the facility. EOI is a wholly owned subsidiary of Entergy Corporation, and also operates nuclear stations for four other Entergy subsidiaries.

Before the Licensing Board, Cajun alleged that both the transfer of operating control to EOI and GSU's merger with Entergy raise concerns about the safety of River Bend's operations. Cajun alleges that EOI may lack sufficient funds...
to operate the plant safely. Cajun states that EOI is thinly capitalized, and that under the new River Bend operating agreement between EOI and GSU, GSU bears the full obligation to compensate EOI for the plant’s operations. Accordingly, Cajun emphasizes that EOI will be dependent upon GSU for the funds to carry out River Bend’s operations, and cannot look to Entergy or to Cajun itself. Cajun alleges that GSU faces potentially severe financial exposure because of pending litigation with Cajun and with Texas regulators, and that potential litigation losses could result in GSU being unable to fund EOI adequately to maintain safe operations at River Bend. 1

The Licensing Board first determined that Cajun has standing to intervene. Cajun seeks to protect its property interest in the River Bend facility from radiological harm. Cajun allegedly has invested approximately $1.6 billion for its 30% ownership share of River Bend. The Licensing Board concluded that radiological harm to Cajun’s property interest is a protected interest under the Atomic Energy Act. LBP-94-3, 39 NRC at 38. The Licensing Board also found that the alleged injury can be redressed because license conditions could be imposed to reduce the potential for injury to Cajun. See id. at 39.

The Licensing Board admitted one of seven contentions proffered by Cajun. The admitted contention alleges that proposed license amendments may result in a reduction in the margin of safety at River Bend. See id. at 41-42. The contention is based on claims identical to those that go to Cajun’s standing; namely, that operations at River Bend may be underfunded because the new operator is thinly capitalized and intends to receive the bulk of its funding from GSU, which in turn faces the risk of substantial financial losses from pending litigation and which, in the event it has difficulty funding EOI, will not receive any assistance in funding EOI from the Entergy Corporation, the parent of both GSU and EOI.

On appeal, GSU claims that the Licensing Board erred in granting Cajun’s petition to intervene because Cajun lacks both standing and an acceptable contention. Brief in Support of GSU’s Appeal (GSU Appeal Brief) at 17-18 (Feb. 15, 1994). In brief, GSU argues that Cajun never alleged how GSU’s merger with Entergy, or how the operation of River Bend by EOI, could adversely affect Cajun’s interests. GSU emphasizes that responsibility for funding River Bend’s operations remains unchanged by the license amendments. GSU Appeal Brief

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1 Cajun has filed a lawsuit against GSU concerning Cajun’s ownership status in River Bend. Cajun seeks to rescind its operating agreement with GSU and obtain damages of at least $1.6 billion for alleged misrepresentation. Two of the Cajun Cooperative’s members also have filed suit against GSU, alleging that the operating agreement between Cajun and GSU is null because it was never submitted to the Louisiana Public Service Commission. Cajun also filed two lawsuits in the D.C. Circuit Court of Appeals against the NRC attacking (apparently on antitrust grounds) the two license amendments granted to GSU in this proceeding. The Court consolidated the two cases but has not set a briefing schedule. Cajun states that GSU also is involved in litigation with the Public Utility Commission of Texas, which disallowed $63.5 million of River Bend plant costs, and ordered GSU to place in abeyance approximately $1.4 billion of its investment.
at 7, 22-24. The responsibility for funding plant operations will remain with the plant owners, GSU and Cajun, in proportion to their ownership interests. *Id.* at 24. GSU argues that EOI’s “capitalization” is irrelevant because GSU is not relying on EOI to demonstrate financial qualifications, only to operate the plant. GSU concludes that Cajun’s interests in River Bend could be affected only if GSU is unable to meet its financial obligations to fund plant operations. *Id.* at 18. GSU stresses that such an eventuality could result from GSU losing its pending litigation, but not from the two license amendments, which will have no effect on the pending litigation. *See id.* at 18, 20, 22. Moreover, GSU argues that the pending litigation against GSU is overly speculative a basis upon which to support Cajun’s standing and contention. *Id.* at 23, 36. Lastly, GSU claims that no link exists between a financial qualifications review and plant safety because if adequate funds are not available for safe operation, a plant simply can be shut down. *See id.* at 34-35.

The NRC Staff concurs with the Board’s finding of standing, but argues that the Board erred in admitting the contention.2 The Staff claims that the transfer of operating control to EOI will affect neither GSU’s obligation nor its ability to fund River Bend’s operations, and therefore could not affect the plant’s operations. Staff Appeal Brief at 9-10.

**III. ANALYSIS**

A. Cajun’s Standing

Under section 189a of the Atomic Energy Act, the Commission must provide a hearing upon the request of any person “whose interest may be affected by the proceeding.” 42 U.S.C. § 2239(a). To determine whether a petitioner has alleged the requisite interest to intervene, the Commission applies judicial concepts of standing. *See Cleveland Electric Illuminating Co. (Perry Nuclear Power Plant, Unit I), CLI-93-21, 38 NRC 87, 92 (1993) (Perry).* For standing, a petitioner must allege a concrete and particularized injury that is fairly traceable to the challenged action and likely to be redressed by a favorable decision. *See generally Lujan v. Defenders of Wildlife, 112 S. Ct. 2130, 2136 (1992); Perry, 38 NRC at 92.* The injury must be to an interest that is arguably within the zone of interests protected by the governing statute. Injury may be actual or threatened. *Wilderness Society v. Griles, 824 F.2d 4, 11 (D.C. Cir. 1987); Perry, 38 NRC at 92.*

In the absence of a clear misapplication of the facts or misunderstanding of law, the Licensing Board’s judgment at the pleading stage that a party has

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2 NRC Staff Response to GSU Appeal (Mar. 3, 1994) (Staff Appeal Brief) at 4, 6.
crossed the standing threshold is entitled to substantial deference. "'[W]e are not inclined to disturb a Licensing Board's conclusion that the requisite affected interest . . . has been established unless it appears that that conclusion is irrational.'" *Portland General Electric Co.* (Pebble Springs Nuclear Plant, Units 1 and 2), ALAB-273, 1 NRC 492, 494 (1975).

The Licensing Board's conclusion here that Cajun has alleged sufficient interest and injury for threshold standing is not "irrational." The Atomic Energy Act expressly authorizes the Commission to accord protection from radiological injury to both health and property interests. *See AEA, §§ 103b, 161b, 42 U.S.C. §§ 2133(b), 2201(b).* Cajun alleges a threat of radiological harm to its property interest in the River Bend Station.

We reject GSU's argument that Cajun's stated interests are purely economic and "without a legitimate nexus to 'unsafe plant operation.'" GSU Appeal Brief at 18. Although seeking to protect a property interest, Cajun asserts an adverse impact on that interest from potentially unsafe operation of River Bend if the funding resources for the plant are unduly strained. As the Licensing Board recognized, such a claim is far different from the claims of disgruntled ratepayers or taxpayers whose complaints of rising rates or taxes have been rejected as a basis for standing in our proceedings. *See* 39 NRC at 37 (citing cases). Rather, Cajun's claim bears on safety in relation to the underlying financing for the plant, a matter that our regulations address.

Commission regulations recognize that underfunding can affect plant safety. Under 10 C.F.R. § 50.33(f)(2), applicants — with the exception of electric utilities — seeking to operate a facility must demonstrate that they possess or have reasonable assurance of obtaining the funds necessary to cover estimated operation costs for the period of the license. Behind the financial qualifications rule is a safety rationale. In drafting the original financial qualifications rule (which did not exempt utilities), the Atomic Energy Commission "'must have intuitively concluded that a licensee in financially straitened circumstances would be under more pressure to commit safety violations or take safety "shortcuts" than one in good financial shape.'" 4 Indeed, the Commission has presumed that "[s]hortcuts in safety at full power conceivably could avoid shutdowns . . . and thereby contribute to greater plant availability and revenue from power sales." 5

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3 Quoting Northern States Power Co. (Prairie Island Nuclear Generating Plant, Units 1 and 2), ALAB-107, 6 AEC 188, 193 (1973), aff'd on other grounds, CL1-73-12, 6 AEC 241 (1973), aff'd sub nom. BPI v. AEC, 502 F.2d 424 (D.C. Cir. 1974). *See also* Duquesne Light Co. (Beaver Valley Power Station, Unit 1), ALAB-109, 6 AEC 243, 244 (1973); *cf. Virginia Electric and Power Co.* (North Anna Power Station, Units 1 and 2), ALAB-522, 9 NRC 54, 57 n.5 (1979).


5 *Public Service Co. of New Hampshire* (Seabrook Station, Units 1 and 2), CL1-88-10, 28 NRC 573, 600 (1988); *see also* 49 Fed. Reg. 35,749 (Sept. 12, 1994).
In addition to highlighting EOI's thin capitalization and GSU's potential inability to fund River Bend's operations because of litigation risks, Cajun also stresses that the merger will contribute to the potential for underfunded operations at River Bend. Through the merger, Entergy Corporation will become the parent of GSU. Entergy's obligations to EOI are found in a River Bend Station Guarantee Agreement (Guarantee Agreement) made by Entergy, GSU, and EOI. Under the agreement, Entergy will have no obligation to support EOI financially if GSU ceases to fund EOI. And, according to Cajun, "EOI cannot look to Cajun for payment." 39 NRC at 39.6 Because of GSU's pending litigation risks, Cajun stresses that "[t]he possibility that GSU may be unable to fund EOI operations of River Bend . . . is more than an academic concern." Cajun's Petition for Leave to Intervene (Aug. 6, 1993) (Cajun's Petition) at 17.

Cajun claims that the merger results in Entergy and its shareholders being financially "insulated" from events involving EOI and GSU.7 After the merger, as reflected in the license amendment, GSU no longer is a publicly owned utility, but is a wholly owned subsidiary of the Entergy Corporation. GSU Appeal Brief at 7. Cajun explains that, before the merger, GSU shareholders would have been directly affected by a GSU bankruptcy, but that after the merger Entergy shareholders will be "insulated from liability through the corporate structure of Entergy's subsidiaries, GSU and EOI." Id. at 21. Because Entergy and its shareholders would be protected from any financial responsibility related to the underfunding of River Bend if GSU ceases to fund EOI, Cajun concludes that "EOI may be unable to ensure the safe shutdown of River Bend in the event of a GSU bankruptcy." Id. at 21-22.

In sum, we cannot conclude that the Licensing Board's standing determination was irrational. Whether the restructuring of GSU and the transfer of operating control to EOI ultimately harms or enhances River Bend's operation is a matter over which Cajun and GSU sharply disagree. It may well be that the two actions cannot be shown to have an impact on the safety of River Bend or that our regulations require no more demonstration of financial qualifications than that already found adequate by the Staff. But such findings would require us to reach beyond the minimum threshold for standing. Although we accept the Board's determination that Cajun has made a sufficient showing for threshold standing on the pleadings, we do not intimate any opinion on the merits of Cajun's claims, which upon further factual development may prove inadequate to survive the summary disposition stage.

GSU also argues on appeal that "[b]y rejecting the fact that two — not one — license amendment applications are at issue and collapsing both amendments into a single proceeding, the Licensing Board erroneously concluded that

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6See also Cajun's Brief in Opposition to GSU's Appeal (Mar. 2, 1994) (Cajun Appeal Brief) at 21.
7See Cajun Appeal Brief at 6.
separate standing (and a separate admissible contention) need not be established in connection with each license amendment." GSU Appeal Brief at 13. GSU submits that the Licensing Board’s analysis involves only the transfer of operating control to EOI, and does not reflect any assessment of the potential impact to Cajun’s interests from the merger of GSU with Entergy. See id. at 14-15. GSU complains that the Board did not make separate findings of standing and, in failing to do so, bootstrapped its jurisdiction over the merger amendment.

Although we concur with GSU that licensing boards do not have the liberty to assume jurisdiction over separate license amendments and hold a hearing simply because the same facility and same parties may be involved, we do not believe that the Licensing Board here has overstepped the bounds of its authority. A fair reading of Cajun’s initial pleadings reflects that Cajun sought a hearing on both licensing actions. The Board concluded that “the two amendments appear to be different facets of the same undertaking.” LBP-94-3, 39 NRC at 37. We note, too, that GSU itself has linked the two actions. In its application for the transfer of operating control to EOI, GSU declared that the application was “submitted in contemplation of the proposed merger, and would become effective only upon consummation of the merger.” On appeal, GSU emphasizes that even had the transfer of control been denied, the merger could have proceeded as a matter of law, but this assertion does not erase an apparent relationship between the actions.

In context, the Licensing Board’s finding of standing goes to both challenged amendments. The Board noted that both amendments could increase the potential for underfunded operations at River Bend, and that thus both amendments “are contributors to Cajun’s standing arguments.” Id. at 38.

At this stage we accept, as the Licensing Board has found, that the issues pertaining to both the transfer of control and the merger may overlap, and that Cajun’s alleged injury could result from both actions in tandem. The Board also has found Cajun’s admitted contention pertinent to both actions, and we affirm the threshold admission of the contention in the next section of this Order. Although further litigation of Cajun’s contention may well show it to be of little consequence to one or both of the licensing actions at issue, we discern no reason on the basis of the minimal record before us to disturb the Board’s conclusions.

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8 See, e.g., Cajun’s Amendment and Supplement to Petition, at 5-6 (Aug. 31, 1993). We note that Cajun’s original Petition referred to the Federal Register notice for the proposed merger amendment, while the Petition highlighted the proposed transfer of control, the notice of which appeared on the following page in the Federal Register. When the Office of the Secretary (SECY) referred Cajun’s petition to the Licensing Board on August 17, 1993, SECY noted only the proposed merger amendment. In its Supplement, Cajun clarified its intention to contest both proposed licensing actions. To the extent that any defect existed in the establishment of the Licensing Board, we remove it now.


10 GSU Appeal Brief at 15.
To the extent that the Board consolidated its consideration of the amendments it is empowered to do so under 10 C.F.R. § 2.716 when reasonable. We generally will defer to the Licensing Board’s judgment on consolidation. See Safety Light Corp. (Bloomsburg Site Decontamination and License Renewal Denials), CL1-92-13, 36 NRC 79, 89-90 (1992).

B. Cajun’s Contention

For admission as a party, a petitioner for intervention must proffer at least one admissible contention. The standards for an admissible contention are found under 10 C.F.R. § 2.714(b)(2) and (d)(2). Commission regulations mandate that a contention include a specific statement of the issue of law or fact to be raised or controverted, a brief explanation of the bases of the contention, and a concise statement of the alleged facts or expert opinion that support the contention, together with references to those specific sources and documents on which the petitioner intends to rely to prove the contention. The petitioner also must demonstrate that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions must fall within the scope of the issues set forth in the notice of the proposed licensing action. See Public Service Co. of Indiana (Marble Hill Nuclear Generating Station, Units 1 and 2), ALAB-316, 3 NRC 167, 170-71 (1976).

The contention rule, however, does not require Cajun to prove its case at this point. At the contention filing stage the factual support necessary to show that a genuine dispute exists need not be in formal evidentiary form, nor be as strong as that necessary to withstand a summary disposition motion. What is required is “a minimal showing that material facts are in dispute, thereby demonstrating that an ‘inquiry in depth’ is appropriate.”

The Licensing Board admitted only one of Cajun’s seven proffered contentions. The admitted contention alleges that “the proposed license amendments may result in a significant reduction in the margin of safety.” LBP-94-3, 39 NRC at 41. Central to Cajun’s contention is the concern that EOI will lack adequate funds to operate River Bend safely.

Cajun’s bases for the contention can be summarized as follows:


12 GSU submits that Cajun’s contention contains a fatal defect because the “margin of safety” standard is a term of art that concerns only whether a “significant hazards consideration” exists that could affect the timing of the effectiveness of the licensing actions. We do not believe that the expression “margin of safety” has been used as a term of art in this manner by either Cajun or the Licensing Board. We understand Cajun to be alleging an adverse impact on safety.
1. The new River Bend Operating Agreement underlying the transfer of operating control to EOI runs only between GSU and EOI. Under the agreement, GSU is obligated to provide all of EOI's funding for River Bend's operations. As a result, EOI will be dependent upon GSU for the funds necessary to operate River Bend.

2. EOI is thinly capitalized. Consequently, if GSU ceases to make its operating payments, EOI will have no other source of funds to maintain safe River Bend operations.

3. GSU faces severe financial exposure from litigation with Cajun and from Texas regulatory proceedings. Losses could render GSU unable to make sufficient payments to EOI for continued safe plant operations.

4. Under the merger agreement, Entergy Corporation, the parent of GSU and EOI, will not be responsible for funding EOI's operation of River Bend if GSU ceases to fund EOI.

See id. at 41.

As the Licensing Board found, the arguments both in support of and against the contention are similar to the arguments presented on Cajun's standing. See 39 NRC at 42. Both GSU and Staff stress that the license amendments cannot affect River Bend's safety because funding for the plant's operations will remain primarily the responsibility of GSU, and GSU's financial exposure from litigation risks exists regardless of the amendments. Consequently, GSU believes EOI's financial qualifications to be irrelevant to the proposed actions.

We cannot accept GSU's conclusion that "[t]he financial qualification of EOI is not at issue in this proceeding." GSU Appeal Brief at 32-33. Our regulations make EOI's financial qualification an issue. See p. 48, supra. GSU's arguments simply fail to recognize that EOI as the new operator is subject to the financial qualifications rule, and that the reliability of funding for River Bend's operations has been placed into question. Cajun's contention and its bases bear directly on whether the Commission's regulations are satisfied.

GSU's conclusion that "[t]he financial status of River Bend is, at worst, unchanged by the merger and likely is improved," may upon inquiry prove to be true, but is open to some question. We note that Staff, which objects to the admission of the contention for generally the same reasons as GSU, states that it has examined the financial qualifications of EOI and found "the requisite reasonable assurance of source of funds in the Operating Agreement between GSU and EOI." Staff Appeal Brief at 10 n.6. But this conclusion merely restates the Staff decision. It is contested by Cajun. A Staff conclusion alone is not enough to defeat Cajun's right to litigate a contention.

13 GSU Appeal Brief at 33.
The Licensing Board found that the terms of the merger agreement contribute to the potential for underfunding. 39 NRC at 38. At this stage, we are unable to resolve whether corporate restructuring under the merger will result in "insulation" from liability that can contribute to EOI's potential inability to safely operate or safely shut down the facility. We also cannot assess with finality the significance of the pending lawsuits against GSU,14 or the significance of the new operating agreement making GSU solely responsible for funding River Bend's operations.15 We cannot say, however, that the Licensing Board erred in finding that Cajun has delineated a basis for further inquiry into its contention that underfunding of operations may occur.

How much further examination the contention warrants must now be resolved by the Licensing Board. In sum, all we decide today is that Cajun has met the minimum threshold for the admission of its contention. Cajun has explained the bases, and identified facts and other matters supporting its contention. When Cajun's position is viewed in a light favorable to the petitioner,16 we are unable to conclude that the contention and its bases are wholly immaterial or fail to show a genuine dispute on a material matter. Without engaging in a greater inquiry, more appropriate for a later stage of this proceeding, we cannot resolve the significance of Cajun's allegations about the potential combined effect of EOI's thin capitalization, GSU's financial exposure, and a new corporate structure under Entergy.

IV. CONCLUSION

For the reasons stated in this decision, GSU's appeal is denied and the Licensing Board's order in LBP-94-3 is affirmed.

14 GSU claims that the degree of financial exposure faced by GSU is too speculative to serve as a basis for Cajun's contention. Yet the litigation pending against GSU has been considered of significance by the NRC Staff. When the Staff approved the two applications at issue on December 16, 1993, Staff included a license condition requiring GSU to inform the Director of Nuclear Reactor Regulation within 30 days of any award of damages in the litigation between Cajun and GSU. See, e.g., Amendment No. 69 to Facility Operating License No. NPF-47 (Dec. 16, 1993) at 2. In addition, Cajun notes that Entergy in its planned merger specifically included conditions that would allow it to withdraw from the merger if the Cajun litigation results in a decision against GSU before the merger is consummated. Cajun's Amendment & Supplement to Petition to Intervene at 10. Thus, sufficient interest in GSU's pending litigation has been raised by both the NRC Staff and Entergy that we cannot dismiss Cajun's concern as overly speculative.

15 GSU maintains that although under the new operating agreement, EOI will look only to GSU for the funds to operate River Bend, ultimately the funding for River Bend will not be changed. GSU explains that the initial operating agreement between GSU and Cajun will remain in effect. This agreement has required and will continue to require Cajun to provide 30% of the funds necessary for River Bend's operations. GSU Appeal Brief at 32. The potential effects of the new operating agreement's direct funding relationship between GSU and EOI remains unclear to us at this stage. We cannot comfortably conclude from the limited record before us that the new operating agreement's financial arrangement will not affect River Bend's funding.

16 See Arizona Public Service Co. (Palo Verde Nuclear Generating Station, Units 1, 2, and 3), CLI-91-12, 34 NRC 149, 155 (1991).
It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland,
this 23d day of August 1994.
In the Matter of Docket No. 40-8027-EA
(Decontamination and Decommissioning Funding)

SEQUOYAH FUELS CORPORATION and GENERAL ATOMICS
(Gore, Oklahoma Site)

August 23, 1994

General Atomics ("GA") filed with the Commission a pleading styled "Petition for Review and/or Motion for Directed Certification" of an interlocutory order (LBP-94-17, 39 NRC 359 (1994)) issued by the Licensing Board. In that pleading, GA challenged the Licensing Board’s denial of GA’s motion seeking either an order granting summary disposition in its favor regarding all issues in this proceeding or an order of dismissal. The issue on appeal is whether, pursuant to 10 C.F.R. § 2.786(g), the Commission should exercise its discretion to review the Licensing Board’s interlocutory order. The Commission denies GA’s Petition on the ground that it fails to satisfy either of the two conditions for interlocutory review set forth in 10 C.F.R. § 2.786(g).

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; DIRECTED CERTIFICATION); INTERLOCUTORY REVIEW (DIRECTED CERTIFICATION)

The Commission in this proceeding treats a challenge to an interlocutory order as a Petition for Review under 10 C.F.R. § 2.786 rather than as a Motion for Directed Certification under 10 C.F.R. §§ 2.718(i) and 2.730(f).
RULES OF PRACTICE: INTERLOCUTORY APPEALS

The Commission has a longstanding policy disfavoring interlocutory review (other than appeals pursuant to 10 C.F.R. § 2.714a), and will undertake such review only in the most compelling circumstances.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW)

A licensing board decision refusing to dismiss a party from a proceeding does not, without more, constitute a compelling circumstance justifying interlocutory review.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; DIRECTED CERTIFICATION); INTERLOCUTORY REVIEW (DIRECTED CERTIFICATION)

The Commission, under its present appellate system, has entertained petitions for review of an otherwise interlocutory order — akin to a motion for directed certification — if the petitioner can satisfy one of the criteria under section 2.786(g).

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW)

Section 2.786(g) of the Commission’s regulations allows interlocutory review only where the question presented either: "(1) Threatens the party adversely affected by it with immediate and serious irreparable impact which, as a practical matter, could not be alleviated through a petition for review of the presiding officer’s final decision; or (2) Affects the basic structure of the proceeding in a pervasive or unusual manner."

APPEAL BOARD(S): PRECEDENTIAL WEIGHT ACCORDED DECISIONS


RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; IRREPARABLE IMPACT)

It is well established in Commission jurisprudence that the mere commitment of resources to a hearing that may later prove to have been unnecessary does
not constitute sufficient grounds for an interlocutory review of a licensing board order.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; IRREPARABLE IMPACT)

A party may not obtain interlocutory review merely by asserting potential delay and increased expense attributable to an allegedly erroneous ruling by the licensing board.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; IRREPARABLE IMPACT); BURDEN OF PROOF

Mere generalized representations by counsel or unsubstantiated assertions regarding "immediate and serious irreparable impact" are insufficient to satisfy movant's burden of proof.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; IRREPARABLE IMPACT)

The Commission sees no "substantial harm" arising from a party's continued involvement in a proceeding until the licensing board can resolve factual questions pertinent to the Commission's jurisdiction.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; BASIC STRUCTURE)

Although a definitive ruling by the licensing board that the Commission actually has jurisdiction might rise to the level of a pervasive or unusual effect upon the nature of the proceeding, a preliminary ruling that mere factual development is necessary does not rise to that level.

RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; BASIC STRUCTURE)

The fact that an appealed ruling touches on a jurisdictional issue does not, in and of itself, mandate interlocutory review.
RULES OF PRACTICE: INTERLOCUTORY APPEALS (DISCRETIONARY REVIEW; BASIC STRUCTURE)

The mere issuance of a ruling that is important or novel does not, without more, change the basic structure of a proceeding, and thereby justify interlocutory review.

ORDER
DENYING PETITION FOR INTERLOCUTORY REVIEW AND/OR MOTION FOR DIRECTED CERTIFICATION

On June 24, 1994, General Atomics ("GA") filed with the Commission a "Petition for Review of LBP-94-17 and/or Motion for Directed Certification" ("Petition"). In that filing, GA challenged the Licensing Board's denial of GA's February 17, 1994 motion seeking either an order granting summary disposition in its favor regarding all issues in this proceeding or an order of dismissal. We deny GA's Petition.

BACKGROUND

NRC Staff initiated this proceeding on October 15, 1993, by issuing an order ("Staff Order") holding Sequoyah Fuels Corporation ("SFC") and its parent company, GA, jointly and severally liable for providing (1) the necessary "funding to continue remediation" of the contamination at SFC's facility in Gore, Oklahoma; (2) "financial assurance for decommissioning" of that facility; and (3) "an updated detailed cost estimate for decommissioning and a plan for assuring the availability of adequate funds for completion of decommissioning." Staff Order, 58 Fed. Reg. 55,087, 55,092 (Oct. 25, 1993). Staff concluded that GA was liable because it had constructive or "de facto control" over SFC's daily activities. Id. at 55,091.

On February 17, 1994, GA filed with the Licensing Board a motion for summary disposition or, in the alternative, for dismissal. In that motion, GA asserted that the statutes relied upon in the Staff Order do not authorize the Staff to assert jurisdiction over GA in this proceeding or to impose upon it the non-civil-penalty financial liability set forth in the Staff Order.

On April 28, 1994, the Licensing Board denied GA's February 17th Motion, and set forth its reasons in a Memorandum issued June 8, 1994. LBP-94-17, 1

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1 The Commission treats GA's filing as a Petition for Review under 10 C.F.R. § 2.786. See Unpublished Order in this docket, dated June 29, 1994 (expanding the filing period and the page limit set forth in section 2.786).
39 NRC 359. The Licensing Board explained that the jurisdictional issue was fact-based, that factual issues underlying the jurisdictional question remained in controversy and that, consequently, the resolution of the jurisdictional question "must await the development of litigative factual issues before [the Board]." *Id.* at 363. *See also id.* at 364-65.

On June 24, 1994, GA filed the instant Petition pursuant to 10 C.F.R. §§ 2.718(i) and 2.786(g)(1), (2). The NRC Staff and the two intervenors in this proceeding oppose GA's Petition.

**APPLICABLE LEGAL STANDARDS**

The Commission has a longstanding policy disfavoring interlocutory review (other than appeals pursuant to 10 C.F.R. § 2.714a), and will undertake such review only in the most compelling circumstances. *See, e.g., Sacramento Municipal Utility District* (Rancho Seco Nuclear Generating Station), CLI-94-2, 39 NRC 91, 93 (1994). *See also Arizona Public Service Co.* (Palo Verde Nuclear Generating Station, Units 2 and 3), ALAB-742, 18 NRC 380, 383 (1983); *Pacific Gas and Electric Co.* (Diablo Canyon Nuclear Power Plant, Units 1 and 2), ALAB-504, 8 NRC 406, 410 (1978).2 A licensing board decision refusing to dismiss a party from a proceeding does not, without more, constitute such a compelling circumstance. *See Cleveland Electric Illuminating Co.* (Perry Nuclear Power Plant, Units 1 and 2), ALAB-736, 18 NRC 165, 166 (1983).

"Under our present appellate system, we have entertained petitions for review of an otherwise interlocutory order — akin to a motion for directed certification — if the petitioner can satisfy one of the criteria under section 2.786(g)." *Rancho Seco,* 39 NRC at 93. That section allows interlocutory review only where the question presented either:

1. Threatens the party adversely affected by it with immediate and serious irreparable impact which, as a practical matter, could not be alleviated through a petition for review of the presiding officer's final decision; or
2. Affects the basic structure of the proceeding in a pervasive or unusual manner.

10 C.F.R. § 2.786(g)(1), (2).

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THE PETITION

GA in its Petition asserts that the Licensing Board erred in ruling that the "resolution of the jurisdictional matter must await the development of the litigative factual issues before [the Board]." Petition at 2, quoting LBP-94-17, 39 NRC at 363. GA offers the following three arguments why this error requires immediate Commission attention.

GA's first argument is that the challenged ruling, if allowed to stand, would impose upon GA the following four immediate and serious irreparable impacts (the test set forth in section 2.786(g)(1)): substantial litigation costs, and substantial risks to GA's credit rating, ability to obtain financing, and ability to carry on its work. Petition at 10.

Second, GA asserts that the ruling affects the basic structure of this proceeding in a pervasive or unusual manner (the test set forth in section 2.786(g)(2)); is based upon a legal conclusion without governing precedent; and raises a substantial and important question of law and policy. Petition at 2, 11. In support, GA cites Safety Light Corp. (Bloomsburg Site Decontamination), ALAB-931, 31 NRC 350, 361 (1990) ("Safety Light"), for the proposition that a licensing board's view of its own jurisdictional boundaries affects the basic structure of a proceeding and has a significant and pervasive effect upon the proceeding. GA also argues that the question is one of first impression, and that it affects the jurisdiction of not only the Licensing Board but also the Commission itself. Petition at 11.


DISCUSSION

The issue now pending before the Commission is whether, pursuant to 10 C.F.R. § 2.786(g), the Commission should exercise its discretion to review the Licensing Board's interlocutory order denying GA's February 17th motion for summary disposition or dismissal. For the reasons set forth below, we conclude

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3GA also contends that three recent decisions by the United States Supreme Court support its position that the Commission lacks authority to impose retroactively on GA any liability for decommissioning costs. Petition at 11-15. However, because we are denying the Petition, we do not need to reach the issue whether the three cases support GA's substantive arguments.
that GA's Petition satisfies neither of the two conditions for interlocutory review set forth in section 2.786(g).

1. Immediate and Serious Irreparable Impact

GA, in asserting that its expected litigation costs constitute an immediate and serious irreparable impact, fails to distinguish its situation from those of numerous other parties whose similar arguments have been rejected in other proceedings. It is well established in Commission jurisprudence that the mere commitment of resources to a hearing that may later prove to have been unnecessary does not constitute sufficient grounds for an interlocutory review of a Licensing Board order. See, e.g., Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), ALAB-861, 25 NRC 129, 138-39 (1987) ("Shoreham"); Public Service Co. of New Hampshire (Seabrook Station, Units 1 and 2), ALAB-858, 25 NRC 17, 21-22 (1987); Commonwealth Edison Co. (Zion Station, Units 1 and 2), ALAB-116, 6 AEC 258, 259 (1973). Nor may a party obtain interlocutory review merely by asserting potential delay and increased expense attributable to an allegedly erroneous ruling by the Licensing Board. See, e.g., Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), ALAB-741, 18 NRC 371, 378 n.11 (1983), and authority cited therein.

Regarding GA's remaining three assertions of "irreparable impact," GA provides no substantiation that it will suffer "immediate and serious" risks to its credit rating, ability to obtain financing, and ability to carry on its work. Nor does it cite any legal authority to support its claim that such risks constitute the kind of "immediate and serious irreparable impact" contemplated in section 2.786(g)(1). Mere generalized representations by counsel are not enough. See Commonwealth Edison Co. (Byron Nuclear Power Station, Units 1 and 2), ALAB-735, 18 NRC 19, 23-24 (1983), and authority cited therein; Shoreham, supra, 25 NRC at 138-39. GA's unsubstantiated assertions, in short, do not persuade us that interlocutory review is necessary to prevent an "irreparable impact." Cf. Consolidated Edison Co. of New York (Indian Point, Units 1, 2, and 3), CLI-77-2, 5 NRC 13, 14 (1977) (burden of persuasion with the movant); 10 C.F.R. § 2.732.

GA also relies on two Commission decisions, Vogtle and Oncology, supra, and a policy statement to support the proposition that the Commission grants interlocutory review where a party satisfies either criterion set forth in section 2.786(g). Petition at 11. But that proposition was already obvious from the
plain terms of section 2.786(g). Nothing in *Vogtle* or *Oncology* helps GA here because, unlike this case, they involved clear instances of immediate and tangible risks of irreparable impact. *See Vogtle*, 39 NRC at 193; *Oncology*, 37 NRC at 421. The Policy Statement is similarly unhelpful, as it refers to interlocutory appeals only generally and nowhere suggests that such appeals are permissible in situations like GA's. *See CLI-81-8*, 13 NRC at 456-57.

We instead find persuasive a decision in which the Appeal Board declined to grant interlocutory review regarding an issue somewhat similar to the one in this proceeding. In *Public Service Co. of Indiana* (Marble Hill Nuclear Generating Station, Units 1 and 2), ALAB-405, 5 NRC 1190 (1977), the Appeal Board was faced with a Licensing Board's referred ruling that all proposed co-owners of a nuclear generating facility should be treated as "*de facto* co-applicants" with the "lead" applicant (LBP-77-4, 5 NRC 433, 434 (1977)). In declining review, the Appeal Board concluded that "the ruling below . . . does not appear to threaten the co-owners with any substantial harm to their interests which could not be alleviated by an appeal to us at the conclusion of the proceeding." *Id.* at 1192 (footnote omitted). *A fortiori,* we see no "substantial harm" arising from GA's continued involvement in this proceeding until the Licensing Board can compile a record and conduct a factual inquiry on whether GA has "*de facto* control" over SFC's daily activities (58 Fed. Reg. at 55,091) and is thereby subject to the Commission's jurisdiction.5

2. Pervasive or Unusual Effect on the Basic Structure of the Proceeding

GA cites *Safety Light* for the proposition that a licensing board's view of its own jurisdictional boundaries affects the basic structure of a proceeding and has a significant and pervasive effect upon the proceeding. *Safety Light* is distinguishable. The Licensing Board decision which the Appeal Board reviewed in that case confirmed the Commission's jurisdiction over parties that were denying the existence of such jurisdiction. By contrast, the Licensing Board decision at issue in the instant proceeding never reached the question whether the Commission has jurisdiction over such a party. Instead, the Licensing Board here ruled merely that the jurisdictional issue cannot be resolved without further factual inquiry. *See supra* note 3.

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5 *Cf. Data Disc, Inc. v. Systems Technology Associates*, 557 F.2d 1280, 1285 (9th Cir. 1977) (if questions of fact are raised on a Rule 12(b)(2) motion challenging personal jurisdiction, the court has discretion to take evidence at a preliminary hearing); *Ohio National Life Insurance Co. v. United States*, 922 F.2d 320, 325 (6th Cir. 1990) ("[W]hen facts presented to the district court give rise to factual controversy, the district court must therefore weigh the conflicting evidence to arrive at a factual predicate that subject matter jurisdiction exists or does not exist"); 2A James W. Moore et al., Moore's Federal Practice ¶ 12.07(2-1) at p. 12-54, and ¶ 12.07(2-2) at pp. 12-49 to 12-70 (2d ed. 1994); 5A id. ¶ 52.08 at pp. 52-156 to 52-157 (2d ed. 1993).
Although a definitive ruling by the Licensing Board that the Commission actually has jurisdiction over GA in this proceeding might rise to the level of a pervasive or unusual effect upon the nature of the proceeding, the preliminary ruling on appeal here does not. The fact that an appealed ruling touches on a jurisdictional issue does not, in and of itself, mandate interlocutory review. See Safety Light Corp. (Bloomsburg Site Decontamination), CLI-92-9, 35 NRC 156 (1992). Similarly, the mere issuance of a ruling that is important or novel does not, without more, change the basic structure of a proceeding. See Commonwealth Edison Co. (Braidwood Nuclear Power Station, Units 1 and 2), ALAB-817, 22 NRC 470, 474 & nn.16-17 (1985), and authority cited therein.

CONCLUSION

For the reasons set forth above, we consider it premature to undertake a review of the jurisdictional issue at this early a stage of the proceeding. See Safety Light, CLI-92-9, 35 NRC at 160. Consequently, General Atomics' Petition for Review and/or Motion for Directed Certification is denied.

It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland, this 23d day of August 1994.
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

COMMISSIONERS:

Ivan Sellin, Chairman
Kenneth C. Rogers
E. Gail de Planque

In the Matter of

SEQUOYAH FUELS CORPORATION
and GENERAL ATOMICS
(Gore, Oklahoma Site)

Docket No. 40-8027-EA
(Decontamination and Decommissioning Funding)

August 23, 1994

In an enforcement proceeding involving funding for decontamination and decommissioning of the Sequoyah Fuels Facility near Gore, Oklahoma, the Commission denies appeals of the Atomic Safety and Licensing Board's orders LBP-94-5, 39 NRC 54 (1994), and LBP-94-8, 39 NRC 116 (1994), which granted intervention to a petitioner who favors the enforcement action. The Commission affirms LBP-94-5 which granted standing and affirms LBP-94-8 only to the extent that it relied upon this finding of standing.

ENFORCEMENT ACTION: SCOPE OF PUBLIC PARTICIPATION

The Commission has authority to define the scope of public participation in its proceedings beyond that which is required by statute. Consistent with this authority the Commission permits participation by those who can show that they have a cognizable interest that may be adversely affected if the proceeding has one outcome rather than another, including those who favor an enforcement action.
ENFORCEMENT ACTIONS: AGENCY DISCRETION

Intervention by interested persons who support an enforcement action does not diminish the agency's discretion in initiating enforcement proceedings because the Commission need not hold a hearing on whether another path should have been taken. The Commission may lawfully limit a hearing to consideration of the remedy or sanction proposed in the order.

ENFORCEMENT ACTIONS: SETTLEMENT AGREEMENTS

In enforcement proceedings, settlements between the Staff and the licensee, once a matter has been noticed for hearing, are subject to review by the presiding officer. 10 C.F.R. § 2.203. Thus, once an enforcement order has been set for hearing at a licensee's request, the NRC Staff no longer has untrammeled discretion to offer or accept a compromise or settlement.

RULES OF PRACTICE: STANDING TO INTERVENE

At the heart of the standing inquiry is whether the petitioner has alleged such a personal stake in the outcome of the controversy as to demonstrate that a concrete adverseness exists which will sharpen the presentation of issues. To demonstrate such a "personal stake," the Commission applies contemporaneous judicial concepts of standing. Accordingly, a petitioner must (1) allege an "injury in fact" that is (2) fairly traceable to the challenged action and (3) is likely to be redressed by a favorable decision.

RULES OF PRACTICE: STANDING TO INTERVENE (INJURY IN FACT)

The alleged injury, which may be either actual or threatened, must be both concrete and particularized, not "conjectural" or "hypothetical." As a result, standing has been denied when the threat of injury is too speculative.

RULES OF PRACTICE: STANDING TO INTERVENE (INJURY IN FACT)

An organization seeking representational standing on behalf of its members may meet the "injury-in-fact" requirement by demonstrating that at least one of its members, who has authorized the organization to represent his or her interest, will be injured by the possible outcome of the proceeding.
RULES OF PRACTICE: STANDING TO INTERVENE (INJURY IN FACT)

To meet the "injury in fact" requirement the petitioner need only show a realistic threat of sustaining a direct injury to the petitioner as a result of the challenged action.

RULES OF PRACTICE: STANDING TO INTERVENE (CAUSATION)

It must be demonstrated that the injury is fairly traceable to the proposed action. Such a determination is not dependent on whether the cause of the injury flows directly from the challenged action, but whether the chain of causation is plausible.

RULES OF PRACTICE: STANDING TO INTERVENE (REDRESSABILITY)

It must be likely as opposed to merely speculative that the injury will be redressed by a favorable decision.

MEMORANDUM AND ORDER

The Commission has before it appeals of the Atomic Safety and Licensing Board's orders LBP-94-5, 39 NRC 54 (1994) and LBP-94-8, 39 NRC 116 (1994), which granted intervention in this proceeding to Native Americans for a Clean Environment (NACE). The proceeding stems from a Nuclear Regulatory Commission (NRC) Staff enforcement order holding the Licensee Sequoyah Fuels Corporation (SFC) and General Atomics (GA), SFC's parent company, jointly and severally liable for providing financial assurance for the decommissioning of SFC's facility near Gore, Oklahoma. See 58 Fed. Reg. 55,087 (Oct. 25, 1993). NACE petitioned for intervention to protect its members' interest in having the order sustained. Both SFC and GA appeal pursuant to 10 C.F.R. § 2.714a the Licensing Board's grant of intervention to a party that favors the enforcement action, and they argue that NACE has not met the traditional standards for intervention. We deny the appeals.

I. BACKGROUND

In LBP-94-5, the Licensing Board found that NACE had established standing, but the Board left unresolved the ultimate determination on intervention pending
its ruling on NACE's proffered contentions. The Licensing Board concluded that (1) in a proceeding on a Staff enforcement order issued under 10 C.F.R. § 2.202, there is no prohibition against an otherwise qualified petitioner intervening as of right in support of the order; and (2) petitioner NACE had demonstrated that it possesses the requisite interest to entitle it to standing in this instance.

The Licensing Board referred the first ruling noted above to the Commission pursuant to section 2.730(f) rather than awaiting a final ruling on NACE's intervention, because it believed that this ruling affected significantly the structure of both this proceeding and the Commission's adjudicatory process generally. LBP-94-5, 39 NRC at 75-76. Pursuant to a March 3, 1994 Commission order (unpublished), the parties briefed the questions of whether review of the referred ruling would be appropriate in accordance with 10 C.F.R. § 2.786(g) and, assuming that review would be appropriate, whether the Licensing Board's ruling should be sustained.

Prior to the Commission deciding whether to take review of the referred ruling, the Licensing Board, in LBP-95-8, admitted NACE's contentions and, accordingly, granted NACE intervention. This decision had the effect of making both LBP-94-8 and the earlier ruling in LBP-94-5 appealable to the Commission as of right, pursuant to 10 C.F.R. § 2.714a.1 Because both SFC and GA have appealed the decisions pursuant to 2.714a, the question of whether to review as a matter of discretion the referred ruling in LBP-94-5 is moot. In our review of the Licensing Board's rulings in LBP-94-5, we have fully considered arguments presented in both the parties' briefs on the referred ruling and the parties' subsequent briefs on appeal.

II. ANALYSIS

In their appeals, SFC and GA challenge the conclusion that NACE is entitled to standing. SFC and GA do not challenge the admissibility of NACE's contentions, but appeal LBP-94-8 only to the extent that its ultimate conclusion is to grant NACE intervention.2 With respect to standing, SFC's and GA's arguments are two-fold. First, they argue that a petitioner who supports an enforcement order cannot establish the requisite interest for standing as of right in a proceeding to determine whether an enforcement order should be sustained. Second, they argue that, even if such intervention is permitted, NACE has failed to demonstrate that its members' interest will be harmed if the order is not sustained or that any such harm is likely to be redressed by a favorable decision.

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1 See Detroit Edison Co. (Greenwood Energy Center, Units 2 and 3), ALAB-472, 7 NRC 570, 571 n.1 (1978).
2 GA did not file a separate brief on appeal, but filed a notice of appeal and adopted the grounds and arguments set forth in SFC's brief on appeal. General Atomics' Notice of Appeal (Apr. 7, 1994).
in this proceeding. We turn first to the issue of intervention as of right in proceedings on Staff enforcement orders.

A. Availability of Intervention as of Right to Support a Staff Enforcement Order

The Licensing Board concluded that the Commission's statutory and regulatory framework sanctions intervention as of right even for one who supports rather than challenges an enforcement order. In reaching this determination, the Licensing Board relied on the analysis contained in Nuclear Engineering Co. (Sheffield, Illinois, Low-Level Radioactive Waste Disposal Site), ALAB-473, 7 NRC 737 (1978). In Sheffield, an Atomic Safety and Licensing Appeal Board discussed the question of whether a petitioner who supports a license amendment could intervene as of right in the proceeding. In determining that such a petitioner, if otherwise qualified, could intervene, the Appeal Board stated:

Standing to intervene hinges neither upon the litigating posture the petitioner would assume if allowed to participate nor on the merits of its case. . . . Rather, the test is whether a cognizable interest of the petitioner might be adversely affected if the proceeding has one outcome rather than another.

7 NRC at 743 (citation omitted). The Licensing Board found that this analysis is equally applicable to an enforcement proceeding. LBP-94-5, 39 NRC at 65-66. Thus, once a hearing is requested by the target of the enforcement order, a petitioner who supports the order may be "adversely affected" by the proceeding, because a possible outcome of the proceeding is that the order will not be sustained. Id.

On appeal SFC and GA argue that admitting a private party to a proceeding would be appointing in essence a "private prosecutor" to aid in the enforcement of the order. A "private prosecutor," they warn, would severely limit the Commission's enforcement discretion because such an intervenor could object to compromises reached between the target of the enforcement action and the NRC Staff and thereby unnecessarily prolong the hearing. Thus, SFC and GA argue that such intervention would severely hamper enforcement action which is within the sole discretion of the Commission. Sequoyah Fuels Initial Brief in Opposition to the Ruling in Section II.A of LBP-94-5, at 10-14 (Mar. 11, 1994) (hereinafter SFC Initial Brief).

SFC and GA also maintain that only those who oppose an NRC enforcement order are persons "whose interest may be affected by the proceeding" so as to qualify for a hearing under section 189a(1) of the Atomic Energy Act of 1954 (AEA), 42 U.S.C. §2239(a)(1) (1988), and 10 C.F.R. §2.714(a), the regulation governing intervention in all formal adjudications conducted pursuant to 10
C.F.R. Part 2, Subpart G. According to SFC and GA, the right to intervene in an enforcement proceeding must be "coextensive" with the right to a hearing under the section 189a of the AEA, and section 189a hearing rights extend only to those persons adversely affected by the order, not by the proceeding. SFC Initial Brief at 15-26. If the Commission's rules otherwise provided for intervention in a circumstance where the petitioner was not adversely affected by the enforcement order, SFC and GA contend that "the Commission's rules would violate section 189a of the Act." Id. at 24-25.

We do not find SFC's and GA's arguments compelling. Irrespective of whether this proceeding falls within the scope of those hearings mandated by section 189a of the AEA, the Commission has broad authority to hold hearings as it "may deem necessary or proper to assist it in exercising any authority provided in [the AEA]," to define the scope of public participation in its proceedings beyond that which is required by statute. In exercising this authority, the Commission has permitted participation in its adjudicatory proceedings by those who can show that they have a cognizable interest that may be adversely affected if the proceeding has one outcome rather than another. Intervention in a proceeding under 10 C.F.R. Part 2, Subpart G, is permitted by regulation in 10 C.F.R. § 2.714, which provides that "any person whose interest may be affected by the proceeding" may petition to intervene. Although the particular circumstances of this proceeding may be somewhat novel, the grant of intervention to a petitioner who supports an enforcement order is not. We have identified a number of instances over the years in which petitioners who support an enforcement order have been permitted to intervene.

Contrary to SFC's and GA's arguments, the court in Bellotti v. NRC neither directly nor indirectly prohibited this practice. 725 F.2d 1380 (D.C. Cir. 1983). The question before the court in Bellotti was whether the Commission had the authority under section 189a of the AEA to define the scope of an enforcement proceeding and deny a petitioner a hearing on whether to impose more extensive

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4 Portland General Electric Co. (Pebble Springs Nuclear Plant, Units 1 and 2), CLI-76-27, 4 NRC 610, 614 (1976) (and cases cited therein); Public Service Co. of Indiana (Marble Hill Nuclear Generating Station, Units 1 and 2), CLI-80-10, 11 NRC 438, 440-41 (1980) (hereinafter Marble Hill) (and cases cited therein).

5 See Sheffield, 7 NRC at 743. The Sheffield outcome test was cited as the test for injury in Marble Hill, CLI-80-10, 11 NRC at 439, the first case in which the Commission articulated its policy on the scope of enforcement proceedings that was subsequently approved by the court in Bellotti v. NRC, 725 F.2d 1380 (D.C. Cir. 1983).


7 Sequoyah Fuels Corporation's Initial Brief in Opposition to the Ruling in Section II.A of LBP-94-5 at 16-17 (Mar. 11, 1994). GA did not file a separate brief on these questions but adopted SFC's arguments. General Atomics Response to the Ruling in Section II.A of LBP-94-5 (Mar. 11, 1994).
requirements than the Staff imposed in its original enforcement order. The Bellotti majority did not address the issue that we face here. 8

In Bellotti, the majority of the court expressed the concern that if a petitioner, rather than the Commission, was permitted to define the scope of the enforcement proceeding the Commission would be deluged by petitioners every time the Commission issued an enforcement order, and the scope of many proceedings would be "virtually interminable" and "free ranging." 725 F.2d at 1381. In contrast, NACE recognizes in this instance that it may only intervene with respect to matters found to be within the scope of the Staff's enforcement order and may not expand the breadth of the order or proceeding. 9 Thus, the policy behind the ruling in Bellotti is not relevant here. To the extent that SFC and GA rely on Bellotti to support the notion that a petitioner who favors an order may not intervene as of right, we agree with the Licensing Board that they read Bellotti too broadly.

Moreover, SFC and GA have not raised any argument that would convince us that permitting intervention by a petitioner who supports an enforcement order is detrimental to the Commission's enforcement discretion. Whether and when to initiate enforcement proceedings remains a matter of agency discretion. See Moog Industries, Inc. v. FTC, 355 U.S. 411, 413 (1958); Heckler v. Chaney, 470 U.S. 821, 831 (1985); Advanced Medical Systems, Inc., CLI-94-6, 39 NRC 285, 313 (1994). Permittinng intervention in enforcement proceedings by interested persons does not diminish the agency's discretion in initiating proceedings because, as the Bellotti court held, the Commission need not hold a hearing on whether another path should have been taken. The Commission may lawfully limit a hearing to consideration of the remedy or sanction proposed in the order. See Bellotti, 725 F.2d at 1381-82; Marble Hill, 11 NRC at 440-41.

SFC argues that the agency's discretion will be hampered because a third-party intervenor could object to compromises reached between the NRC Staff and the Licensee and thereby thwart settlement and unnecessarily prolong a hearing. Once proceedings have been initiated, however, the Staff's discretion is never absolute. While the agency's enforcement discretion may be at its zenith as the agency decides whether to initiate enforcement action, that discretion does not negate the participatory rights in agency proceedings under statute or regulation once a proceeding has been initiated or a matter set for hearing.

8 However, the dissent recognized the availability of standing for a petitioner who supports an enforcement order. In reiterating the Commission's position, and hence the position accepted by the majority of the court in Bellotti, the dissent stated that:

If there were a chance that the proceeding would overturn the amendment, the public would have standing, since the plant could return to or remain in its pre-amendment unsafe condition. But this is not a possibility unless the licensee seeks a hearing. 725 F.2d at 1386 (Wright, J., dissenting).

Even in the absence of a third-party intervention in a proceeding, settlements between the Staff and the Licensee, once a matter has been noticed for hearing, are subject to the review of the presiding officer. 10 C.F.R. § 2.203. Thus, once an enforcement order has been set for hearing at a licensee’s request, the NRC Staff no longer has untrammeled discretion to offer or accept a compromise or settlement. In any pending proceeding, the presiding officer’s approval of settlement is a matter that must give due consideration to the public interest. 10

As we noted, the admission of an intervenor like NACE to an enforcement proceeding is not new. The Commission has permitted such intervention for approximately two decades, and the alleged detrimental effects on the Commission’s enforcement discretion warned by SFC and GA have not materialized. In this instance, a hearing will be held in any event at the request of SFC and GA, so considerable NRC resources will be devoted to a hearing irrespective of NACE’s intervention. We see no harm to either the Commission’s enforcement discretion or the public interest in permitting third-party participation in a hearing on contested matters that are within the scope of the enforcement action originally brought by the NRC Staff.

We conclude that the Licensing Board correctly applied the Sheffield “outcome” test to the circumstances here and correctly determined that an otherwise qualified petitioner may intervene as of right to support a Staff enforcement order issued pursuant to section 2.202. We turn next to the question of whether NACE has demonstrated the requisite interest to be granted intervention in this proceeding.

B. NACE’s Standing

In order for NACE to be admitted as a party in this enforcement proceeding it must first demonstrate that it has an interest that may be affected by the proceeding; i.e., it has standing to participate. At the heart of the standing inquiry is whether the petitioner has “alleged such a personal stake in the outcome of the controversy” as to demonstrate that a concrete adverseness exists which will sharpen the presentation of issues. Duke Power Co. v. Carolina Environmental Study Group, Inc., 438 U.S. 59, 72 (1978) (quoting Baker v. Carr, 369 U.S. 186, 204 (1962)). To demonstrate such a “personal stake,” the Commission applies contemporaneous judicial concepts of standing. Accordingly, a petitioner must (1) allege an “injury in fact” that is (2) fairly traceable to the challenged action” and (3) is “likely” to be “redressed by a

10 However, parties may not simply object to settlement in order to block it, but must show some substantial basis for disapproving the settlement or the existence of some material issue that requires resolution. See generally Pennsylvania Gas & Water Co. v. FPC, 463 F.2d 1242, 1246-47, 1249-52 (D.C. Cir. 1972).
favorable decision.”\textsuperscript{11} The Licensing Board found that NACE satisfied the threshold elements for standing. Absent a gross misapplication of the facts or applicable law, we are not inclined to disturb the Licensing Board’s judgment on standing. See Gulf States Utilities Co. (River Bend Station, Unit 1), CLI-94-10, 40 NRC 43, 47-48 (1994). We address each of the standing elements in turn.

1. Injury in Fact

The alleged injury, which may be either actual or threatened,\textsuperscript{12} must be both concrete and particularized,\textsuperscript{13} not “conjectural,” or “hypothetical.” O’Shea v. Littleton, 414 U.S. 488, 494 (1974). As a result, standing has been denied when the threat of injury is too speculative. See, e.g., Whitmore v. Arkansas, 495 U.S. 149, 158-59 (1990); Los Angeles v. Lyons, 461 U.S. 95, 105 (1983). An organization seeking representational standing on behalf of its members may meet the “injury-in-fact” requirement by demonstrating that at least one of its members, who has authorized the organization to represent his or her interest, will be injured by the possible outcome of the proceeding. Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-535, 9 NRC 377, 389-400 (1979).

NACE provided an affidavit from one of its members, Mr. Ed Henshaw, who authorized NACE to represent his interest. Mr. Henshaw asserted that, if the Sequoyah Fuels facility is not decommissioned properly, his and his family’s health will be adversely affected because contaminated ground and surface water will migrate from the SFC site and contaminate the nearby Henshaw property. He believes that if GA and SFC succeed in their challenge to Staff’s enforcement order adequate funds will not be available to properly decommission the site. To support Mr. Henshaw’s assertions, NACE provided affidavits from Mr. Timothy P. Brown, a professional hydrogeologist. Mr. Brown examined data regarding the flow paths of groundwater in the area and concluded from the available data that one could not rule out the possibility that contaminated groundwater could migrate from beneath the SFC site and contaminate groundwater and eventually the well water on the Henshaw property. Mr. Brown provided examples of flow paths that lead to the Henshaw property and asserted that migration of contamination into these paths could not be ruled out without further testing.\textsuperscript{14}

\textsuperscript{11}Lujan v. Defenders of Wildlife, 112 S. Ct. 2130, 2136 (1992) (citations and internal quotations omitted); see also Cleveland Electric Illuminating Co. (Perry Nuclear Power Plant, Unit 1), CLI-93-21, 38 NRC 87, 92 (1993).


\textsuperscript{14}NACE’s Reply to SFC’s Answer in Opposition to NACE’s Motion to Intervene [hereinafter NACE Reply], Attachment C (Dec. 30, 1993).
Although the NRC Staff concedes that NACE has standing,15 SFC, joined by GA, oppose the sufficiency of NACE's showing of standing. Answer in Opposition to NACE's Motion to Intervene (Dec. 6, 1993) (hereinafter SFC Answer). According to SFC, data gathered from extensive testing at the SFC site indicate that no groundwater flow path exists that would allow flow of groundwater from beneath the site to reach Mr. Henshaw's property. To support this conclusion, SFC provided affidavits from Mr. John S. Dietrich, its Technical Services Vice President,16 Mr. Bert J. Smith, Director of Hydrogeology for a consulting firm that provided groundwater characterization studies for the SFC facility, and Mr. Kenneth Schlag, a hydrogeologist with SFC.17 SFC also submitted a June 28, 1993 order issued by a Hearing Examiner for the Oklahoma Water Resources Board, which denied NACE intervention in a proceeding involving SFC's application for revision of a waste disposal permit. SFC Answer, Enclosure 3. The order is a brief, one-page document in which, without explanation, the Hearing Examiner concluded that NACE's members who live within 1 1/2 to 4 miles away from the flow of groundwater do not have standing.

The Licensing Board found that NACE had established the requisite injury to intervene in this proceeding. The Board found that there is uranium contamination of the soil and groundwater beneath the SFC main processing facility and nearby pond areas. Further, after reviewing various data submitted by NACE and SFC, including analysis in the Brown, Dietrich, Schlag, and Smith affidavits, the Licensing Board found that groundwater flow charts "at a minimum" support Mr. Brown's assertion that the groundwater flow patterns are "variable and complex." LBP-94-5, 39 NRC at 70. Essentially, the Board concluded that there is a possibility that contaminated groundwater could find its way to Mr. Henshaw's property by either a fault zone running from the SFC site to the Henshaw property or by way of deeper flow patterns undetected by SFC. The Licensing Board found particularly compelling the fact that SFC itself had stated that deeper flow patterns are "expected" and that the direction of these deeper flow patterns had not been measured. Id. (citing SFC Reply to NACE's Reply, Encl. 1, Attach. A-2, at HYD 5-2).

On appeal, SFC and GA argue that the Licensing Board improperly concluded that there is any possibility that contaminated groundwater could flow from SFC's site to Mr. Henshaw's property.18 Both NACE and the NRC Staff filed responses in opposition to these arguments.

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15 NRC Staff's Response to NACE's Motion for Leave to Intervene, at 5 (Dec. 13, 1993).
16 SFC Answer, Encl. 2.
18 SFC Brief on Appeal of LBP-94-5 and LBP-94-8 [hereinafter SFC Appeal], at 24-26 (Apr. 7, 1994).
SFC asserts that the injury is speculative. However, SFC does not challenge two important findings that formed in part the basis for the Board’s conclusion that NACE had demonstrated injury in fact: (1) that there is a fault running from the SFC site to Mr. Henshaw’s property and (2) that deeper groundwater flow patterns are “expected” and unmeasured. LBP-94-5, 39 NRC at 69-70. Although NACE has not established the existence of these flow patterns with certainty, such certainty is not required at this threshold stage.19

SFC argues that, even if it were possible for contaminated groundwater to be carried onto Mr. Henshaw’s property, NACE has failed to show whether Mr. Henshaw has ever used or can use the groundwater under his property. Such proof would entail still more technical studies, which at this threshold stage are unnecessary. Mr. Henshaw has alleged a reasonable threat of contamination of his well water. In addition, Mr. Brown, a professional hydrogeologist, stated that if the groundwater on Mr. Henshaw’s property becomes contaminated it may adversely affect the quality of well water on the property, thereby impacting the health of the Henshaw family. Although SFC’s hydrogeologists challenged many of the matters raised in Mr. Brown’s first affidavit, these hydrogeologists did not challenge the conclusion that groundwater contamination on Mr. Henshaw’s property could affect the well water on that property.

The determination by the Oklahoma Hearing Examiner is neither binding on the Commission nor compelling. It does not address many of the specific issues raised in this proceeding. Indeed, it is devoid of any explanation for its conclusion that NACE had failed to show injury.

Thus, we conclude that NACE is not required to go further at this threshold stage to establish injury in fact. It is enough that NACE has demonstrated a realistic threat to Mr. Henshaw of sustaining a direct injury as result of contaminated groundwater flowing from the SFC site to his property.20

Finally, we note that the Board and parties have spent considerable time discussing whether the Commission’s recent Perry21 decision provided new standards for determining standing. It did not. Notwithstanding that we have

19 See generally Los Angeles v. National Highway Traffic Safety Administration, 912 F.2d 478, 495 (D.C. Cir. 1990); Hodel, 839 F.2d at 713 (standing granted to an organization representing petitioner claiming injury from soil disturbance from mining, despite industry’s arguments that the alleged injury could only occur “upon the chance occurrence of eight events,” one of which only had “a 0.8% chance of occurring”).

20 NACE also argued that insufficient funds for decommissioning could lead to inadequate security and survey checkpoint measures, increasing the risk that contaminated materials could be transported off site. In support of this argument, NACE cited a December 1993 incident where contaminated radios were found offsite, a November 1992 incident of leakage of radioactive material found on a vehicle transporting material from SFC site, and leakage of uranium-contaminated slurry from an SFC tank truck during shipment to New Mexico. NACE Reply at 22-23. The Licensing Board did not address NACE’s arguments that inadequate funds could lead to improper surveying and security leading to offsite contamination. Because we determine that NACE has demonstrated injury in fact from potential contamination of groundwater, for the purposes of this case we need not reach this separate issue.

21 Perry, CLI-93-21, supra note 11.
already determined that NACE has demonstrated a particularized injury, we briefly discuss our holding in *Perry* to avoid any further confusion.

In *Perry*, the petitioner challenged an amendment authorizing a procedural change to remove the reactor vessel specimen withdrawal schedule from the licensee's Technical Specifications. Although the licensee's continued adherence to the withdrawal schedule is required by Commission regulations, this change eliminated the opportunity for a hearing in the future changes to the withdrawal schedule. The Commission determined that the petitioner had alleged a particularized procedural injury that was fairly traceable to the challenged amendment and was likely to be redressed by a favorable decision. 38 NRC at 93. Then, in finding that this procedural injury was linked to a concrete injury, the Commission employed a commonly applied presumption in Commission case law; i.e., persons who have frequent contacts in the area near a nuclear power plant are presumed to meet the requirements for standing by demonstrating that the proposed action involves an "obvious potential for offsite consequences." *Id.* at 95 (quoting *Florida Power and Light Co.* (St. Lucie Nuclear Power Plant, Units 1 and 2), CLI-89-21, 30 NRC 325, 329-30 (1989)). The Commission determined that the presumption applied in *Perry* because the "material condition of the plant's reactor vessel obviously bears on the health and safety of those members of the public who reside in the plant's vicinity." *Perry*, 38 NRC at 96.\(^{22}\)

2. **Causation**

The second element of standing is causation. It must be demonstrated that the injury is fairly traceable to the proposed action. *See Hodel*, 839 F.2d at 705. Such a determination is not dependent on whether the cause of the injury flows directly from the challenged action, but whether the chain of causation is plausible. *Id.* The question at issue here with respect to causation is whether NACE has demonstrated that the threat of injury to Mr. Henshaw is fairly traceable to improper decontamination and decommissioning of the SFC site

\(^{22}\)Contrary to SFC's arguments, such a presumption based on geographic proximity is not confined solely to Part 50 reactor licenses, but is also applicable to materials cases where the potential for offsite consequences is obvious. *Armed Forces Radiobiology Institute* (Cobalt-60 Storage Facility), ALAB-682, 16 NRC 150, 153-54 (1982). The determination of how proximate a petitioner must live or have frequent contacts to a source of radioactivity depends on the danger posed by the source at issue. The rule of thumb generally applied in reactor licensing proceedings (a presumption of standing for persons who reside or frequent the area within a 50-mile radius of the facility) is not applied in material cases. *See Final Rule, Informal Hearing Procedures for Materials Licensing Adjudications*, 54 Fed. Reg. 8269, 8272 (Feb. 28, 1989); *Proposed Rule, Informal Hearing Procedures for Materials Licensing Adjudications*, 52 Fed. Reg. 20,089, 20,090 (May 29, 1987). However, a presumption based on geographical proximity (albeit at distances much closer than 50 miles) may be applied where there is a determination that the proposed action involves a significant source of radioactivity producing an obvious potential for offsite consequences. *See, e.g., Armed Forces*, 16 NRC at 153-54; *Northern States Power Co.* (Pathfinder Atomic Plant), LBP-90-3, 31 NRC 40, 45 (1990).
and whether improper decontamination and decommissioning of the facility is fairly traceable to insufficient decommissioning funding.

The Commission has already recognized that adequate funds are necessary to ensure timely and proper decommissioning to protect public health and safety. In adopting the final rule involving general requirements for decommissioning, the Commission indicated that its intent was to ensure that all facilities are decommissioned in a safe and timely manner and that "adequate licensee funds will be available for this purpose." General Requirements for Decommissioning Nuclear Facilities, Final Rule, 53 Fed. Reg. 24,018 (June 27, 1988). The NRC Staff asserts here that the reason behind issuance of the order is that Staff lacked adequate assurance that the funds would be available to properly decontaminate and decommission the SFC site. NRC Staff Response in Opposition to SFC's Appeal of LBP-94-5 and LBP-94-8, at 9 (Apr. 29, 1994). Therefore, as in the general case, the threat of inadequate decommissioning here is fairly traceable to insufficient funds. However, the question remains whether the threat of injury to Mr. Henshaw is fairly traceable to improper decommissioning.

SFC did not contest the Board's finding here that the Staff's October 1993 enforcement order made it "clear" that there is uranium contamination of the soil and groundwater on the SFC main processing facility and the nearby pond areas with sufficient safety significance to warrant remediation before the property can be released for unrestricted use. LBP-94-5, 39 NRC at 68-69. In our discussion above regarding "injury in fact," we have already determined that there is a threat that this contaminated groundwater, if not remedied, may find its way to flow paths leading to Mr. Henshaw's property. Since the decontamination and decommissioning activities are intended to prevent or remediate the groundwater and other contamination on the SFC site, we find that NACE has demonstrated that the threat of injury to Mr. Henshaw is fairly traceable to inadequate decontamination and decommissioning.

3. Redressability

The third element of standing requires that "it must be 'likely,' as opposed to merely 'speculative' that the injury will be 'redressed by a favorable decision.'" Lujan, supra, 112 S. Ct. at 2136 (quoting Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26, 38, 43 (1976)). On appeal, SFC argues that the threat of injury to Mr. Henshaw is not redressable. It notes that, pursuant to Staff's October 1993 order, the Director of Nuclear Materials Safety and Safeguards retained the authority to relax or rescind the order. SFC maintains that, even if the Licensing Board sustains the order, the Director could still subsequently relax it. Therefore, according to SFC, the alleged threat to Mr. Henshaw will remain irrespective of the outcome of this proceeding. SFC Appeal at 27-28.
Clearly one possible outcome of the proceeding is that the order will be sustained, without subsequent modification or rescission, and SFC and GA will be held responsible for providing the full financial assurance required by the order. SFC does not challenge that this outcome would redress Mr. Henshaw's threatened injury. Full responsibility for the entire amount required by the order is the most likely result, if the order is sustained. SFC's suggestion that the Staff, after receiving a favorable decision sustaining the order, would then modify or rescind the order, is the more speculative outcome. Moreover, even if the order is modified, such modification could not be accomplished without the Staff's determination that good cause warranted such relief, consistent with the public health and safety, and adjudicatory findings by the Board relating to necessary funding to ensure public health and safety could not be ignored. Therefore, it is likely, as opposed to merely speculative, that if the order is sustained it will assure proper funding for decontamination and decommissioning and thereby redress the threat of injury to Mr. Henshaw.

Having found an injury in fact that is redressable by a favorable decision, we conclude that the Licensing Board properly found that NACE demonstrated standing as of right to participate in this proceeding.\(^{23}\)

III. CONCLUSION

For the reasons stated in this decision, SFC and GA's appeals are denied. The Licensing Board's order in LBP-94-5 granting standing to NACE is affirmed. To the extent that LBP-94-8 relies upon a finding of standing, LBP-94-8 is affirmed.\(^{24}\)

It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland, this 23rd day of August 1994.

\(^{23}\)Having found that NACE has standing as of right to participate in this proceeding, we need not reach the question of whether NACE should be granted discretionary intervention.

\(^{24}\)The Licensing Board's decision in LBP-94-8 addresses NACE's submitted contentions. SFC and GA did not appeal the Board's findings with respect to the contentions, but only the Board's reliance upon an earlier finding of standing for NACE. Accordingly, the Commission reaches no conclusion on LBP-94-8's discussion of the contentions.
In an enforcement proceeding involving funding for decontamination and decommissioning of the Sequoyah Fuels Facility near Gore, Oklahoma, the Commission denies appeals of LBP-94-19, 40 NRC 9 (1994), in which the Atomic Safety and Licensing Board granted intervention to the Cherokee Nation. Relying on the analysis contained in a companion decision, CLI-94-12, 40 NRC 64 (1994), the Commission finds that otherwise qualified petitioners are not barred from participation in hearings simply because they seek to support an enforcement order.

MEMORANDUM AND ORDER

Pursuant to 10 C.F.R. § 2.714a, the Sequoyah Fuels Corporation (SFC) has appealed the Atomic Safety and Licensing Board Memorandum and Order LBP-94-19 (40 NRC 9 (1994)). The Board granted the Cherokee Nation standing and admitted the Cherokee Nation to this proceeding. The NRC Staff opposes the SFC appeal. The Commission denies the appeal and affirms LBP-94-19.
This proceeding involves a challenge to an NRC enforcement order issued to SFC and its parent corporation, General Atomics (GA), on October 15, 1993.1 The Staff order holds SFC and GA jointly and severally responsible for ensuring the availability of adequate funds for the decommissioning of SFC's facility near Gore, Oklahoma. SFC and GA sought this hearing to challenge the Staff's order.

The order permitted "any other person adversely affected" by the order to request a hearing. In November 1993, the Native Americans for a Clean Environment (NACE) filed a motion for leave to intervene in this proceeding. The Cherokee Nation — subject of this appeal — filed its request for intervention on April 20, 1994. Both parties requested intervention for the purpose of arguing that the Staff order should be fully sustained.

The NACE motion for intervention first placed into question whether a petitioner may intervene as of right in support of a Staff enforcement order. SFC and GA argued that a petitioner who supports an enforcement order cannot establish the requisite interest for standing. The Licensing Board determined in section II.A of LBP-94-5, 39 NRC 54, 63-66 (1993), that an otherwise qualified petitioner may intervene to support an enforcement order in an adjudicatory hearing convened under 10 C.F.R. § 2.202. The Board also found that NACE had demonstrated "injury in fact" sufficient for standing to intervene. In a subsequent decision, the Licensing Board found NACE's two contentions admissible and admitted NACE as a party to this proceeding. LBP-94-8, 39 NRC 116 (1994). SFC and GA appealed LBP-94-5 in its entirety and appealed LBP-94-8 to the extent that the decision relied on a finding of standing for NACE. We decide the appeal of those decisions in a companion order issued today.

Before us now is SFC's appeal of LBP-94-19, which admitted the Cherokee Nation as a party to this proceeding, after finding that the Cherokee Nation demonstrated standing to intervene. SFC does not challenge any of the factual predicate with respect to the Cherokee Nation's standing. The Licensee questions only whether the Cherokee Nation may intervene at all. SFC bases its appeal of LBP-94-19 on only one argument — that "the Cherokee Nation favors the enforcement action at issue in this proceeding and therefore cannot be adversely affected by this proceeding."2 SFC thus appeals the Licensing Board's admission of the Cherokee Nation on the same ground that SFC and GA challenge the Licensing Board's ruling in Section II.A of LBP-94-5 regarding NACE's ability to intervene.3

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1 See In the Matter of Sequoyah Fuels Corporation General Atomics (Gore, Oklahoma, Site Decontamination and Decommissioning Funding), 58 Fed. Reg. 55,087 (Oct. 25, 1993).
2 SFC's Notice of Appeal of LBP-94-19, Incorporated Supporting Brief, and Request That Appeals Be Consolidated (July 18, 1994) at 2.
3 SFC requested that its appeal of LBP-94-5 and LBP-94-8, regarding the admission of NACE, be consolidated with the appeal of LBP-94-19. The Commission denies the request as moot. We address the appeals involving NACE in a separate — albeit related — decision issued today.
In a companion decision issued today, we affirm Section II.A of LBP-94-5. Otherwise qualified petitioners are not barred from participation in hearings simply because they seek to support an enforcement order. See CLI-94-12, 40 NRC 64, 68-71 (1994). Thus, the Cherokee Nation's interest in supporting the Staff enforcement order does not preclude the Cherokee Nation from intervening in this proceeding. Accordingly, and because SFC submits no other basis for its appeal of the admission of the Cherokee Nation, we deny SFC's appeal of LBP-94-19.4

CONCLUSION

In summary, the request that appeals be consolidated is denied as moot, the Sequoyah Fuels Corporation appeal of LBP-94-19 is denied, and the Atomic Safety and Licensing Board order LBP-94-19 is affirmed.

It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland, this 23d day of August 1994.

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4 We take the occasion of this decision involving the Cherokee Nation to call the attention of the Licensing Board and the parties to a recent Presidential directive on relations with Native American tribal governments. In a Memorandum for the Heads of Executive Departments and Agencies, dated April 29, 1994, President Clinton directed federal departments and agencies to operate within a government-to-government relationship with federally recognized tribal governments, to ensure that tribal rights and concerns are considered. See Government-to-Government Relations with Native American Tribal Governments, 59 Fed. Reg. 22,951 (May 4, 1994).
The Licensing Board, in response to a notice of withdrawal with prejudice of the only intervenor in the proceeding, grants the withdrawal and terminates the proceeding.

MEMORANDUM AND ORDER
(Terminating Proceeding)

This proceeding was remanded to this Atomic Safety and Licensing Board by the Commission’s Memorandum and Order dated March 3, 1993, CLI-93-3, 37 NRC 135, reconsideration denied, CLI-93-12, 37 NRC 355 (1993), further clarified in CLI-93-19, 38 NRC 81 (1993). The Commission determined that the Environmental and Resources Conservation Organization (ECO) possessed standing (as a matter of discretion), that it had submitted one valid contention, and that it should be permitted to submit additional contentions in three designated areas.
In our Second Prehearing Conference Order, dated November 30, 1993, LBP-93-23, 38 NRC 200, discretionary review denied, CLI-94-2, 39 NRC 91 (1994), we admitted several portions of ECO's contention on decommissioning funding but granted the Licensee's motion for summary disposition of the single contention admitted by the Commission. We subsequently established discovery schedules that were scheduled to end on August 1, 1994. Memorandum and Order (Telephone Conference Call re: Discovery Schedules), dated April 19, 1994 (unpublished).

On August 1, 1994, ECO filed a "Notice of Withdrawal with Prejudice and Suggestion of Termination of Proceeding." In that document, ECO gave "notice" of its withdrawal from the proceeding, together with the withdrawal of its contentions, its petition for leave to intervene, and its request for a hearing, all with prejudice. ECO also expressed the opinion that its withdrawal "brings the proceeding to a close" and suggests that we issue an order terminating the proceeding.

Treating ECO's "Notice" as a motion to withdraw, we hereby grant it. The proceeding is thus terminated.

In CLI-93-3, the Commission specifically provided that "[p]ending further order of the Commission following action by the Licensing Board on remand, the Staff is directed to withhold issuance of the Decommissioning Order." 37 NRC at 155. Because this Memorandum and Order constitutes our final action in this proceeding, we are advising the Commission so that it may issue any necessary order concerning effectiveness of the Decommissioning Order.

IT IS SO ORDERED.

THE ATOMIC SAFETY AND LICENSING BOARD

Charles Bechhoefer, Chairman
ADMINISTRATIVE JUDGE

Dr. Richard F. Cole
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Rockville, Maryland
August 11, 1994
This Memorandum and Order weighs whether or not to order the deposition of a person who is seriously ill. The Board declined to order the deposition. It determined that Intervenor had failed to demonstrate that the benefit of the proposed discovery outweighs the burden, given the importance of the issues at stake in the litigation and the importance of the proposed discovery in resolving the issues.

However, the Board also noticed that the proposed deponent was willing to be deposed. It therefore established conditions under which a voluntary deposition might be taken.

RULES OF PRACTICE: DEPOSITION OF ILL PERSON; MOTION TO COMPEL DENIED

Intervenor has the burden of demonstrating that the benefit of a deposition of a seriously ill person outweighs the burden, given the importance of the issues at
stake in the litigation and the importance of the proposed discovery in resolving the issues.

RULES OF PRACTICE: DEPOSITION OF SICK PERSON; PERSON WILLING TO BE DEPOSED

The lawyer of an ill individual sought as subject of a deposition may not assert that the deposition would impose an undue burden unless the proposed subject seeks to be protected or there is some reason to question the rationality behind the person’s willingness to be deposed.

RULES OF PRACTICE: ALTERNATIVE DISPUTE RESOLUTION

The Licensing Board establishes conditions under which a voluntary agreement may be reached concerning the deposition of a seriously ill individual.

MEMORANDUM AND ORDER
(Deposition of Mr. Bill Shipman)

We have decided to deny conditionally the motion of Mr. Allen Mosbaugh (Intervenor) to depose Mr. Bill Shipman, who is seriously ill and who has been deposed previously for 4.5 hours. The denial shall be subject to further explanation by Georgia Power. It is without prejudice to a future request for a deposition, particularly if Mr. Shipman’s health improves or if there is further explanation of the reasons why a deposition is so important that it should be held despite hardships for Mr. Shipman.

At the Board’s suggestion, Intervenor filed a “Motion to Compel GPC1 to Produce Bill Shipman” on August 15, 1994 (Motion). Georgia Power filed a “Response to Intervenor’s Motion to Compel GPC to Produce Bill Shipman,” on August 16, 1994 (Response). The Staff of the Nuclear Regulatory Commission declined to submit a filing on this issue.2

I. THE LAW

Section 2.740(c) of 10 C.F.R. provides:

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1 Georgia Power Company, et al., also referred to as Georgia Power.

2 In response to an e-mail inquiry about whether the Staff would file a response concerning the Shipman Deposition, Staff declined to make a filing and served its response on the parties to this proceeding.
Protective order. Upon motion by a party or the person from whom discovery is sought, and for good cause shown, the presiding officer may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense.

The provision of the Federal Rules of Procedure that parallels the Nuclear Regulatory Commission's procedural rule, and which may be used as a helpful interpretive suggestion is:

The frequency or extent of use of the discovery methods otherwise permitted under these rules and by any local rule shall be limited by the court if it determines that... the burden or expense of the proposed discovery outweighs its likely benefit, taking into account the needs of the case, the amount in controversy, the parties' resources, the importance of the issues at stake in the litigation, and the importance of the proposed discovery in resolving the issues. [Emphasis added.]

II. PRIOR ACTION OF THE LICENSING BOARD

At the August 12 Prehearing Conference in this case, Georgia Power raised the question of whether or not Mr. Shipman should be required to complete a deposition on August 22, two days before scheduled major surgery for liver and stomach cancer. Georgia Power offered to make Mr. Shipman available on August 18 — a date unacceptable to Intervenor because its lead counsel on this issue is on vacation.

During the Prehearing Conference the Board required written filings of the concerned parties. It also described the required filings, at Tr. 653, in this way:

[W]hat [the Licensing Board would]... need is a motion that would show why it's sufficiently urgent to require this deposition two days before the surgery. If you showed a cross-examination plan that was important enough, [the Board]... might be able to... uphold it.

II. ANALYSIS OF THE FILINGS

We find that Intervenor's Motion is woefully incomplete. In particular, the Motion failed to discuss the benefits it is seeking to obtain during the continued deposition of Mr. Shipman. There was no "cross-examination" plan, as was suggested by the Board, and there was no discussion demonstrating that the previous deposition of this witness was conducted in a manner consistent with his fragile health or that the questions left to be asked are truly important.

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4 Tr. 651-56.
Although Intervenor did say why Mr. Shipman is an important witness, in his motion at 5 n.4, he did not discuss what had been accomplished in the already-completed deposition session and what is left to be accomplished. In short, Intervenor ignored the suggestion of the Board that he demonstrate, with respect to the requested second deposition session with Mr. Shipman, what the Federal Rules of Procedure describes as, “the importance of the proposed discovery in resolving the issues.”

One aspect of the filings before us gives us pause about reaching our conclusions. We applaud Georgia Power's truthfulness in disclosing that, “Mr. Shipman has personally stated that he will attend a deposition on August 22, if that is what the Company deems to be in its best interest.”5 Under the circumstances, we are somewhat puzzled that Georgia Power's lawyers and Mr. Shipman's lawyers felt that they were authorized to oppose the deposition on grounds of hardship. A ground that Georgia Power asserted for its motion is “Intervenor's apparent insensitivity to Mr. Shipman's situation.”6

This Board is prepared to establish conditions that would be responsive to Mr. Shipman's needs, including conducting the deposition in a convenient location or by telephone and limiting the total time available for the deposition. In addition, the Board's Chair could attend or be available by phone, pursuant to Mr. Shipman's wishes, to ensure that unnecessary hardship does not occur. Prior to the deposition, a transcript of the previous deposition and a cross-examination plan could be made available to the Board, so that it could ensure that needless duplication or irrelevant questioning is avoided.

We infer from the motion that Mr. Shipman's counsel and Georgia Power's counsel feel that Mr. Shipman's willingness to be deposed should not be fully respected, perhaps because the lawyers perceive a hardship related to the advanced stages of his illness. However, we will require Georgia Power to do one of the following: (1) file with the Board an affidavit discussing why Mr. Shipman's willingness to attend a deposition should not be honored by this Board, or (2) state that a deposition can be conducted under conditions that meet the criteria described by this Board. We note that, despite Mr. Shipman's expressed wishes, whether or not this deposition occurs does not depend on “what the Company deems to be in its best interest.”7

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5 Response at 6.
6 Id. at 7.
7 Id. at 6.
III. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 18th day of August 1994, ORDERED that:

1. Intervenor's Motion to Compel GPC to Produce Bill Shipman, filed August 15, 1994, is denied, subject to the conditions that follow.

2. Georgia Power Company, et al., shall: (1) file with the Board an affidavit discussing why Mr. Shipman's willingness to attend a deposition should not be honored by this Board, or (2) state that Mr. Shipman will attend a deposition subject to specific conditions that are consistent with the Board's decision and are acceptable to Mr. Shipman.

FOR THE ATOMIC SAFETY
AND LICENSING BOARD

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
These proceedings involve two enforcement actions brought by the NRC Staff. The first would have directed Nuclear Support Services, Inc. (NSSI) to remove an individual from NRC-licensed or regulated activities for 5 years. The
second would have prohibited that same individual from participating in NRC-licensed or regulated activities for the same period. Certain near-term corrective actions were also sought.

By Memorandum and Order (Consolidating Proceedings and Granting Extension of Time), dated May 4, 1994 (unpublished), we granted the requests for a hearing and consolidated the two proceedings. On June 27, 1994, we issued a Notice of Hearing and Prehearing Conference, 59 Fed. Reg. 34,454 (July 5, 1994). Following a July 12, 1994 prehearing conference, we issued our First Prehearing Conference Order (Establishing Initial Discovery Schedules), dated July 15, 1994 (unpublished). In that Order, we noted that at the conference we had urged the parties seriously to consider settlement of these proceedings. (On June 21, 1994, prior to the conference, NSSI/Dailey advised us that they had reached a settlement agreement with regard to the short-term relief sought by the Staff and were withdrawing their requests for a hearing with respect to those aspects of the Staff's NSSI enforcement order.)

On August 11, 1994, the parties filed a Joint Motion to Approve Settlement Agreement and Terminate Proceeding. A copy of the agreement was attached, and is appended to this Order. According to the Motion, NSSI and Mr. Dailey have entered a compromise because they desire to avoid the expense and hardship of litigation. The Staff believes that the settlement agreement is in the public interest.

We have carefully reviewed the compromise agreement and note that it provides a significant degree of the relief sought by the Staff. We agree with the parties that it is consistent with the public interest and, consequently, we grant the Joint Motion, approve the settlement agreement, and, accordingly, terminate the proceeding.
IT IS SO ORDERED.

THE ATOMIC SAFETY AND LICENSING BOARD

Charles Bechhoefer, Chairman
ADMINISTRATIVE JUDGE

Dr. Richard F. Cole
ADMINISTRATIVE JUDGE

Dr. Jerry R. Kline
ADMINISTRATIVE JUDGE

Rockville, Maryland
August 18, 1994

ATTACHMENT

SETTLEMENT AGREEMENT

WHEREAS, on March 22, 1994 the Nuclear Regulatory Commission ("NRC") issued an order to Nuclear Support Services, Inc. ("NSSI") captioned "EA 93-236" (59 Fed. Reg. 14429 (March 28, 1994)) (hereafter "NSSI Order"), and issued an order to Robert C. Dailey captioned "IA 94-003" (59 Fed. Reg. 14688 (March 29, 1994)) (hereafter "Dailey Order"); and

WHEREAS, NSSI and Mr. Dailey have answered the NRC's orders and have requested a hearing on the orders, and NSSI and the NRC Staff later entered into a Settlement Agreement with regard to Part IV.B of the NSSI Order on June 21, 1994; and

WHEREAS, NSSI and Mr. Dailey have engaged in negotiation and compromise because they desire to avoid the expense and hardship of litigation; and

WHEREAS, the remaining issue before the NRC's Atomic Safety and Licensing Board ("Board"), whether the Dailey Order and Part IV.A of the NSSI Order should be sustained, need not be adjudicated because the NRC Staff, Mr. Dailey and NSSI have reached a compromise by which NSSI and Mr. Dailey have agreed to accept certain restrictions on Mr. Dailey's activities, as described below; and
WHEREAS, the NRC Staff believes that this Settlement Agreement is in the public interest;

NOW, THEREFORE, in consideration of the mutual promises made herein, NSSI, Mr. Dailey, and the NRC Staff agree as follows:

1. NSSI agrees to restrict Mr. Dailey from conducting security screening or fitness-for-duty activities (10 CFR Parts 26, 50, & 73) until March 22, 1996.

2. NSSI agrees that, if contacted by another person or company considering employing Mr. Dailey to conduct security screening or fitness-for-duty activities (10 CFR Parts 26, 50, & 73) prior to March 22, 1996, NSSI will advise that person of the existence of this Settlement Agreement and will provide them a copy of this Settlement Agreement.

3. Mr. Dailey agrees that he will not conduct security screening or fitness-for-duty activities (10 CFR Parts 26, 50, & 73) while employed by NSSI or any other person or company prior to March 22, 1996.

4. Mr. Dailey agrees that, during the one year period from March 22, 1996 until March 22, 1997, he will provide notice to the Director, Office of Enforcement within thirty days after commencing employment with any organization other than NSSI, where his duties include responsibilities for conducting security screening or fitness-for-duty activities (10 CFR Parts 26, 50, & 73).

5. The NRC Staff hereby rescinds and vacates the Dailey Order and Part IV.A of the NSSI Order.

6. The NRC Staff agrees that Mr. Dailey’s role as NSSI's Vice President Corporate Safety is consistent with this Settlement Agreement, in that his duties do not include responsibilities for conducting security screening or fitness-for-duty activities (10 CFR Parts 26, 50, & 73).

7. Nothing in this agreement shall be construed so as to restrict Mr. Dailey from being subject to security screening or fitness-for-duty requirements.

8. NSSI and Mr. Dailey and the NRC Staff agree to file a joint motion requesting the Board to approve this Settlement Agreement and terminate the proceeding, pursuant to the Commission's regulations in 10 CFR §2.203. If the Settlement Agreement is not approved or is changed in any substantive manner by the Board, it may be voided by any party by giving written notice to the parties and the Board. The parties agree that under these circumstances and upon request they will negotiate in good faith to resolve differences.

9. The parties understand and acknowledge that there has not been any adjudication of any wrongdoing by Mr. Dailey and that this Settlement Agreement is the result of a compromise and shall not for any purpose be construed: (a) as an admission by NSSI or Mr. Dailey of any wrongdoing or regulatory violation; (b) as an admission that the NRC has jurisdiction to issue orders to NSSI or Mr. Dailey; or (c) as a concession by the NRC Staff that
no violation or wrongdoing occurred or that the NRC lacks jurisdiction to issue orders to NSSI or Mr. Dailey.

10. The parties agree that no inference adverse to either party shall be drawn based upon the parties having entered into this agreement.

IN WITNESS WHEREOF, Mr. Dailey, NSSI and the NRC Staff have caused this Settlement Agreement to be executed by their duly authorized representatives on this 10th day of August, 1994.

James Lieberman
Director, Office of Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Robert C. Dailey
Vice President Corporate Safety
Nuclear Support Services, Inc.
West Market Street
Campbelltown, PA 17010

Joe C. Quick
Chairman and President
Nuclear Support Services, Inc.
West Market Street
Campbelltown, PA 17010
The Board held that the Staff stands on the same footing as any party with respect to requests for admissions. Neither 10 C.F.R. § 2.742 nor any other section of the regulations provides for any different treatment of the Staff. The Board also found that Rule 36 of the Federal Rules of Civil Procedure is helpful in interpreting the Commission's rules concerning admissions. The Board said that the Staff would not be held to its admissions if new information causes it to change its view of the public interest.

With respect to interrogatories asked of the Staff, the Board held that the Staff is not required to answer interrogatories unless this Licensing Board finds: (1) answers to the interrogatories are necessary to the determination of this case, and (2) answers to the interrogatories are not reasonably attainable from any other source. 10 C.F.R. § 2.720(h)(2)(ii); compare 10 C.F.R. § 2.740b(a).
RULES OF PRACTICE: REQUEST FOR ADMISSIONS TO STAFF

With respect to requests for admissions addressed to the Staff, the Board held that the Staff stands on the same footing as any party. Neither 10 C.F.R. § 2.742 nor any other section of the regulations provides for any different treatment of the Staff. The Board also found that Rule 36 of the Federal Rules of Civil Procedure is helpful in interpreting the Commission's rules concerning admissions. The Board also said that the Staff would not be held to its admissions if new information causes it to change its view of the public interest.

RULES OF PRACTICE: REQUESTS FOR ADMISSIONS BY THE STAFF

With respect to interrogatories asked of the Staff, the Board held that the Staff is not required to answer interrogatories unless this Licensing Board finds: (1) answers to the interrogatories are necessary to the determination of this case, and (2) answers to the interrogatories are not reasonably attainable from any other source. 10 C.F.R. § 2.720(h)(2)(ii); compare 10 C.F.R. § 2.740b(a).

MEMORANDUM AND ORDER
(Staff Responses to Intervenor's First Request for Admissions, Second Set of Interrogatories)

On August 1, 1994, Mr. Allen Mosbaugh (Intervenor) filed two motions to compel responses from the Staff of the Nuclear Regulatory Commission (Staff). 1 Staff responded on August 16, 2 relying in part on its July 15 response to the discovery motions. 3

I. APPLICABLE LAW

The Staff is not required to answer interrogatories unless this Licensing Board finds: (1) answers to the interrogatories are necessary to the determination of this case, and (2) answers to the interrogatories are not reasonably attain-

1 "Intervenor's Motion to Compel Response from NRC Staff to Intervenor's Second Set of Interrogatories and Request for Documents from Staff of the U.S. Nuclear Regulatory Commission," August 1, 1994 (Interrogatory Motion), and "Intervenor's Motion to Compel Response from NRC Staff to Intervenor's First Request for Admissions from the NRC Staff," August 1, 1994 (Admissions Motion).
2 "NRC Staff Response to Intervenor's Motions to Compel the Staff to Respond to Second Set of Interrogatories and First Request for Admissions and Staff Motion to Strike a Part of Intervenor's Motion."
3 "NRC Staff Response to Intervenor's Second Set of Interrogatories and Request for Production of Documents," July 15, 1994 (Reply to Interrogatories).
able from any other source. 10 C.F.R. § 2.720(h)(2)(ii); compare 10 C.F.R. § 2.740b(a). Similarly, the Staff is not required to produce a document in response to a discovery request unless the Licensing Board finds: (1) that the record or document is relevant to the proceeding; and (2) that the record or document is not exempt from disclosure or that, if exempt from disclosure, that its disclosure is necessary to a proper decision in the proceeding; and (3) that the document or the information therein is not reasonably attainable from another source. 10 C.F.R. § 2.744(d).

We note that the Staff advised Intervenor that these provisions were applicable. Reply to Interrogatories at 2.

With respect to requests for admissions, the Staff stands on the same footing as any party. Neither 10 C.F.R. § 2.742 nor any other section of the regulations provides for any different treatment of the Staff. On the other hand, the Staff is not applying for a license and its admissions cannot, therefore, be held against it. Furthermore, as a protector of the public interest, Staff will remain free to change its position in light of new information that may be produced in the course of a trial. 4

II. REQUEST FOR ADMISSIONS

This section of our Memorandum and Order addresses a matter of first impression concerning the obligations of the Staff to amend its response to a Request for Admissions. 5

We conclude that the section relied on by Intervenor to authorize its motion to compel is applicable to interrogatories and does not provide authority with respect to a request for admissions. The nonapplicability of this section, however, makes it easier for Intervenor to prevail because he need not demonstrate that a response to a Request for Admissions is "necessary to a proper decision in the proceeding." There is no analogous restriction in the rules pertaining to requests for admissions.

We interpret Intervenor's motion as a request for us to require that an amended answer be served. 6 This we shall do. We consider a 30-day period, ending on

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4 Note that Rule 36(b) of the Federal Rules of Civil Procedure, which is helpful in interpreting the Commission's rule on request for admissions, states that the court may permit withdrawal or amendment of an admission when the presentation of the merits of the action will be served thereby. This gives the Board adequate flexibility to preserve the Staff's freedom to shift its position in order to protect the public interest.

5 On May 17, 1994, Intervenor filed its First Request for Admissions to NRC Staff, pursuant to 10 C.F.R. § 2.740b. The Staff filed its Response to Intervenor's May 17, 1994, First Request for Admissions to NRC Staff on July 15, 1994. Then, Intervenor filed a Motion to Compel Response from NRC Staff to Intervenor's First Request for Admissions from the NRC Staff, on August 1, 1994. Intervenor claimed to file its Motion to Compel pursuant to 10 C.F.R. § 2.720(h)(2)(ii), which deals with motions to compel responses to interrogatories, not to admissions. The NRC Staff filed its Response to Intervenor's Motions to Compel the Staff, etc., on August 16, 1994.

6 Although the rule also would permit us to rule that requests not answered by the Staff are admitted, we shall not do this at this time.
September 22, to be an adequate time for Staff to prepare its amended response. In the alternative, since a response provided at a later date may be more helpful to Intervenor, Intervenor and Staff may reach an agreement about a mutually agreed-upon date.

We have examined 10 C.F.R. § 2.742, as well as Rule 36 of the Federal Rules of Civil Procedure. It is our conclusion that the two rules are consistent with one another and that Rule 36, which is more complete, is an excellent guide to the proper interpretation and use of section 2.742. Here are some of the most important portions of the Federal Rule:

If objection is made, the reasons therefor shall be stated. The answer shall specifically deny the matter or set forth in detail the reasons why the answering party cannot truthfully admit or deny the matter. . . .

* * *

An answering party may not give lack of information or knowledge as a reason for failure to admit or deny unless the party states that the party has made reasonable inquiry and that the information known or readily obtainable by the party is insufficient to enable the party to admit or deny. . . .

* * *

If the Court determines that an answer does not comply with the requirements of this rule, it may order either that the matter is admitted or that an amended answer be served. . . .

We consider a request for admissions to be an important way to narrow issues in a proceeding. To the extent that the Staff can carefully respond to these requests, it may find a way to make admissions that will narrow the matters in contention in this case. We urge the Staff to make that kind of careful review.

In particular, we urge the Staff to review the findings in the OI Investigation Report, which is a major document in this proceeding, and to respond to the request to determine whether each numbered sentence or statement in the document is true and correct. Likewise, it should respond to the request to examine the numbered factual findings and the numbered evidentiary findings in the OI Report and to state whether they are true or accurate.7 It is our ruling, as suggested by Federal Rule 37, that "any admission made by a party . . . is for the purpose of the pending action only and is not an admission for any other purpose nor may it be used against the party in any other proceeding." The parties may rely on this assurance of the Board.

The OI Report is a major Staff effort. It differs somewhat in its conclusions from the conclusions of the Vogtle Coordinating Group Analysis, which Staff

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7 The specificity requested by Intervenor in its Request for Admissions appears to be generally correct and to fall within the principles of the Federal Rules of Civil Procedure.

We also note that the evidentiary findings do not make conclusions as to ultimate truth. They are findings about what has been said, stated, or advised. As such, they merely require a comparison of the statements to the exhibits. This is a legitimate request that is being made by Intervenor.
says is the basis for its case. Tr. 523. Consequently, it is helpful in narrowing
the issues in this case for Staff to review the OI Report and determine which
statements in that report are true and which are not. In this way, the Licensing
Board may be greatly assisted in comparing the relative value of the two different
Staff views. It also will make it unnecessary for Intervenor to attempt question-
by-question cross-examination of Staff witnesses, which could produce a very
long trial. While the response to the Request for Admissions will indeed be
time-consuming, the difficulty is produced by the nature of this case and not by
any fault of Intervenor.\footnote{We are hopeful that, since the investigation in this case began almost 5 years ago, the Staff will utilize enough
resources to permit it to fulfill its discovery obligations within its target deadlines in this case. We note that many
of the issues raised by the request for admissions also are raised by Georgia Power’s response to the NOV and that
Intervenor may further crystallize those issues in the context of the NOV through his promised reply to Georgia
Power.}

Any stipulations or agreements between the parties that reduce the dimensions
of this task would be welcomed and likely would be approved by the Board.

III. INTERROGATORIES

A. Interrogatory 1: About Ken McCoy

In Interrogatory 1, Intervenor sought information relating to an investigation
that the Staff is said to have conducted concerning Mr. Ken McCoy. We consider
this request to be within the scope of permissible discovery, since it relates to
the character of a person who is likely to be a witness in the case. However,
Staff also stated that the information is publicly available and Intervenor has not
refuted that alleged fact. Staff Response at 5; Interrogatory Motion at 6-7. This
Staff answer is adequate.

B. Interrogatory 2: Vogtle Coordinating Group

In Interrogatory 2, Intervenor seeks detailed information about the Vogtle
Coordinating Group, which is the author of “Vogtle Coordinating Group Anal-
ysis of Evidence and Conclusions,” February 9, 1994. The report followed “a
detailed review of evidence associated with allegations that senior officials of
Georgia Power Company (GPC) made material false statements regarding the
reliability of diesel generators at the Vogtle facility.”\footnote{Memorandum from David B. Matthews, Chairman, Vogtle Coordinating Group, to Thomas E. Murley, Director,
Office of Nuclear Reactor Regulation,” February 9, 1994, at 1.} Hence, it is clear that the
work of the Vogtle Coordinating Group is relevant to this proceeding.

This interrogatory seeks a variety of information about the Vogtle Coordinat-
ing Group, whose report is a basis for the Staff’s position in this proceeding.
Tr. 523. Consequently, we are troubled that Staff also is claiming that the information about the work of the Vogtle Coordinating Group is not necessary for a proper decision in this proceeding. Apparently, the Staff takes the position that it will present its case concerning the findings of the Vogtle Coordinating Group and Intervenor will not be permitted to obtain discovery concerning how that position was developed. It is our conclusion, to the contrary, that the Staff’s answers to questions concerning the credibility of its case are necessary to the proper determination of this case. See General Electric Co. (Vallecitos Nuclear Center, General Electric Test Reactor), LBP-78-33, 8 NRC 461 464-68 (1978) (information about people relied on by intervenors to review, analyze, and study contentions is discoverable).

Consequently, we shall order answers to this interrogatory, other than with respect to exceptions stated in this Memorandum and Order. Staff need not produce any document that is part of this request and that is already publicly available, providing that the Staff informs Intervenor about the location of the document. 10 C.F.R. § 2.740(b)(1).

Some of the documents requested in Interrogatory 2(e)(v) and (vi) are pre-decisional documents that may contain opinions that are protected from disclosure in order to protect frank, open discussion within the federal government. We will permit the Staff to withhold these opinion portions, providing they promptly file a justification for the withholding of the opinion portion of each such document or related class of documents. Consumers Power Co. (Palisades Nuclear Power Facility), ALJ-80-1, 12 NRC 117, 119-28 (1980) (especially page 125, which cites one case where the Appeal Board upheld a claim of privilege and another case in which the Commission held that certain information found necessary to a proper decision would be revealed).

The Staff shall segregate out all factual information contained in these documents and shall produce those factual portions in discovery. Portions that contain predecisional Staff opinions, including those that are inextricably intertwined with factual information, shall remain privileged at this time and Staff may delete those portions, subject to the justification we required above.

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10 We do not interpret 2(e)(i) and (ii) to include drafts of documents that were prepared by the Staff prior to these meetings. Final drafts used by the Staff at the meeting should not be considered predecisional and should be produced in discovery.

11 The burden is upon the claimant of the executive privilege to demonstrate a proper entitlement to exemption from disclosure, including a demonstration of precise and certain reasons for preserving the confidentiality of governmental communications. Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), LBP-82-82, 16 NRC 1144, 1165 (1982), citing Smith v. FTC, 403 F. Supp. 1000, 1016 (D. Del. 1975); Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), ALAB-773, 19 NRC 1333, 1341 (1984).

12 Intervenor may then file an opposing brief, but he will need to be more specific than the general statement contained in Intervenor’s Motion at 7. Specific transcript citations are likely to be necessary in order to persuade us to abrogate Staff’s specific claims of privilege.
However, we have concluded that Staff may be required to disclose relevant dissenting professional opinions, if any. Dissenting professional opinions may have special value in testing the credibility of the majority’s opinions. If these dissenting opinions develop important subjects that are relevant to the validity of the findings of the Vogtle Coordinating Group, they shall be produced in discovery. *Long Island Lighting Co.* (Shoreham Nuclear Power Station, Unit 1), LBP-82-82, 16 NRC 1144, 1164 (1982) (citing *EPA v. Mink*, 410 U.S. 73, 87-88 (1973). If there are dissenting professional opinions that are not important, the Staff may withhold them and file a justification for its claim of privilege.

C. Interrogatory 4: Office of Investigation (OI) Report

Staff responds that the first page of the OI report lists all people involved in the preparation of the report other than secretarial personnel. We have determined that this is an adequate response to the first portion of the interrogatory.

However, Intervenor requests “all documents used in the creation of the OI Report or which resulted from its creation.” Staff responds that “documents used to complete the OI report are cited in the document.” This is not fully responsive since it does not exclude the possibility that there are documents used in the preparation of the OI Report but not cited in the final product. We interpret Intervenor’s interrogatory to request all documents used in creating the Report, regardless of whether they were cited in that report. The request should be interpreted to include all transcripts of interviews and all significant notes of interviews or communications. A note shall be considered significant if it contains information of sufficient gravity to have been considered important and relevant at some point in the decision process. We do not interpret the request to include predecisional nonfactual material reflecting the decision process used by OI in preparing its report. Our interpretation is that the only document that “resulted from its [the OI Report’s] creation” is the final OI report.

D. Interrogatory 5: Notice of Violation (NOV)

We have determined that the Staff should disclose the names of people involved in creating and issuing the NOV and a brief statement of the nature of the expertise they contributed. (Staff need not disclose how they participated in the process, thus exposing the process itself, which is privileged.) If Staff introduces the NOV into this proceeding, Intervenor is entitled to know who participated in issuing the document. Even if Staff does not introduce the NOV, it is relevant to this proceeding and Intervenor should be permitted to conduct discovery in order to determine whether to introduce the document itself or to choose to attack its credibility.
We grant another aspect of this request. Intervenor should be provided with any document or portion of a document that has not already been disclosed and that contains segregable factual information that was considered by any person (including Commissioners and their staffs) in deciding whether or not to issue the NOV.

E. Interrogatory 6: Regulatory Authority to Form the Vogtle Coordinating Group

We agree that the authority to form the Vogtle Coordinating Group is not an issue in this proceeding because it does not affect the credibility of that Group’s findings. In addition, this is a legal issue not a factual one. If Intervenor suspects that there is some illegality, it should brief us on that illegality, not request that the Staff provide a legal argument to support its wild legal hypotheses.

F. Interrogatory 8: Similar to Interrogatory 6

This interrogatory is denied for the same reason that we have denied Interrogatory 6.

G. Interrogatory 9: Timing of Creating Vogtle Coordinating Group

This interrogatory requests information about whether the NRC Staff had been advised of OI findings when it created the Vogtle Coordinating Group. Because this relatively straightforward information should not be difficult to obtain and because it may help to understand the purpose and credibility of the work of the Vogtle Coordinating Group, this interrogatory should be answered.

H. Interrogatory 10: Regulatory Authority of the Vogtle Coordinating Group

This interrogatory is based on an invalid premise. We take administrative notice of the fact that OI Reports are not binding on the agency. They are recommendations. Thus, if another Staff group considers the same facts, it would be free to agree or disagree with the OI Findings. It would not “negate” an OI Finding. It would just disagree with it.

This question is primarily legal and not factual. We will not require the Staff to do Intervenor’s legal research.
IV. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 22d day of August 1994, ORDERED that:

1. The Staff of the Nuclear Regulatory Commission (Staff) shall file an amended response to Intervenor's First Request for Admissions to NRC Staff, filed May 17, 1994. The amended response shall include all matters discussed in this Memorandum and Order.

2. Any admission is for the purpose of the pending action only and is not an admission for any other purpose nor may it be used against the party in any other proceeding.

3. Staff shall respond to Interrogatory 2, except for matters that they need not disclose pursuant to this Memorandum and Order.

4. Staff shall provide to Intervenor all documents used in creating the Office of Investigation's Report in Docket No. 50-424/50-425, regardless of whether they were cited in that report. The request should be interpreted to include all significant factual information, including transcripts of interviews and notes of significant interviews or communications. A note shall be considered significant if it contains information of sufficient gravity to have been considered important and relevant at some point in the decision process. Staff need not include predecisional, nonfactual material reflecting the decision process of the Office of Investigations in preparing its report.

5. Staff shall provide to Intervenor any document or portion of a document that has not already been disclosed and that contains factual information that was considered by any person (including Commissioners and their staffs) in deciding whether or not to issue the Notice of Violation issued to Georgia Power Company, et al., on May 9, 1994. Staff shall also disclose the names of the people involved in preparing and issuing the NOV and a brief statement of the nature of the expertise they contributed (Staff need not disclose how they participated in the process, thus exposing the process itself, which is privileged.)

6. Staff shall respond to Interrogatory 9.

7. All responses required by this Order shall be filed so that they are received by 5 p.m. on September 22, 1994.
8. In all other respects, Intervenor's Motion to Compel Response from NRC Staff to Intervenor's First Request for Admissions from the NRC Staff, filed August 1, 1994, is denied.

FOR THE ATOMIC SAFETY
AND LICENSING BOARD

James H. Carpenter (by PBB)
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
In the Matter of

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

Peter B. Bloch, Chair
Dr. James H. Carpenter
Thomas D. Murphy

In the Matter of Docket Nos. 50-424-OLA-3
50-425-OLA-3
(ASLBP No. 93-671-01-OLA-3)
(Re: License Amendment;
Transfer to Southern Nuclear)

GEORGIA POWER COMPANY, et al.
(Vogtle Electric Generating Plant,
Units 1 and 2) August 26, 1994

RULES OF PRACTICE: LATE-FILED BASIS FOR CONTENTION;
STANDARD FOR CONSIDERATION

The test to be applied to determine whether to admit for litigation a new basis
for an admitted contention is "whether the motion [to admit the contention] was
timely and whether it presents important information regarding a significant
issue." Consumers Power Co. (Midland Plant, Units 1 and 2), LBP-84-20, 19
NRC 1285, 1296 (1984). Applying this test, Intervenor's motion to admit a new
basis for an admitted contention is denied.
ALLEGED VIOLATION OF TECHNICAL SPECIFICATIONS: INTERPRETATION

To determine whether technical specifications have been violated, the wording of the specifications must be carefully examined to determine the precise meaning of those specifications.

ALLEGED COMMITMENT TO NRC: CONTAINMENT HATCH

The Board rejected an allegation that Licensee had breached a commitment to the NRC that went beyond its technical specifications. The alleged commitment related to keeping the containment hatch closed. Yet opening of the hatch was an open and obvious action and the Board does not accept the argument that the action reflected adversely on the character and competence of the Licensee.

TECHNICAL ISSUES DISCUSSED

Action statements: technical specifications;
Containment equipment hatch;
Emergency mode: diesel operation;
Emergency power;
Limiting conditions of operation: technical specifications;
Loss of all electrical power;
Operable: definition in technical specifications;
Residual heat removal system: operability;
Site area emergency.

MEMORANDUM AND ORDER
(Denying Motion to Accept Additional Factual Basis)

I. MEMORANDUM

Mr. Allen Mosbaugh (Intervenor) moved to admit into this proceeding a new basis for his admitted contention. The new basis he advances is an allegation that Georgia Power misled the Nuclear Regulatory Commission concerning an allegedly improper opening of the containment equipment hatch, breaching containment integrity, during the March 20, 1990 site area emergency.1 Georgia Power has responded to this motion in an extensive factual filing. Georgia Power

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1Intervenor's Motion to Accept Additional Factual Basis in Support of the Admitted Contention, July 6, 1994 (Intervenor's Motion).
and the Staff argue that Intervenor's Motion is seeking to raise a new "issue" in an untimely fashion.\(^2\)

The question before us is whether or not to admit the new basis into this proceeding.

**II. STANDARD FOR ADMITTING A NEW BASIS FOR A CONTENTION**

Our prior Memorandum and Order, LBP-94-22, 40 NRC 37, 39 (1994), has established the standard we shall use to determine whether or not to admit a new basis for the admitted contention. As we said in that Memorandum and Order:

We have admitted into this proceeding Intervenor's following contention: 3

The license to operate the Vogtle Electric Generating Plant, Units 1 and 2, should not be transferred to Southern Nuclear Operating Company, Inc., because it lacks the requisite character, competence, and integrity, as well as the necessary candor, truthfulness, and willingness to abide by regulatory requirements.

This contention was based on specific allegations about: (1) false or misleading statements about Vogtle's diesel generators, and (2) illegal transfer of the authority to operate the Vogtle Plant.

A Licensing Board has the authority to make an appropriate decision about whether the new basis shall be admitted. It has the authority to conduct a fair and impartial hearing and to take appropriate action to avoid delay.\(^4\) We note that a Licensing Board, in an analogous context, held that an issue that fell within an admitted contention could be litigated. The test that was developed and applied, to determine whether to admit the new issue, was "whether the motion was timely and whether it presents important information regarding a significant issue." *Consumers Power Co.* (Midland Plant, Units 1 and 2), LBP-84-20, 19 NRC 1285, 1296 (1984). We accept this test.

Thus, the test for whether or not to admit the new basis for Intervenor's contention has two prongs: (1) is it timely, and (2) does it present important information regarding a significant issue.

**A. Timeliness**

Deciding whether or not this contention is timely could entail the resolution of a difficult factual issue. Mr. Allen Mosbaugh made Tape 25. He was present

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\(^2\) Georgia Power Company's "Answer to Intervenors' Motion to Accept Additional Factual Basis in Support of the Admitted Contention," July 21, 1994 (Georgia Power's Answer); Staff of the Nuclear Regulatory Commission, "Response to Intervenor Motion for Admission of Late-Filed Contention Basis," July 26, 1994 (Staff's Response).

\(^3\) LBP-93-5, 37 NRC 96, 110 (1993).

\(^4\) 10 C.F.R. § 2.718.
when Mr. Frederick made a statement that Mr. Mosbaugh relies on as a basis for this new contention. Mr. Mosbaugh now places great safety significance on these events. Yet he apparently lived through these events himself without realizing their safety significance. His attorney now states that he "had no independent recollection of events contained on Tape 25." He provided that tape to the NRC in 1990. Mr. Mosbaugh claims that his memory was refreshed when the NRC returned the tape to him, believing it did not contain relevant evidence. At that time, Mr. Mosbaugh quickly sent a complete tape back to the NRC. Since Mr. Mosbaugh has not informed us of the precise date on which this occurred, we lack knowledge with which to determine whether he acted with reasonable promptness in filing a new basis before the Board, based on the date on which he states that he first became aware of the basis for this contention.

Mr. Mosbaugh has some responsibility for his failure of memory, prior to the time he replaced the NRC's tape. Were we to consider the additional basis in this proceeding, discovery would need to start now and there would be otherwise avoidable delay because of this tardy filing. If the allegation were sufficiently important, then its significance would outweigh this delay. However, as we shall state in the next portion of this Memorandum and Order, we have concluded that there is not sufficient significance in the allegations to permit us to overlook Mr. Mosbaugh's tardiness in raising them.

B. Significance of Proposed New Basis

For reasons set forth in Section II of this Memorandum and Order, we conclude that there is no basis for the belief that Georgia Power violated its technical specifications or misled the Nuclear Regulatory Commission (NRC) when it opened the containment hatch while Diesel 1A was inoperable. Hence we have determined that there is no significance to the new basis that Intervenor has offered. Accordingly, we conclude that the new basis should not be further litigated and the motion to admit the new basis shall, therefore, be dismissed.

III. POSITIONS OF THE PARTIES

A. Intervenor's Position Concerning Technical Specification Violations

Intervenor proposes the following scenario as its new basis. After the declaration of a site area emergency on March 20, 1990, at Plant Vogtle, containment integrity was restored by closing the containment equipment hatch.

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5 Intervenor's Reply to the Board's Memorandum and Order of July 28, 1994 Concerning Intervenor's Motion to Accept Additional Factual Basis, August 12, 1994 (Intervenor's Reply to the Board) at 12.
6 Intervenor's Reply to the Board at 13.
at 9:42 a.m. as required by Technical Specification 3.9.8.2. By that evening both Unit 1 emergency diesel generators were declared inoperable. As a consequence of both diesels being declared inoperable, Intervenor alleges that both trains of the Residual Heat Removal (RHR) system were inoperable and thus placed Plant Vogtle in violation of its Technical Specifications, specifically Technical Specification 3.8.1.2 and Technical Specification 3.9.8.2. Intervenor also alleges that GPC made prior commitments to the NRC not to open the containment hatch until the diesel and the Reserve Auxiliary Transformer (RAT) were operable. In violation of that commitment, Plant Vogtle managers opened the containment equipment hatch at 10:00 p.m.

Intervenor states that the motivation for this action was improper, consisting of a need to remove an impediment to maintaining the critical path on the Plant Vogtle outage schedule. By its action, Plant Vogtle was intentionally placed in a less safe condition. Intervenor alleges that although Plant Vogtle recognized that it needed a waiver from the NRC to enter into Mode 5 (Cold Shutdown) from Mode 6 (Refueling), which it verbally received on March 21, 1990, by opening the containment equipment hatch, it was in violation of Technical Specification 3.9.8.2. Intervenor alleges that the waiver was sought to cover up violations of Technical Specification and to speed up the outage.7

Intervenor supplemented his motion at the request of the Licensing Board.8 Intervenor states that Technical Specification 3.8.1.2 requires an absolute minimum of one source of offsite power feeding both safety buses with at least one emergency diesel generator fully operable when the plant is in Mode 6 with Reactor Coolant System water level less than 23 feet above the top of the reactor vessel flange (i.e., during refueling). In addition, Technical Specification 3.9.8.2 requires that there must be two independent RHR electrical trains operable with no less than one train operating. Again Intervenor reiterates that one fully operable emergency diesel generator must be available for the RHR systems to be declared operable.9 To do otherwise, according to the Intervenor would represent a "continuing disregard to conservatively interpret Technical Specifications when significant safety issues are directly implicated."10 Intervenor cites support for this position in an NRC Staff memo.11 Again Intervenor stresses that with both emergency diesel generators inoperable, opening the containment (equipment) hatch constitutes a violation of Technical Specification 3.8.1.2 and Technical Specification 3.9.8.2 and as such places the plant in its last echelon of defense before core damage. Intervenor argues that logic and reason demand that

7 Intervenor's Motion at 1-4.  
8 Intervenor's Reply.  
9 Id. at 1-4.  
10 Intervenor's Reply at 4.  
11 Id. at 4, ¶3.
plant operators not engage in nonconservative activity that further degrades safety by removing the last barrier of defense to a radiation release to the public. Intervenor argues that taking nonconservative action that absolutely and knowingly degrades existing safety barriers after entering a Technical Specification immediate action statement constitutes a violation of the intent, meaning, and purpose of that Technical Specification.\textsuperscript{12}

B. Georgia Power's Position Concerning Technical Specification Violation

Georgia Power claims that Intervenor inaccurately characterized Plant Vogtle Technical Specification; failed to discuss the NRC's interpretation of the Technical Specifications; and provided no meaningful support for his assertions.\textsuperscript{13} Georgia Power contends that Intervenor does not cite any evidence supporting the allegation that opening the containment equipment hatch violated Technical Specifications.

Georgia Power states that Technical Specification 3.8.1.2 established A.C. electric power limiting conditions for operation applicable to refueling and cold shutdown modes. It requires one offsite power source and one emergency diesel generator to be operable in both modes. With less than these minimum requirements, certain operations were prohibited. Significantly, no action was required regarding the equipment hatch.\textsuperscript{14} Technical Specification 3.9.8.2 established a limiting condition for operation applicable to the refueling mode when water level was less than 23 feet above the top of the reactor flange. It requires two independent RHR trains to be operable, at least one operating. If this requirement was not met, the Technical Specification requires action to restore RHR as soon as possible, or bring reactor vessel water level at least 23 feet above the reactor vessel flange. With no RHR in operation, all containment penetrations providing direct access from the containment to the outside atmosphere were to be closed within 4 hours.

Georgia Power states that Intervenor claims that the inoperability of the two emergency diesel generators on the evening of March 20, 1990, made both RHR trains inoperable is inaccurate and unsupported. Georgia Power cites an NRC Staff memo in support of this position.\textsuperscript{15} The NRC Staff position at the time considered both trains of an RHR system operable if they were powered from their respective safety electrical buses. Emergency onsite power sources

\textsuperscript{12} \textit{id. at 7.}
\textsuperscript{13} Georgia Power Company's Answer to Intervenor's Motion to Accept Additional Factual Bases in Support of the Admitted Contention, July 21, 1994 (GPC's Answer).
\textsuperscript{14} Intervenor's Reply at 5.
\textsuperscript{15} GPC Answer, Exh. A.
were not required to consider a system operable. Georgia Power states that both trains of the RHR system were operable when the containment equipment hatch was open. Both RATs were supplying offsite power to each RHR system independently. Therefore Georgia Power claims that there was no violation of Technical Specification.

C. Staff Position Concerning Alleged Technical Specification Violation

At a prehearing conference held on July 29, 1994, the Licensing Board invited the Staff’s views on the merits of Intervenor’s allegations. Tr. 496-97. The Staff responded in an Affidavit filed August 18, 1994. The Staff disagreed with the Intervenor’s position that RHR systems were not operable since emergency power is not available. Therefore containment penetrations were not required to be closed. The Staff avers that the change from Mode 6 to Mode 5 was made following verbal approval by the NRC to GPC. Since there was no indication that either RHR system was inoperable at this time, GPC did not need a waiver of TS 3.9.8.2. Since RHR was not inoperable, when the containment was open, this did not violate Technical Specifications and did not require a 10 C.F.R. § 50.59 safety evaluation. The Staff also considers the actions taken by GPC to provide a secondary reactor coolant method to be conservative.

IV. BOARD ANALYSIS

The parties have argued many specific issues in order to support or oppose the admission of the new contention. However, we have decided that it is important for the Board to understand the sequence of events in the site area emergency and the relationship of these events to the technical specifications for Vogtle. Through this review, we have concluded that the core issues that need to be understood, as of the time of the site area emergency, are relatively simple. The following sections of this Memorandum and Order contain our discussion of these issues.

16 NRC Staff Response to Licensing Board Inquiry, August 18, 1994 (Staff Supplemental Response) and Attached Affidavit of Pierce R. Skinner, August 17, 1994 (Pierce Affidavit).
17 Pierce Affidavit at 3, 4.
18 Id. at 4, 5.
A. What Technical Specification Required the Closing of the Containment Hatch at the Vogtle Plant?

On March 20, 1990, a site area emergency was declared at Vogtle. The act that initiated the incident was the backing of a truck into an electrical support pole, causing the power line to fall to the ground and the transformer breakers to trip. Diesel Generator 1A, which was the only diesel generator available, started automatically but stopped after 80 seconds. Eighteen minutes later, there was a second attempt to start 1A, which operated about 70 seconds this time. About 36 minutes after the power was disrupted (at 9:56 a.m.), an emergency start of Generator 1A (accomplished after disabling all but the four most crucial trips) was undertaken, resulting in a successful, continuous run of about 4.5 hours.

Approximately 15 minutes into the incident, the Unit 1 shift superintendent directed that the containment building be closed. This was required by a limiting condition of operation in Technical Specification 3.9.8.2:

3.9.8.2 Two independent residual heat removal (RHR) trains shall be OPERABLE, and at least one RHR train shall be in operation. . . .

* * *

b. With no RHR train in operation. . . . Close all containment penetrations providing direct access from the containment atmosphere to the outside atmosphere within 4 hours.

[Emphasis added.]

The applicable definition of OPERABLE is found in technical specification 1.20:

1.20 A system, subsystem, train, component or device shall be OPERABLE or have OPERABILITY when it is capable of performing its specified function(s), and when all necessary . . . electrical power . . . that [is] . . . required for the system . . . to perform its function(s) are also capable of performing their related support functions.

At the time the containment hatch was ordered closed, there was no electrical power — external or emergency — available for either train of the residual heat

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20 Id. at 2-3.
21 Id. at 2-4.
22 Id.
23 Id. at 2-5.
24 See Encl. 1 at 3/4 9-9. This enclosure is an attachment to a Nuclear Regulatory Commission memorandum from Charles E. Rossi, Director of the Division of Operational Events Assessment Office of Nuclear Reactor Regulation to William T. Russell, Associate Director for Inspection and Technical Assessment, Office of Nuclear Reactor Regulation (August 16, 1991) (Rossi Memo). The memorandum was attached, as Exhibit A, to Georgia Power Company’s Answer to Intervenor’s Motion to Accept Additional Factual Bases in Support of the Admitted Contention, July 21, 1994 (Georgia Power’s Answer).
25 Rossi Memo, Encl. 1 at 1-4.
removal system and neither train was in operation. Hence, the Action Statement 3.9.8.2(b) was called into operation and the containment hatch was required to be closed.

B. What Conditions Required That the Hatch Be Closed? At What Point Did Those Conditions No Longer Exist?

As we have just stated, it was:

1. the non-operability of the residual heat removal systems, because of the absence of all electrical power, and
2. that the residual heat removal systems were not in operation, that required the containment hatch to be closed. The technical specifications require closing the containment hatch only when both of these conditions are met.

Under the technical specifications in effect at Vogtle, as soon as one train of the residual heat removal system was in operation there was no requirement that the containment hatch be closed. In addition, as soon as both trains of the RHR system were "operable" because they were receiving the electrical power necessary to perform their functions, then Vogtle was in compliance with 3.8.9.2 and no action statement would have been applicable.26

By 9:56 a.m., Diesel Generator 1A had been successfully started in emergency mode. At 10 a.m., the A train of the residual heat removal system was started for decay heat removal. At 11:40 a.m., power was restored to the 1B Reserve auxiliary transformer, which was connected in parallel to the 1A safety bus.27 At this point, both RHR trains had electrical power and were OPERABLE because:

all necessary . . . electrical power . . . that [is] . . . required for the system . . . to perform its function(s) are also capable of performing [its] . . . related support functions.

It is important to note that the criterion for operability is met because it had the electrical power that is necessary to perform the system's functions. The definition of operability does not extend to emergency electrical power. Only to necessary power.28 In addition to these sources of electrical power, at 6:41

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26 This was consistent with the revised technical specifications issued by the NRC in 1981. See Rossi Memo at 2.
27 NUREG-1410 at 2-5.
28 Note that Intervenor, in his Reply to the Board's Memorandum and Order of July 28, 1994, Concerning Intervenor's Motion to Accept Additional Factual Basis," August 12, 1994 (Intervenor's Reply to the Board), at 3, changed the meaning of Definition 1.20 by deleting the word "necessary," which is essential to a full understanding of this definition.
p.m., the IA Reserve Auxiliary Transformer was energized from offsite power, providing still another source of electrical supply.29

C. Did the NRC Have an Official Position About What Was Needed for a System to Be Operable?

The NRC's official position on power supply has been the interpretation at Vogtle since it was licensed.30 Under this position, a system does not have to be declared inoperable solely because its emergency power source (usually the associated diesel generator) is not available. Under this position, a plant could meet its technical specification requirements with one operable offsite power source and one operable diesel generator as long as power was supplied to both safety buses.31

D. What, If Anything, Is the Significance of a Dissenting View Among the Staff of the NRC That Would Have Resulted in Tightening the Definition of an Operable System?

There is a differing professional view in the Staff of the Commission concerning the interpretation of the Vogtle technical specifications. Under this view, a system is not considered operable unless all its electrical power, including emergency sources of power, is available. In addition, the Staff recognizes that the technical specifications in this area need to be clarified and apparently will be as a result of an ongoing shutdown risk study.32

At the time of the Site Area Emergency, the NRC accepted an interpretation of the Technical Specifications that is different from the just-discussed differing professional view and recommendation. The existence of these other points of view does not in any way indicate that Georgia Power acted improperly or that the Nuclear Regulatory Commission was deceived about a technical-specification violation.

Pierce H. Skinner, an NRC Inspector responsible for both the Hatch and Vogtle inspection programs, has determined that Georgia Power's actions with respect to the containment hatch were conservative. He filed an affidavit on August 17, 1994, in which he stated:

Since RHR was not inoperable when the containment equipment hatch and possibly other penetrations were open, this did not violate [technical specifications] . . . .

29 NUREG-1410 at 2-22.
30 Rossi Memo at 2.
31 Id. Note that if both power buses have electrical power, then both trains of the RHR system have the electrical supply necessary for them to run. Thus, under the definition of operable, they are operable.
32 Id. at 3.
I determined the actions taken by GPC were conservative at the time the waiver of compliance was granted. I consider that aligning the systems such that a secondary cooling method would be more readily available by tensioning the reactor vessel head was a conservative condition. If water had been added to the reactor coolant system with the head detensioned, there would have been some probability that leakage at the flange could have occurred. Tensioning the head bolts ensures that any added water would have been contained within the reactor coolant system.\textsuperscript{33}

We conclude that Intervenor has provided no basis for the belief that Georgia Power (or some of its officers) demonstrated a lack of character and competence in the way it treated the technical specifications.

E. Did Vogtle Violate Its Technical Specifications When It Issued a Limiting Condition of Operability ("LCO") Against Diesel 1A? If So, What Are the Consequences of That Violation with Respect to Opening the Containment Hatch?

Yes. Vogtle was in violation of the following limiting condition of operation, only:\textsuperscript{34}

3.8.1.2 As a minimum, the following A.C. electrical power sources shall be operable:

a. One circuit between the offsite transmission network and the Onsite Class IE Distribution System, and
b. One diesel generator . . . .

What is the consequence of this violation? To determine that, you must look at the remainder of 3.8.1.2. First, you discover that the LCO was applicable at the time, to Vogtle, because it is applicable to Modes 5 and 6. Then, you examine the action statement to determine the effect:

ACTION: With less than the above minimum required A.C. electrical power sources OPERABLE, immediately suspend all operations involving CORE ALTERATIONS, positive reactivity changes, movement of irradiated fuel, or crane operation with loads over the fuel storage pool, and provide relief capability for the Reactor Coolant System in accordance with Specification 3.4.9.3. In addition, when in MODE 5 with the reactor coolant loops not filled, or in MODE 6 with the water level less than 23 feet above the reactor vessel flange, immediately initiate corrective action to restore the required sources to OPERABLE status as soon as possible.

\textsuperscript{33} NRC Staff Response to Licensing Board Inquiry, August 18, 1994, in the attached Affidavit of Pierce H. Skinner at 4-5.

\textsuperscript{34} We have discussed above, beginning at pp. 110-11, that LCO 3.9.8.2 was not applicable, primarily because an emergency diesel generator is not necessary for the operation of the residual heat removal system.
This was the entire action statement that came into effect for violation of LCO 3.8.1.2. There is no indication that Georgia Power failed to adhere to this action statement. More important, in light of the alleged new basis, there was no requirement to keep the containment hatch closed under this limiting condition for operation. It could be opened for any legitimate reason, such as conducting outage-related activities. Motive is simply irrelevant.35

F. Has Intervenor Demonstrated a Basis for His Belief That Georgia Power Breached a Promise It Made with the NRC to Keep the Containment Hatch Closed, Regardless of Whether or Not That Was Required by the Vogtle Plant’s Technical Specifications?

Intervenor alleges, based on a tape-recorded statement by Mr. Frederick and on an entry in the Vogtle War Room Log, that Georgia Power made a commitment to the NRC that it would not open the containment hatch until it had a fully operable A Diesel. The quotations on which Intervenor relies are:

[From transcript of Tape #25, Side B, as recorded by Allen Mosbaugh without the knowledge of Mr. Frederick:]36

Frederick:

And basically, at the meeting [between Georgia Power and the NRC] I thought that the final discussion that I got from George [Bochhold] and Skip [Kitchens], because they said it 4 times for clarification, I remember it had to be said 4 times before everybody understood, that we wouldn’t reopen the hatch until we had the diesel and the RAT. And we never got the diesel. That night they wrote an LCO on it.

War Room Log, March 20, 1990 day entry, at p. 51.37

Outage work is slowly getting back to normal after emerg. termination. Before mid loop work can continue or equip. hatch be opened, AA02 and BA03 must be in normal alignment from respective RATS [Reserve Auxiliary Transformers] and A diesel be fully operable with question about low jacket [water] pressure trips having been answered.

We are persuaded by the bases that Intervenor has filed that Georgia Power personnel at one time decided, first orally and then recorded in the War Log, that the equipment hatch would not be opened until after the A diesel was fully operable. The oral statements were made at a meeting in which the NRC was present. While the words apparently were not accompanied by a handshake or

35 Compare Intervenor’s argument: Intervenor’s Reply to the Board at 6.
36 Intervenor’s Motion to Accept Additional Factual Basis in Support of the Admitted Contention,” July 6, 1994, Attach. 1, at 1 of 2.
37 Intervenor’s Reply to the Board, Exh. 2.
by statements that "it's a deal," it is quite likely that NRC personnel who were present were aware of Georgia Power's plans.38

Whatever was said at this meeting, however, Georgia Power subsequently changed its mind and decided to open the equipment hatch. The hatch is not a small, covert plant component. It is about four to five times the height of a man. It is opened using motors and a polar crane.39 It is an open and visible condition that would have been immediately obvious to any member of the NRC who was within the containment or who chose to look up at the containment from an appropriate position on the outside.

We conclude that Intervenor has failed to establish a rational basis for believing that Georgia Power deceived the NRC or otherwise failed to live up to standards of candor and honesty. There is no basis for believing that Georgia Power misled the NRC by breaching an "agreement" with it. We, therefore, also conclude that Intervenor's allegation about breaching a promise to the NRC does not demonstrate any lack of character and competence on the part of Georgia Power or its officials.

V. BOARD ANALYSIS AND CONCLUSION

We conclude, based on the analysis presented above, that Intervenor's Motion for a New Basis is untimely and does not present important information regarding a significant issue. The Motion shall be denied.

VI. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 26th day of August 1994, ORDERED that:

38 We note that the NRC Staff Response to Licensing Board Inquiry did not address at all whether a commitment had been made to the NRC. Since NRC personnel present during the discussions with Vogtle would be most knowledgeable as to whether a "commitment" was made to the NRC, this silence of the Staff is puzzling to the Board.

39 See NUREG-1410 at 3-70, 2-8.
Intervenor's Motion to Accept Additional Factual Basis in Support of the Admitted Contention, July 6, 1994, is denied.

THE ATOMIC SAFETY AND LICENSING BOARD

James H. Carpenter
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
MEMORANDUM AND ORDER
(Approving Settlement Agreement and Terminating Proceeding)

By joint motion dated August 24, 1994, the parties to this proceeding, Indiana University School of Medicine (Licensee) and the Staff of the Nuclear Regulatory Commission (Staff) request that we approve a Settlement Agreement (Agreement) and terminate this proceeding.

Pursuant to section 234 of the Atomic Energy Act of 1954, as amended (AEA), 42 U.S.C. § 2282, and 10 C.F.R. § 2.203, we have reviewed the Settlement Agreement to determine whether approval and termination is in the public interest. On the basis of that review, we have concluded that the parties' Agreement and the termination of this proceeding are consistent with the public interest.
Accordingly, pursuant to sections 81, 161b, 161i, 161o, 191, and 234 of the AEA, 42 U.S.C. §§ 2111, 2201(b), 2201(i), 2201(o), 2241, and 2282, and 10 C.F.R. § 2.203, the joint motion of the parties is granted and we approve the "Settlement Agreement," which is attached to and incorporated by reference in this Order. Further, pursuant to 10 C.F.R. §§ 2.203, 2.718, and 2.721, the Board terminates this proceeding.

IT IS SO ORDERED.

THE ATOMIC SAFETY AND LICENSING BOARD

James P. Gleason, Chairman
ADMINISTRATIVE JUDGE

Dr. Peter S. Lam
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Rockville, Maryland
August 29, 1994

SETTLEMENT AGREEMENT

THIS AGREEMENT is made by and between the Indiana University School of Medicine (University) and the Staff of the United States Nuclear Regulatory Commission (NRC Staff or Staff), to wit:

WHEREAS the University is the named licensee on Byproduct Material License No. 13-02752-08 (License), issued by the NRC, which License authorizes the possession and use of byproduct material at the University’s facility located at the Indiana University Radiation Oncology Center, 535 Barnhill Drive, Indianapolis, Indiana (facility); and

WHEREAS the License, as amended on October 6, 1989, authorizes, inter alia, the possession and use of 7000 curies of cobalt-60 in a Picker Corporation Model 6296 teletherapy unit and 6670 curies of cobalt-60 in a Thomson CGR Medical Corporation Model Alcyon II unit; and
WHEREAS on November 13-14, 1992, the University used the Alcyon II unit to treat a patient, and the treatment resulted in a misadministration in which the patient received twice the dose intended to be administered; and

WHEREAS on October 7, 1993, the NRC Staff issued to the University a Notice of Violation and Proposed Imposition of Civil Penalty (NOV), in which the Staff asserted a violation of the NRC's requirements in 10 C.F.R. § 35.32, identified as a result of the November 13-14, 1992, misadministration, and, pursuant to 10 C.F.R. § 2.202, proposed a civil penalty of $5000 for the violation asserted in the NOV; and

WHEREAS on January 18, 1994, the Staff issued an Order Imposing Civil Monetary Penalty (Order) to the University, requiring it to pay a civil penalty in the amount of $5,000 within 30 days of the date of the Order for the reasons described in the Order and the Appendix to the Order; and

WHEREAS the University has requested a hearing on the Staff’s Order, in response to which proceedings have been convened and remain pending before an Atomic Safety and Licensing Board (Board) at this time; and

WHEREAS the University denies and continues to deny that it violated the NRC’s requirements as stated in the Order, and the Staff maintains that the violation occurred as stated in the Order, and the parties consider this issue unresolved, but the undersigned parties recognize that certain advantages and benefits may be obtained by each of them through settlement and compromise of all of the matters now pending in litigation between them, which the parties recognize and believe to be in the public interest;

IT IS NOW, THEREFORE, AGREED AS FOLLOWS:

1. The University hereby agrees to pay, and the Staff agrees to accept, the amount of $2,500 within 15 days of the date of the Board’s approval of this Agreement, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555.

2. The Staff will transmit to the University a list of deficiencies in the University’s written Quality Management Program (QMP), including, without limitation, deficiencies identified by the Staff in its review of the November 1992 misadministration and deficiencies identified by the Staff’s contractor’s routine review of the University’s written QMP.

3. As further described in Paragraph 5, below, the University agrees to resolve to the Staff’s satisfaction each item on the list of deficiencies identified in Paragraph 2, above, by submitting proposed revisions to the QMP to the
NRC\(^1\) within sixty (60) days of the date of the Staff's transmittal of the list to the University.

4. The Staff agrees to review and comment on the University's proposed revisions to the QMP within 120 days of the date of the Staff's transmittal of the list of deficiencies to the University, and the University agrees to resolve the Staff's comments to the Staff's satisfaction within the same time.

5. Upon written notice from the NRC Staff that the University has resolved to the Staff's satisfaction each item on the list of deficiencies identified in Paragraph 2, above, and each of the Staff's comments on the University's proposed revisions to the QMP, provided for in Paragraph 4, above, the University agrees to retain an independent contractor, approved by the Staff in writing, to audit the University's implementation of its QMP. The University will ensure that the audit is completed within ninety (90) days of the date of the Staff's notice, or the date of written Staff approval of the independent contractor, whichever is later, The University agrees further that it will obtain a report of the results of the audit from the independent contractor within thirty (30) days of completion of the audit.

6. The University agrees to submit to the Staff a copy of the report of the independent contractor identified in Paragraph 5, above, within thirty days of the date of the report.

7. The parties agree that, as an integral part of this Agreement, upon execution of this Agreement, the parties will file a joint request for approval of this Agreement and termination of the proceeding on the Staff's Order of January 18, 1994, with prejudice, it being understood and agreed that this Agreement resolves all outstanding issues with respect to the Staff's Order of January 18, 1994.

8. The University agrees that if:
   (a) the University fails to pay $2,500 in accordance with Paragraph 1; or
   (b) the University fails to submit proposed revisions to the QMP as specified in Paragraph 3, above; or
   (c) the University fails to resolve to the Staff's satisfaction each item on the list of deficiencies identified in Paragraph 2, above, or to resolve to the Staff's satisfaction the Staff's comments identified in Paragraph 4, above, within 120 days of the date of the Staff's transmittal of the list of deficiencies to the University; or
   (d) the University fails to retain an independent contractor as specified in Paragraph 5, above; or

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\(^1\)The University shall submit its proposed revisions to the QMP to Dr. John E. Glenn, Mail Stop T8-F5, U.S. Nuclear Regulatory Commission, Washington, DC 20555.
(e) the University fails to submit the independent contractor's report to the NRC as specified in Paragraph 6, above;
the Staff may, by letter signed by the Director of the Office of Enforcement, NRC, declare the University in default of the Agreement.

9. In the event of a default under Paragraph 8, above:
   (a) the provisions of this Agreement, with the exceptions of Paragraphs 8, 9, 10, 11, 12, 13, and 14, are null and void; and
   (b) the University agrees to pay $5,000, less the amount paid under Paragraph 1, if any, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555.

The payment under this Paragraph shall be made within thirty (30) days of the date of the Staff's letter notifying the University of the default.

10. It is expressly understood and agreed that, in the event of a default by the University declared by the Staff under Paragraph 8, above, the Staff may take such legal actions against the University as the Staff may then deem to be appropriate including, without limitation, the right to resort immediately to a court of law in a collection action, by referral of the civil penalty to the United States Department of Justice for collection or otherwise, and the University hereby waives any right it may have to seek an administrative remedy in connection therewith, in accordance with Paragraph 11, below.

11. The University hereby waives any and all rights or opportunity it may have to request a hearing or otherwise contest the Order Imposing Civil Monetary Penalty dated January 18, 1994, in the event that the Staff declares a default under Paragraph 8, above.

12. In the event the University makes payments totalling $5,000 under Paragraphs 1 and 9, above, the University shall have no further obligations under this Agreement and the Order.

13. For good cause shown, the Staff may, in writing, extend the time to complete any action set forth in any provision of this Agreement. It is expressly understood that if the University shows that it has fewer than 30 days from the date of a Staff comment, provided under this Agreement, in which to respond to the comment, the University will have demonstrated good cause for an extension allowing the University to respond within 30 days of the date of any such Staff comment. Extensions shall be signed by the Director, Office of Enforcement, or the Director's designee.

14. It is expressly understood and agreed that nothing contained in this Agreement shall relieve the University from complying with all applicable NRC regulations and the terms and conditions of the License, and, further, that nothing
contained in this Agreement shall be binding on, or preclude lawful action by, any other Government agency or department.

15. It is expressly understood and agreed that nothing contained in this Agreement shall preclude the NRC Staff from taking further action as it deems appropriate to resolve any issue regarding the completeness and accuracy of information submitted to the NRC Staff by the University or involving the adequacy of the investigation of the November 1992 misadministration performed by the University’s Radiation Safety Officer.

For the Indiana University
School of Medicine:

Thomas P. Gannon
Attorney for Indiana University

For the NRC Staff:

Robert M. Weisman
Counsel for NRC Staff

Dated this 24th day of August 1994.
By joint motion filed August 26, 1994, Licensee Oncology Services Corporation (OSC) and the NRC Staff ask that we terminate this case. In their motion, OSC and the Staff assert that such action is warranted because recent events have rendered this case moot. Because we agree, we grant the parties' joint motion and dismiss this proceeding.

This adjudication was instituted in February 1993 in response to OSC's request for a hearing to challenge a January 20, 1993 Staff enforcement order. That immediately effective order suspended OSC's byproduct materials license authorizing the use of sealed-source iridium-192 for high dose rate (HDR) brachytherapy treatments at six OSC facilities in Pennsylvania. See 58 Fed. Reg. 6825 (1993). In their joint motion, the parties advise us that, in response to OSC requests, the Staff recently (1) issued individual byproduct materials licenses
for five of these facilities that authorize HDR brachytherapy treatments at each facility, and (2) terminated the single OSC license that was suspended pursuant to the order at issue in this case. See Joint Motion to Terminate Proceeding (Aug. 26, 1994) at 2. The parties contend that these events render this adjudication moot so that it should be discontinued.

Thus far in this proceeding, the Board has issued rulings dealing with a variety of prehearing matters such as the timing and scope of discovery and the scope of the substantive issues to be considered. The Board, however, has not rendered any findings of fact or conclusions of law about the propriety of the Staff’s January 1993 suspension order in this proceeding. Nor will we. With the Staff’s actions issuing the individual facility licenses requested by OSC and terminating the single OSC license that is the subject of the contested suspension order, it is clear that this case is moot. We will, therefore, dismiss it.

For the foregoing reasons, it is, this thirty-first day of August 1994, ORDERED, that

1. The parties’ August 26, 1994 joint motion to terminate proceeding is granted and this proceeding is dismissed as moot.

2. If this determination becomes final agency action because the Commission declines review, see 10 C.F.R. § 2.786(a), within seven days of the date the Commission declines review, Staff counsel should advise the Board and the Office of the Secretary, in writing, whether the Staff prefers that the Board and the Commission record copies of the June 9, 1994 “NRC Staff’s In Camera Ex

1 Three of the six facilities included in the suspended OSC umbrella license — the Exton Cancer Center, Inc., Exton, Pennsylvania; the Indiana Regional Cancer Center, Inc., Indiana, Pennsylvania; and Stoneboro Oncology Associates, P.C., Stoneboro, Pennsylvania — were issued individual licenses after the Staff conducted prelicensing inspections. See Joint Status Report on Outstanding Licensing Issues (Aug. 17, 1994) at 1. Two other covered facilities — the Greater Harrisburg Cancer Center, Inc., Harrisburg, Pennsylvania, and the Greater Pittsburgh Cancer Center, Inc., Pittsburgh, Pennsylvania — were issued individual licenses without prelicensing inspections because they have been operating since June 1993 pursuant to a Staff-approved relaxation of the suspension order. See id. See also LBP-93-10, 37 NRC 455, 464, aff’d, CLI-93-17, 38 NRC 44 (1993). OSC withdrew its request for an individual license for the Mahoning Valley Cancer Center, Lehighton, Pennsylvania, which was the other facility included in the suspended license. See Memorandum (Referring Document for Docketing) (Aug. 31, 1994), attach. 1 (unpublished).

2 See, e.g., LBP-94-2, 39 NRC 11 (1994) (scope of proceeding); LBP-93-20, 38 NRC 130 (1993) (discovery timing); LBP-93-10, 37 NRC 455 (same); LBP-93-6, 37 NRC 207 (same), vacated in part as moot, CLI-93-17, 38 NRC 44 (1993); Order (Ruling on Discovery Matters) (May 6, 1994) (scope of discovery) (unpublished).

3 Although we are dismissing this proceeding, we retain jurisdiction over two other pending adjudications that may involve some of the same issues implicated in this case. See Indiana Regional Cancer Center (Order Modifying and Suspending Byproduct Materials License No. 37-28179-01), Docket No. 030-30485-EA; Dr. James E. Bauer (Order Prohibiting Involvement in NRC-Licensed Activities), Docket No. IA-94-011. We expect Staff counsel and OSC corporate counsel, who also represents the Indiana Regional Cancer Center (IRCC) and Dr. James Bauer, IRCC’s radiation safety officer, to retain all materials obtained through discovery in this proceeding that would avoid duplicitious discovery in the other adjudications.
Parte Response to Board Order Dated May 26, 1994" be returned to the Staff or destroyed. 

THE ATOMIC SAFETY AND LICENSING BOARD

G. Paul Bollwerk, III, Chairman
ADMINISTRATIVE JUDGE

Charles N. Kelber
ADMINISTRATIVE JUDGE

Peter S. Lam
ADMINISTRATIVE JUDGE

Rockville, Maryland
August 31, 1994

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4 Copies of this Memorandum and Order are being sent this date to OSC counsel by facsimile transmission and to Staff counsel by electronic mail transmission through the agency's wide area network system.
In the Matter of
ARIZONA PUBLIC SERVICE
COMPANY
(Palo Verde Nuclear Generating
Station, Units 1, 2, and 3)
August 12, 1994

The Director of the Office of Enforcement denies a Petition dated February 1, 1994, filed with the Nuclear Regulatory Commission (NRC) by Thomas J. Saporito, Jr., and supplemented on May 18, 1994, requesting enforcement action pursuant to 10 C.F.R. § 2.206 (Petition). The Petition requested that the NRC: (1) require a show-cause proceeding pursuant to 10 C.F.R. § 2.202 to modify, suspend, or revoke the Licensee's operating licenses for Palo Verde Generating Station; (2) initiate "appropriate actions" to require the Licensee to recognize the Buckeye, Arizona Regional Office of the National Whistleblower Center (Buckeye) as an agency to which Licensee employees may raise safety concerns about operations at Palo Verde without fear of retaliation by the Licensee; (3) request the Licensee to encourage employees at Palo Verde to contact Buckeye to identify safety concerns about operations at Palo Verde to ensure a working environment that is free of hostility and promotes the raising of safety concerns by employees without fear of retaliation; and (4) cause the Licensee to encourage employees at Palo Verde to contact the NRC in the same way as it would Buckeye.

On May 18, 1994, Petitioner supplemented his Petition and requested that the NRC require Licensee contractors to: (1) provide information regarding filing complaints with the Department of Labor to their employees "as part of their
normal employment package”; and (2) properly post the NRC Form 3 in and around the contractor’s place of business and site business trailers and offices.

After an evaluation of the Petition, the Director concluded that Petitioner did not raise any issues that would warrant granting the requested actions.

**DIRECTOR’S DECISION UNDER 10 C.F.R. § 2.206**

**I. INTRODUCTION**

On February 1, 1994, Thomas J. Saporito, Jr., (Petitioner) filed a request for enforcement action pursuant to 10 C.F.R. § 2.206 (Petition). The Petition requested that the NRC: (1) institute a show-cause proceeding pursuant to 10 C.F.R. § 2.202 to modify, suspend, or revoke the Licensee’s operating licenses for Palo Verde Generating Station (Palo Verde); (2) initiate “appropriate actions” to cause the Licensee to recognize the Buckeye, Arizona Regional Office of the National Whistleblower Center as an agency to which Licensee employees may raise safety concerns about operations at Palo Verde without fear of retaliation by the Licensee; (3) initiate “appropriate actions” to cause the Licensee to encourage employees at Palo Verde to contact the Buckeye, Arizona Regional Office of the National Whistleblower Center to identify safety concerns about operations at the facility as part of its procedural requirements to ensure a working environment that is free of hostility and promotes the raising of safety concerns by employees without fear of retaliation; and (4) initiate “appropriate actions” to cause the Licensee to encourage employees at Palo Verde to contact the NRC to identify safety concerns about operations at the facility as part of its procedural requirements to ensure a working environment that is free of hostility and promotes the raising of safety concerns by employees without fear of retaliation.

On May 18, 1994, Petitioner supplemented his Petition by requesting that the NRC require Licensee contractors: (1) to provide information regarding filing complaints with the Department of Labor (DOL) to their employees “as part of their normal employment package”; and (2) to properly post the NRC Form 3 in and around the contractor’s place of business and site business trailers and offices.

As grounds for his request, Petitioner asserts that: (1) the NRC has identified Palo Verde as the second highest source of whistleblower complaints in the nation; (2) the Licensee’s spokesman for Palo Verde, Mark Fallon, made public comments to the West Valley View newspaper that increase the “chilling effect” at the facility by discouraging employees from raising safety concerns to the Buckeye, Arizona Regional Office of the National Whistleblower Center; and
(3) Mr. Fallon's comments to the *West Valley View* newspaper increased the existing "chilling effect" at Palo Verde by clearly discouraging employees from raising safety concerns to the NRC. On May 5, 1994, the Licensee provided a response to NRC questions on these matters.

II. DISCUSSION

With respect to his request for a show-cause proceeding to modify, suspend, or revoke the Licensee's operating licenses for Palo Verde, the Petitioner asserts that the NRC has identified Palo Verde as the second highest source of whistleblower complaints in the nation. This, in itself, is insufficient to support an action to modify, suspend, or revoke a license, unless it is also shown that a significant threat to the public health and safety exists. The Petitioner has not shown, nor is there independent evidence from the NRC inspection program that would establish, that the conditions and practices at Palo Verde warrant an order to modify, suspend, or revoke the license. In fact, Petitioner has provided nothing more than the bare allegation that the number of whistleblower complaints indicates that there is a problem.

The number of whistleblower complaints in itself is not evidence of discrimination; many such complaints are found to be without merit. For Palo Verde, some complaints of discrimination have been confirmed and others have been found to be without merit. While discrimination is never acceptable, the findings of discrimination at Palo Verde thus far do not warrant an order modifying, suspending, or revoking the Palo Verde license. Where discrimination is sufficiently widespread that it substantially undermines NRC's confidence that the facility will be operated in compliance with NRC requirements, the action requested by Petitioner — an order suspending or revoking the license — might be appropriate.1 Such a conclusion cannot be drawn from the facts submitted with the Petition, and Petitioner's allegation in this regard does not justify the initiation of a show-cause proceeding against the Palo Verde Licensee. Therefore, this portion of the request is denied.

The next two requests relate to: (1) recognition of the Buckeye, Arizona Regional Office of the National Whistleblower Center as an agency to which Licensee employees may raise safety concerns; and (2) the Licensee encouraging

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1 The NRC has a range of regulatory actions available to it in these circumstances. As the Commission has stated: "It goes without saying that a violation posing an undue risk to public health and safety will, of course, result in prompt remedial action, including shutdown if necessary. In other instances, however, the Commission has a wide spectrum of remedies for dealing with violations of regulations. These include show cause proceedings and proceedings for civil monetary penalties. The choice of appropriate mechanism for correction of an assumed violation rests within the sound discretion of this agency." (*Petition for Emergency and Remedial Action*, CLI-78-6, 7 NRC 400, 405-06 (1978), quoting *Petition for Shutdown of Certain Reactors*, CLI-73-31, 6 AEC 1069, 1071 (1973).)
employees to contact the Buckeye Center and identify concerns. Currently, employees may report their safety concerns directly to the Licensee or to the NRC. In fact, the Licensee has an "employee concerns program" that provides one avenue for employees to raise their concerns within the Licensee's organization. Reporting directly to the licensee in situations where the employee does not fear retaliation is especially beneficial because it brings the concern directly to the party responsible for taking corrective action and it should result in a timely and effective resolution of such concerns.

The Licensee has recently taken several steps to improve the effectiveness of the employee concerns program at Palo Verde. Specifically, the program has: (1) been divided into two parts, one to follow technical issues and one to address personnel issues using human resource personnel; (2) been changed to allow an appeal to a group of technical managers or to senior Licensee management, as appropriate; (3) included training for all managers to improve their ability to discuss issues in an objective and fair manner and training for site personnel to explain the goals of the employee concerns program; and (4) decreased by more than 50% the backlog of unresolved employee-concerns-program complaints.

On the other hand, the Licensee is required to, and does, post NRC Form 3 which makes it clear that employees may take their safety concerns directly to the NRC. Reporting to the NRC in situations where the employee does fear retaliation is appropriate in that the NRC has regulatory authority over the licensee. In such circumstances, the NRC: (1) can and, where necessary for prompt attention to a potentially significant safety problem, will forward the technical safety issue to the licensee to address without identifying the person raising the concern; and (2) if the safety concern is not appropriately corrected, will take additional enforcement action, as necessary.

The NRC has no authority to require that a private contact for raising safety concerns, independent of the NRC or the licensee, be established. Likewise, lacking this authority, the NRC cannot require a licensee to encourage its employees to utilize such a third party. More importantly, even if reports were made to the Buckeye Center, that organization has no responsibility to protect public health and safety nor any authority to require the Licensee to address safety problems. Therefore, this portion of the request is denied.

The Petition also requested that the NRC require the Licensee to encourage employees at Palo Verde to contact the NRC to identify safety concerns about operations at the facility as part of its procedural requirements to ensure a working environment that is free of hostility and promotes the raising of safety concerns by employees without fear of retaliation. As stated above, reports made directly to the Licensee in situations where the employee does not fear retaliation are preferable in that the report is made directly to the entity that is primarily responsible for safe operation and maintenance of the facility and the report can, therefore, result in more timely and effective corrective actions.
It would be counterproductive to require the Licensee to encourage employees who are not intimidated or do not fear discrimination or retaliation to contact the NRC instead of the Licensee with their safety concerns. In any event, the required posting of NRC Form 3 explains to employees that they may take their safety concerns to the NRC and, as stated above, the Licensee does post this form.

With respect to Petitioner's claim that statements made to a newspaper by an official at Palo Verde undermined employees' going to NRC, we have examined those statements and requested an explanation from the Licensee. Based on our review of the Licensee's response and the statement apparently quoted in the article, I have concluded that the official's remarks cannot reasonably be read as discouraging employees from going to the NRC. Rather, those remarks touted the Licensee's claimed improvement in its employee concerns program and simply expressed a view that, with such improvement, employees likely will not find a need to go to NRC. In summary, I find that there is no basis at this time to require the Licensee to further encourage its employees to take their concerns to the NRC. Accordingly, this portion of the request is denied.

The supplement to the Petition requested that the NRC require Licensee contractors to provide information concerning filing complaints with the DOL to their contract employees as part of their normal employment package and to require that contractors post NRC Form 3 in and around the contractor's place of business. Section 211, formerly section 210, of the Energy Reorganization Act has always included contractors in the requirements of that section and the Energy Policy Act of 1992 amended section 211 to require posting of the provisions of section 211 "in any place of employment to which [section 211] applies." The NRC has had a requirement for many years that licensees post NRC Form 3 to provide this notice to employees. While the NRC requirements for posting do not extend to contractors, section 211 now requires contractors to post the provisions of that section. At bottom, these provisions already require that licensee contractors provide notice to their employees of the provisions of section 211 and that NRC licensees post NRC Form 3 at their facilities wherever there are employees working. Therefore, there is no need for the actions requested in this portion of the Petition.

2 It should be noted that the Commission is in the process of developing a Policy Statement that will address the responsibilities of contractors, as a result of a recommendation from the Review Team on Protecting Allegers Against Retaliation.
III. CONCLUSION

As explained above, the Petitioner has not raised any issues that would warrant the requested actions. Therefore, for the reasons given above, the Petition is denied.

A copy of this decision will be filed with the Secretary of the Commission for the Commission to review in accordance with 10 C.F.R. § 2.206(c). As provided by that regulation, the decision will constitute final action of the Commission 25 days after issuance, unless the Commission, on its own motion, institutes a review of the decision within that time.

James Lieberman, Director
Office of Enforcement

Dated at Rockville, Maryland,
this 12th day of August 1994.
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

COMMISSIONERS:

Ivan Selin, Chairman
Kenneth C. Rogers
E. Gall de Planque

In the Matter of

Docket No. 50-312-DCOM
(Decommissioning Plan)

SACRAMENTO MUNICIPAL UTILITY
DISTRICT
(Rancho Seco Nuclear Generating
Station)

September 2, 1994

The Commission lifts its earlier restriction on the Nuclear Regulatory Commission Staff's ability to issue a decommissioning order, given that no issue remains for adjudication and the Licensing Board terminated the proceeding.

ORDER

The Commission in a Memorandum and Order issued March 3, 1993, CLI-93-3, 37 NRC 135, reconsideration denied, CLI-93-12, 37 NRC 355 (1993), granted the Environmental and Resources Conservation Organization (ECO) discretionary intervention, remanded this proceeding to the Atomic Safety and Licensing Board, and directed that the NRC Staff withhold issuance of a decommissioning order pending a resolution of the proceeding by the Licensing Board. CLI-93-3, 37 NRC at 152, 155. The Licensing Board in LBP-94-23, 40 NRC 81 (1994), granted the intervenor ECO's request to withdraw from this proceeding and terminated the proceeding. The Commission does not discern any matter warranting sua sponte review. In the absence of any remaining issue for adjudication, the Commission lifts its earlier restriction on the Staff's ability to issue a decommissioning order.
It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland,
this 2d day of September 1994.
On July 7, 1994, the Presiding Officer granted a 3-week period to the Earth Day Coalition (Coalition) to supplement a deficient hearing request. The Coalition’s petition failed to demonstrate that the Commission’s standing requirements were met or that the concerns asserted were germane to the subject matter of the proceeding.\footnote{See LBP-94-20, 40 NRC 17, 18-19 (1994).} The hearing request concerned Chemetron Corporation’s application for a license amendment. No supplement having been filed by the Coalition and the time period having expired, the Licensee moves...
that the Coalition's petition be denied and the proceeding be dismissed.\textsuperscript{2} The Chemetron motion is granted herein.

ORDER

1. The request by the Earth Day Coalition for a hearing on Chemetron Corporation's license amendment is denied.
2. The motion of the Chemetron Corporation for a dismissal of this proceeding is granted.

James P. Gleason, Presiding Officer
ADMINISTRATIVE JUDGE

Rockville, Maryland
September 1, 1994

\textsuperscript{2}Chemetron Corporation Motion to Dismiss Proceeding (Aug. 15, 1994). The NRC Staff response indicates no objection to the Chemetron motion (Aug. 18, 1994).
The Board denied a Staff motion for reconsideration, setting forth standards for motions for reconsideration. Such motions must be filed within 10 days of the date of issuance of the motion being challenged. The Board also adopted the substantive standard that a motion for leave to reargue or rehear a motion will not be granted unless it appears that there is some decision or some principle of law that would have a controlling effect and that has been overlooked or that there has been a misapprehension of the facts.

The Board said that it is appropriate to require the Staff to answer requests for admissions concerning the truth of findings in its own report, which contains important collateral facts. It also is appropriate to require the Staff to release segregable facts on which decisions have been made, even if those facts are contained in predecisional documents. Facts that are inextricably intertwined with opinions in predecisional documents need not be released.

It is appropriate to require the Staff to reveal the names of individuals involved in completing important Staff work. Intervenors may only call as witnesses Staff
members who are necessary to their case, but an important step in helping them to determine if testimony is necessary is to find out who was involved. For the same reason, it is appropriate to require the Staff to disclose the name of an individual who may have filed a formal differing professional opinion.

A stay shall not be granted when the only harm to a party is a strategic loss through complying with a request for admissions. However, a party may delay the need to respond by filing a motion for an extension of time.

RULES OF PRACTICE: MOTION FOR RECONSIDERATION; TIMELINESS

Motions for reconsideration must be filed within 10 days of the date of issuance of a challenged order.

RULES OF PRACTICE: MOTION FOR RECONSIDERATION; SUBSTANTIVE STANDARD

A motion for leave to reargue or rehear a motion will not be granted unless it appears that there is some decision or some principle of law that would have a controlling effect and that has been overlooked or that there has been a misapprehension of the facts.

RULES OF PRACTICE: ADMISSIONS; COLLATERAL FACTS

It is appropriate to require the Staff to answer requests for admissions concerning the truth of findings in its own report, which contains important collateral facts.

RULES OF PRACTICE: DISCOVERY OF DOCUMENTS; RELEASE OF SEGREGABLE FACTS REQUIRED

It also is appropriate to require the Staff to release segregable facts on which decisions have been made, even if those facts are contained in predecisional documents. Facts that are inextricably intertwined with opinions in predecisional documents need not be released.

RULES OF PRACTICE: INTERROGATORIES TO STAFF; NAMES OF STAFF

The Staff must respond to interrogatories requesting the names of Staff involved in issuing a key report or involved in issuing a formal differing professional opinion.
RULES OF PRACTICE: STAY AND EXTENSION OF TIME COMPARED

A stay shall not be granted when the only harm to a party is a strategic loss through complying with a request for admissions. However, a party may delay the need to respond by filing a motion for an extension of time.

MEMORANDUM AND ORDER
(Motion for Reconsideration: Admissions; Second Order)

The Board has received "NRC Staff Motion for Reconsideration, Motion for Clarification and Request for a Stay Pending Ruling and Appeal of LBP-94-26," September 6, 1994 (Motion). We have determined that it is appropriate to decide this motion before responses are filed. The motion shall be denied. Staff may file a motion for an extension of time within which to file its response to LBP-94-26.

I. STANDARDS FOR A MOTION FOR RECONSIDERATION

The only mention of "reconsideration" in the procedural regulations is in 10 C.F.R. § 2.771, Petition for reconsideration. That section applies to petitions for reconsideration of a final decision of a presiding officer. By analogy, it suggests that motions for reconsideration may be filed under similar conditions pursuant to the general authority to file motions.

Petitions for reconsideration of a final decision must be filed within 10 days after the date of the decision. This Licensing Board applies that time period by analogy and limits such motions to 10 days after the decision being challenged. In this instance, the petition is untimely because the decision was issued August 22 and was served on the Staff on that very day, and the petition was filed September 6. (Despite the untimeliness of the Motion, we also will consider its merits.)

Untimeliness in motions for reconsideration will not be tolerated since the issues addressed in such motions already have been considered and they represent additional delay in a case. That this elapsed period is untimely for an ordinary motion is clear to this Board since the analogous time period in the regulations is for final decisions, which are far more difficult to respond to in the form of a motion for reconsideration.

Motions for reconsideration are special exceptions to the rule of finality. Generally, when a tribunal decides an issue it is put to rest. This is necessary
in order to avoid continuous argument between litigious parties about already resolved issues. It is sound law that

a motion for leave to reargue or rehear a motion will not be granted unless it appears that there is some decision or some principle of law which would have a controlling effect and which has been overlooked or that there has been a misapprehension of the facts.\(^1\)

We adopt that principle as our own because it is a reasonable way to balance the desire to avoid error against the interest in finality of decisions.

II. BOARD IS CONCERNED

The Board is concerned at the posture that the Staff continuously takes in this proceeding because it is the Staff that is the principal impediment to reaching an efficient conclusion to this case. It is now over 4 years since the Site Area Emergency at Vogtle. Staff issued a Notice of Violation on May 9, 1994, and is still involved in evaluating the comments of Georgia Power\(^2\) and is awaiting comments from Mr. Allen Mosbaugh.\(^3\) Until it finishes this process, the Staff does not know what positions to take in this proceeding. Therefore, it is pressed into the uncomfortable and unconstructive position of constantly arguing that it should not be required to take a position.

In the instant motion, the Staff is resisting stating whether it will admit the facts relied on in the Office of Investigation Report on the Vogtle Site Area Emergency. All the findings of fact in that report were implicitly found relevant to the diesel generator issue by a respected Staff office after a lengthy investigation. Yet Staff is suggesting that before it should be required to admit or deny the truth of those findings, Intervenor first should certify whether these facts are relevant.\(^4\)

While the Staff is claiming that responding to this request for admissions is a momentous task, we note that Georgia Power has quietly completed the task of

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\(^1\) 56 Am. Jur. 2d 22, Motions, Rules, and Orders § 27 (1971). Note also that new evidence may not be presented in a motion for reconsideration. When there is an intervening change of law or facts, a motion to renew may be in order rather than a motion for reconsideration. 56 Am. Jur. 2d Supp. 24-25 (cf. authority that motions for reconsideration are always in order until final judgment).

\(^2\) Georgia Power and six named individuals filed replies on July 31, 1994.

\(^3\) Tr. 577-78, 618.

\(^4\) Motion at 12-13.

The facts cited by the Intervenor were cited in the OI Report and are therefore considered relevant. Requests for admissions concerning the transcription of other tape passages, not cited in the OI Report, must be accompanied by attorney certifications of relevance.
responding to precisely the same request for admissions that the Staff resists.\(^5\)

We are taken aback by the unwillingness of the Staff to verify facts contained in its own report.\(^6\)

### III. FACTS

We find the Staff filing confusing because it seems to state that it is being required to respond to items that are not facts. Yet Staff does not define what a fact is. In trying to disentangle this confusion, we have unsuccessfully tried to determine how it defines facts. Its confusion seems related to how to define a fact. It seems to think that facts to which it must stipulate must be either "major" facts or must be determinative of the case. Instead, the rule is that a question is one of fact if — in a case tried to a jury. — it properly falls within the traditional ambit of the jury.\(^7\)

We note that in a contentious case like this one, admissions are likely to be obtained only with respect to collateral facts, thus gradually reducing the area of the unknown a little. An example of this principle is provided by the interrogatory cited in the Motion on page 7. Staff is being asked to admit or deny whether Mr. Aufdenkampe made the following statement:

> AUFDENKAMPE said that he had always assumed that the numbers (18 and 19) in the April 9, 1990, letter came from the April 9, 1990 presentation, and that he could not recall if BAILEY had told him that. (Exhibit 38, p. 26.)

It should be pointed out that the numbers "18 and 19" are key numbers in this case. They are numbers of consecutive successful starts provided by Georgia Power to the NRC on April 9, 1990. It is those numbers that Intervenor claims to have been inaccurate. It is based on this evidentiary statement and 219 others that the Office of Investigation concluded:

> Based on the evidence developed during this investigation, it is concluded that on April 9, 1990, BOCKHOLD deliberately presented incomplete and inaccurate information to NRC regarding the testing of the VEGP [Vogtle] Unit 1 EDGs [Emergency Diesel Generators] conducted subsequent to a March 20, 1990 SAE [Site Area Emergency] at VEGP. . . .\(^8\)

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\(^5\) Motion at 10 n.14. We disagree with Staff's analysis of the effect of Georgia Power admissions. Even if Georgia Power has not admitted a particular fact, an admission by the Staff could be useful. For example, Intervenor could introduce evidence of an oral admission of a Georgia Power official. At that point, Intervenor might choose to rest if the Staff had admitted the fact. Without the Staff admission, further proof might be introduced.

\(^6\) In its Motion at 6 n.10, the Staff raises a question concerning ambiguity of our Order. We are not aware, however, of any portion of our Order that creates this ambiguity. The Staff may rely on the Order. LBP-94-26, 40 NRC at 96.

\(^7\) Ernest Gelhorn and William F. Robinson, Jr., Summary Judgment in Administrative Adjudication, 84 Harv. L. Rev. 612 (1971), at 613.

\(^8\) OI Report, in Case No. 2-90-020R at 42.
Although the Staff of the Commission appears to have veered away from this finding of the Office of Investigations, we are an independent adjudicatory body that must decide whether or not the Office of Investigation's point of view is correct. Hence, we must look at the underlying facts and ascertain for ourselves whether we consider them to be true. If the Staff admits facts (or refuses to admit them and then explains the reasons for their refusal), this will be very helpful to the decisional process.

IV. ONLY THE FACTS

We also are concerned that the Motion does not faithfully respond to our Memorandum and Order, LBP-94-26, Staff Responses to Intervenor's First Request for Admissions, Second Set of Interrogatories, August 22, 1994 (LBP-94-26). For example, we ordered the release of factual information (that is not inextricably intertwined with opinions) that was considered by the Nuclear Regulatory Commission in issuing a Notice of Violation to Georgia Power. We note this factual information, even though found in predecisional documents, is available under the Freedom of Information Act and is not privileged. We said:

Intervenor should be provided with any document or portion of a document that has not already been disclosed and that contains segregable [emphasis added] factual information that was considered by any person (including Commissioners and their staffs) in deciding whether or not to issue the NOV.

The Staff characterizes this order as requiring "various predecisional documents." What it does not state is that our order was carefully limited to discovery of the facts on which a decision was made. Such factual information is not exempt from disclosure. Furthermore, only important facts are required to be disclosed. Staff must disclose only those facts that this agency considered in deciding whether or not to issue a Notice of Violation concerning the very same facts as are before us in this case. We conclude that the facts that are

10 Staff appears to be concerned that it must "identify every document that supports its answers to an admission." Motion at 21. However, this requirement appears to stem from Intervenor's First Request for Admission to NRC Staff (May 17, 1994). As we read the request, e.g., at page 9, the requirement for documentation applies only when the Staff identifies a sentence or statement that is said to be not true or not accurate. It is entirely reasonable that when Staff disavows an OI finding it provide a complete explanation and documentation. We consider this set of interrogatories to be both skillfully drafted and reasonable in its requirements.
11 Motion at 18.
12 Staff also objected to the disclosure of facts that may have been considered by the Commission. However, they provided no authority for this proposition. We are not asking for any disclosure concerning how the disclosed facts were considered in the decision process. Thus, disclosed facts could have been considered either by the Staff or the Commission. We do not require disclosure of opinions or of preliminary discussions or of any of the traditionally protected predecisional information.
required to be disclosed are necessary to a full and fair consideration of this case.

V. NAMES OF PEOPLE INVOLVED IN CREATING THE NOV

We consider the disclosure of the names of the professionals involved in creating the NOV to be important and necessary discovery in this case. Intervenor in this case can call only witnesses that it demonstrates to be necessary to its case. However, it cannot determine what witnesses are necessary unless it can obtain information about what individuals are involved. We have not been told of any agency need to keep these identities secret. Hence, we assume that there is no special need to keep confidential any of the names of people professionally involved in issuing the NOV.13

VI. DOCUMENT REQUESTS

As we interpret the Request for Admissions, the only documents that are requested are those that are necessary to support a Staff answer that it does not admit the truth of an OI Finding.14 We find that it is necessary to the determination of this case that the Staff provide such documentation for the disavowal of a prior Staff finding. We therefore will order that the documents be produced.

VII. DIFFERING PROFESSIONAL OPINION

When we required that a differing professional opinion be produced in discovery, our principal purpose was to require that if a differing professional opinion were formally filed15 then that fact should be made known so that we could determine whether testimony from that individual was necessary to the decision in this case. We required only that differing professional opinions be disclosed, and we will not alter our opinion in that regard.16 Again, we do not

13 Although Staff suggested that our Order required disclosing as well the names of secretarial Staff, we think that argument more tongue in cheek than a serious concern about what was intended. We would also permit the Staff to keep confidential the names of any paralegals involved.

14 See Intervenor's First Request for Admissions to NRC Staff (May 17, 1994). As we read the request, e.g., at page 9, ¶8, the requirement for documentation applies only when the Staff identifies a sentence or statement that is said to be not true or not accurate.

15 Motion at 17 n.28.

16 The Staff, as servants of the public, is interested in developing a full and fair factual record. In a case where a company's reputation is being called into question, we would expect the Staff to make known important dissenting views that might change the Board's view of the evidence. In our opinion, the Staff "wins" only when the whole truth is revealed.
require that opinions or preliminary discussions be disclosed. If these matters are inextricably intertwined with facts, then neither the opinions nor the facts need be disclosed.

VIII. STAY

The principal harm to Staff from complying with our order is strategic, requiring it to evaluate the Office of Investigation's work and to state point by point whether it is still considered to be correct. There is not even the remotest chance that the Staff is being required to divulge privileged material. We are not persuaded that this kind of "hardship" is sufficient to support the issuance of a stay. Given that no Staff opinions and no privileged documents are being released, there would not appear to be grounds either for a stay or for an interlocutory appeal. Hence, we will not grant a stay pending appeal.¹⁷

IX. EXTENSION OF TIME

The Board is vitally concerned about maintaining the schedule and completing this case expeditiously. However, several portions of Staff's Motion appear to be in the nature of an incomplete argument for an extension of time. Within 5 calendar days, the Staff may file such a motion, with supporting estimates of Staff capabilities and suggested deadline dates for its filings. Staff should discuss its request with the parties and attempt to elicit their agreement. If necessary, we would convene a telephone prehearing conference to consider this request for an extension of time.

X. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 9th day of September 1994, ORDERED that:

1. The "NRC Staff Motion for Reconsideration, Motion for Clarification and Request for a Stay Pending Ruling and Appeal of LBP-94-26," September 6, 1994, is denied both because it is untimely and because it is lacking in merit.

2. The Atomic Safety and Licensing Board determines that it is necessary to the fair determination of this case that the Staff of the Nuclear Regulatory

¹⁷Staff is not required to respond until September 22 and we are willing to consider a motion for an extension of time beyond that date. If the Staff files an appeal, there will be ample time for the Commission to apply the stay criteria and to decide whether or not to issue a stay.
Commission produce documents to demonstrate its reasons for not admitting to the truth of findings of the Office of Investigations.

FOR THE ATOMIC SAFETY AND LICENSING BOARD

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
By immediately effective order dated May 23, 1994, the NRC Staff placed conditions on the involvement of Kelli J. Hinds in NRC-licensed activities. See 59 Fed. Reg. 28,433 (1994). Shortly thereafter, Ms. Hinds requested that this proceeding be convened to permit her to contest the validity of the Staff’s order. See 59 Fed. Reg. 31,654 (1994). Now, by joint motion dated September 26, 1994, the parties request that we approve a September 9, 1994 settlement agreement they have provided and dismiss this proceeding without adjudication of any of the legal or factual matters at issue.

Pursuant to section 81 and subsections (b) and (o) of section 161 of the Atomic Energy Act of 1954, 42 U.S.C. §§2111, 2201(b), 2201(o), and 10 C.F.R. § 2.203, we have reviewed the parties’ settlement accord to determine whether approval of the agreement and termination of this proceeding is in the public interest. On the basis of that review, and according due weight to the position of the Staff, we have concluded that both actions are consonant with
the public interest. Accordingly, we grant the parties' joint motion to approve the settlement agreement and dismiss this proceeding.

For the foregoing reasons, it is, this third day of October 1994, ORDERED that

1. The September 26, 1994 joint motion of the parties is granted and we approve their September 9, 1994 "Settlement Agreement," which is attached to and incorporated by reference in this Memorandum and Order.

2. This proceeding is dismissed.*

THE ATOMIC SAFETY AND LICENSING BOARD

G. Paul Bollwerk, III, Chairman
ADMINISTRATIVE JUDGE

Peter S. Lam
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Rockville, Maryland
October 3, 1994

*Copies of this Memorandum and Order are being sent this date to counsel for Ms. Hinds by facsimile transmission and to Staff counsel (without the accompanying attachment) by E-mail transmission through the agency's wide area network system.
SETTLEMENT AGREEMENT

On May 23, 1994, the NRC Staff (Staff) issued an Order Prohibiting Involvement in Licensed Activities (Effective Immediately) to Kelli J. Hinds. 59 Fed. Reg. 28433 (June 1, 1994) (Order).


After discussions between the Staff and Ms. Hinds, both the Staff and Ms. Hinds agree that it is in the public interest to terminate this proceeding without further litigation and without reaching the merits of the underlying Order, subject to the approval of the Atomic Safety and Licensing Board.

NOW THEREFORE, IT IS STIPULATED AND AGREED by and between the NRC Staff and Kelli J. Hinds as follows:

1. The Staff agrees to withdraw Section IV.B.1 of the Order. The Staff further agrees to withdraw in its entirety requirement (1) of the third paragraph of Section III of the Order. Such withdrawals will become effective upon the approval of this Settlement Agreement by the Atomic Safety and Licensing Board.

2. Ms. Hinds agrees to withdraw with prejudice her request for and otherwise waives her right to a hearing in connection with this matter and waives any right to contest or otherwise appeal this Settlement Agreement once approved by
the Atomic Safety and Licensing Board. Such withdrawal will become effective upon approval of this Settlement Agreement by the Atomic Safety and Licensing Board.

3. All other provisions of the Order as issued to Ms. Hinds on May 23, 1994, will remain in effect.

4. The parties acknowledge that execution of this Settlement Agreement does not constitute any admission on the part of Ms. Hinds that she has violated any law or committed any wrongful act.

5. This Settlement Agreement constitutes full settlement with regard to Kelli J. Hinds and the NRC and the NRC agrees not to initiate or pursue any further administrative proceedings against Ms. Hinds arising out of the facts alleged in the Order dated May 23, 1994.

6. This Settlement Agreement serves only to settle the civil matter between Ms. Hinds and the NRC as set forth in IA 94-12. Nothing in this Settlement Agreement shall preclude criminal prosecution arising out of the facts alleged in the Order dated May 23, 1994.

FOR THE NRC STAFF: FOR KELLI J. HINDS:

Susan S. Chidakel Kelli J. Hinds
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD PANEL

Before Administrative Judges:

James P. Gleason, Presiding Officer
Thomas D. Murphy, Special Assistant

In the Matter of Docket No. 40-8681-MLA-3
(ASLBP No. 94-693-02-MLA-3)
(Source Materials License No. SUA-1358)

ENERGY FUELS NUCLEAR, INC. October 21, 1994

MEMORANDUM AND ORDER
(Petition for Hearing)

INTRODUCTION

The Petitioner, Norman Begay (Begay), opposes the issuance of a license amendment to Energy Fuels Nuclear (EFN) and requests a hearing.¹ The amendment would authorize EFN to dispose at its White Mesa Mill in Blanding, Utah, of 2.6 million cubic yards of uranium mill tailings now stored at a Department of Energy uranium processing site in Monticello, Utah. Although not stated in the filings, it appears the reason for the proposed amendment is that the White Mesa Mill would be accepting tailings produced elsewhere, an act not contemplated under its initial license.² Begay’s challenge is to demonstrate that

¹ Request for Hearing (May 14, 1984). NRC Staff (Staff), pursuant to 10 C.F.R. § 2.1213, indicates its intention to participate if a hearing is granted. See Staff Response to Begay Hearing Request at 2 n.3 (June 10, 1994).
² Source Materials License No. SUA-1358. It should be noted also that the Staff states in its first Response that most (of the tailings) are clearly 111(c)(2) (byproduct) materials, although there has been some question as to the classification of the vanadium pile. Staff Response at 3 n.5.
the act of disposing of the remote tailings will affect him adversely in a way different from the activities already authorized at the White Mesa Mill. For his efforts, outlined below, the Presiding Officer finds that Begay has alleged such an impact and as a consequence has established threshold standing allowing party status in the proceeding.³

STANDARDS

Under the provisions of 10 C.F.R. § 2.1205, Begay is required to set forth his interest in the proceeding, how his interest would be affected by the issuance of the license amendment, and his “areas of concern” about the licensing activity that is the subject matter of the proceeding.⁴ The Presiding Officer must determine whether Begay’s specified areas of concern are germane to the subject matter of the proceeding and whether he meets the judicial standards for standing. Among other factors, the Presiding Officer must consider the nature of Begay’s right under the Atomic Energy Act to be made a party to the proceeding; the nature and extent of his property, financial, or other interests in the proceeding; and the possible effect of any order that may be entered in the proceeding upon his interests.⁵

AREAS OF CONCERN

In Begay’s hearing requests⁶ and through counsel at an informational conference held on September 22 in Monticello, Utah, he outlines three areas of concern which he alleges are germane to granting EFN the right to import and dispose of 2.6 million cubic yard of tailings: First, that the license amendment will bring “irreparable loss of cultural and archeological resources”; second that, “groundwater and drinking water [will be contaminated by] ... further development of the White Mesa Mill site”; and finally, that there are “increased risks associated with the transportation of the mill tailings along Highway 191 from Monticello to Blanding.”⁷ These concerns will be addressed seriatim.

Archeological and Religious Resources

The Presiding Officer is impressed by the gravity of Begay’s concern for the antiquities, including human remains, that the EFN property and surrounding

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³ Both the Licensee and Staff have withdrawn their objections to Begay’s hearing request. See Tr. 33, 36-37.
⁴ 10 C.F.R. § 2.1205(d).
⁵ 10 C.F.R. 2.1205(g).
⁷ Tr. 10-11.
lands may contain. As a member and representative of the Ute Tribe, Begay has intense cultural, emotional, and religious ties to the area known as White Mesa. It is not lost on the Presiding Officer that the entire area has been determined eligible for inclusion in the National Historic Register and that many of Begay's ancestors are buried in the area. Nor is the Presiding Officer less impressed by the importance to the Ute Tribe, as "host people," of the recently documented, ancient Hopi temple located within 3 miles (and within sight) of the White Mesa Mill. Begay adequately expressed that his life is tied to this site and to White Mesa itself by a "spiritual feeling."

As explained at the informational conference, the matter of burials and ancient sites is probably more important to the Ute people than historical monuments would be to others. The Ute people "have a concept of Mother Earth that when their people are buried, they return to the Mother Earth." They have sacred rights and rituals that must be observed whenever a burial is discovered or disturbed in any way. It is possible that the sacred rights of the Ute Tribe were violated in the past when ancient Native American habitation sites were surveyed, and in some cases excavated, as part of the development of the White Mesa Mill site. Members of the tribe learned recently of the whereabouts of the human remains and artifacts that were removed as a result of those activities. Begay pleaded to the Presiding Officer, as a representative of the NRC, to "help us out." But in this respect, we are mandated to follow the Commission's regulations.

As compelling as they may be, there is little the Presiding Officer can do to alleviate Begay's concerns for Native American archeological resources, because those concerns arose from the initial issuance of the source materials license, not from the proposed amendment to that license. Cell 4, the site chosen for the disposal of the DOE tailings, was surveyed for archeological resources prior to the opening of the White Mesa Mill. Those habitation sites considered significant by the State archaeologists were excavated and their artifacts removed, apparently to the State Historical Museum in Salt Lake City. Begay does not allege that there are more resources located under Cell 4. Moreover, Begay, through his counsel, seems to concede that no archeological resources are immediately affected by the importation of the DOE tailings:

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8 Begay became a member of the White Mesa Ute Tribal Counsel on October 1. Tr. 10.
9 The role of the host people would be those occupying the land today who hold it for the benefit of all Native American tribes who occupied it in the past and who left their ancestors buried there or left holy sites. Tr. 13.
10 Tr. 13.
11 Id.
12 Tr. 14.
13 Tr. 28.
If Energy Fuels is allowed to dispose of an additional 2.6 million yards of tailings, it would either fill up one or more, approximately one-and-a-half of the existing tailings ponds. If the market permits and they are able to process the full amount of ore which they are allotted or allowed under their license, they will have to build new tailings in addition to the area that has already been cleared and the areas where ponds have already been established. I think we have to assume that they are going to process and produce as much as they are licensed to produce and if that means additional tailings ponds will be constructed, additional archeological sites will be disturbed or destroyed, that simply we have to assume today. Counsel acknowledges that any disturbance of archeological sites is linked to activities contemplated under the original source materials license and is not directly related to the importation of the DOE tailings.

While no one can say whether the construction of the White Mesa Mill would have taken place given more vocal concern on the part of the Ute Tribe at that time, we may not revisit the initial licensing of the plant today. The scope of this hearing request is limited to the future importation and disposal of mill tailings from a remote site, nothing more. Therefore, since that activity will not impact on any archeological or religious resources, in any degree more than they could have under the existing license, Begay’s concerns for those resources are not, in this limited context, germane to the subject matter of this proceeding. His allegations, therefore, cannot support an opportunity for hearing in this instance.

Water Resources

Begay stated in his filings and at the informational conference that over the past 8 years his drinking water has become noticeably discolored and odorous. He alleges that mandatory testing of the wells has indicated a steady increase within the past few years in the traces of copper and other minerals.

As with the issue of archeological resources, we are constrained to view Begay’s concern within the scope of the license amendment, not the EFN source materials license. It is evident that the water pollution complained of started years before the license amendment was contemplated. If it arose from activities at the White Mesa Mill, it arose as a result of activities under the original license — and those issues are not germane to this proceeding. Begay’s proper

14 Tr. 15-16.
15 Conditions 15 and 16 of Source Materials License No. SUA-1358 specifically require EFN to avoid, where feasible, operations in certain archeologically sensitive areas and to conduct archeological studies and/or recovery operations in other areas prior to disturbance. Moreover, archeological contractors must meet the approval of the State Historic Preservation Officer and certain standards under NRC oversight. Therefore, while these sites would be disturbed or destroyed, they would not be disregarded and lost.
16 The President of the Ute Tribal Organization appears to have agreed to the construction of the White Mesa Mill at the time the original EIS was done in 1979. Tr. 35. See also Staff Response to Supplement to Request for Hearing Filed by Norman Begay, Attachment at FES A-57.
17 Tr. 26.
18 Begay Supplemental Response at 2.
recourse in this instance is not with this Presiding Officer. He may seek a 10 C.F.R. § 2.206 determination from the Director of the NRC, under the agency’s simplified procedures, on the issue that the original source material license is in some manner failing to protect the public’s health and safety.19

However, the water resources issue should not be completely ruled out of this proceeding. The Staff has had a public meeting with EFN on groundwater concerns20 and EFN has requested Begay to step forward with information concerning well completion data.21 It appears both sides would benefit from such information. It would therefore be prudent for Begay to put forth evidence detailing what specific effects the addition of 2.6 million cubic yards of tailings will have on his groundwater concerns even though it does not serve as a platform upon which to establish standing.

Transportation Issue

Begay alleges that the residents of the White Mesa community share their primary access road, Highway 191, with the White Mesa Mill.22 Because of the high volume of heavy-equipment traffic expected to be generated by the movement of the tailings from Monticello (approximately 27 miles north of the mill), Begay states that his safety, and that of his family, will be threatened. In the Final Environmental Statement prepared for the issuance of the original source material license, transportation issues involving the White Mesa Mill were addressed. Heavy-truck traffic was estimated at approximately 68 round trips daily between area mines and buying stations serving the mill.23 As the FES notes, this traffic would have been disbursed over several roads leading to the buying stations.

The FES estimates the impact of shipments of ore from the buying stations to the mill. Based on the lifetime milling capacity for the mill, it was estimated that it would take 30-ton-capacity ore trucks over 22,500 trips per year to deliver the ore to the mill. The FES further estimates that this amount of truck traffic would produce accidents involving trucks at the rate of 7.6 per year.24

At this point, we know little of the manner in which the Monticello tailings will be shipped to the White Mesa Mill. Counsel for Begay made an uncontested

19 In this respect, any of the injuries Mr. Begay alleges from the activities of the White Mesa Mill that his counsel claims were not given due consideration by the NRC in its original licensing action could form the basis for a 10 C.F.R. § 2.206 petition, including those issues arising in a religious context.
20 Staff electronic memorandum, Turk to Pierce, August 9, 1994.
21 Tr. 33-34.
22 Request for Hearing at 2.
23 NUREG-0556, Final Environmental Statement Related to Operation of White Mesa Uranium Project (May 1979) at 4.8.5.
24 Id. at 5.3.2.
statement at the informational conference that trucks carrying tailings would be "coming or going, empty or full, every three minutes." Moreover, he stated that this transportation scenario might take place 24 hours a day over an uncertain time period. What we do know is that if all 2.6 million cubic yards of tailings were moved in 30-ton trucks, as assumed in the FES, it would take approximately 86,666 round-trips between Monticello and the White Mesa Mill. The FES based its analysis of transportation impacts on 22,667 round-trips per year.

As stated before, the proposed license amendment must be viewed in light of activities already contemplated for the White Mesa Mill under its source materials license. If in fact there will only be 22,667 or fewer heavy-vehicle trips to the Mill each year, activities already contemplated under the Mill's license, Mr. Begay has shown nothing upon which to build a claim of injury. But this issue takes on a different light when viewed in terms of EFN's capability to move the Mill to full-capacity operation if the market for uranium picks up. In that light, the movement of tailings from Monticello could take place simultaneously with full-scale uranium production. In fact, any round-trips added to the highway would be beyond the assumptions used in the FES to calculate the impacts of heavy-equipment traffic under the source materials license. In this respect, Mr. Begay's concern clearly evolves as a possible consequence of the proposed amendment and not the existing source materials license. This is enough to bring the issue within the scope of this hearing and make it germane to the subject matter of the proceeding.

STANDING

In order to participate in this proceeding, Begay is required by 10 C.F.R. § 2.1205(d) to demonstrate that he also meets the judicial concepts of standing. He must show that the intended licensing action will cause injury in fact to an interest that is within the zone of interests protected by the Atomic Energy Act or the National Environmental Policy Act. Further, Begay must establish (a) that he personally has suffered or will suffer a distinct and palpable harm that constitutes injury in fact; (b) that the injury can fairly be traced to the challenged action; and (c) that the injury is likely to be redressed by a favorable decision in the proceeding.
Since Begay has made no concrete demonstration that his archeological and groundwater concerns are germane to the license amendment, we need not address further those concerns in their relation to standing.

Begay and his family live in the White Mesa Native American community within 5 miles of the White Mesa Mill. Begay says he and his family use the road running past the entrance to White Mesa Mill every day to reach Blanding. Begay alleges that his and his family's safety will be placed at risk due to increased heavy-vehicle traffic on the highway and the resulting higher rates of traffic accidents. As has been postulated above, truck trips may be increased under the license amendment.

Highway 191 from Blanding to the White Mesa Mill site narrows from a four-lane, service-oriented road, to a two-lane road as it leaves the Blanding commercial district and heads toward the mill site. Begay states that the road is often covered by snow and ice in the winter months and trucks to the mill could easily run off the road.\[31\]

Begay has alleged a potential injury to the health and safety of his person and his family that is both concrete and particularized and the potential injury would be a direct result of the licensing decision at issue in this proceeding. Begay has, therefore, established the requisite showing to be allowed standing to participate in a hearing concerning the EFN license amendment.

ORDERED

1. The request for a hearing by Norman Begay on Energy Fuels Nuclear's application for a license amendment is granted.
2. Within 30 days, pursuant to 10 C.F.R. §2.1231, the NRC Staff will furnish a hearing file to the Presiding Officer and parties in this proceeding.
3. Within 10 days of service of this Order, the other parties may appeal the Presiding Officer's decision.

It is so ORDERED.

James P. Gleason, Presiding Officer
ADMINISTRATIVE JUDGE

Rockville, Maryland
October 21, 1994

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\[31\] Begay's concern also relates to the fact that his daughter rides a school bus from the White Mesa community to Blanding each school day. Tr. 22.
The Director of the Office of Nuclear Reactor Regulation granted in part and denied in part a Petition dated October 14, 1994, submitted by the National Whistleblower Center (NWC), the Coastal Alliance for a Safe Environment, and Charles A. Webb (Petitioners) requesting that the Nuclear Regulatory Commission take action with regard to the Brunswick Steam Electric Plant (Brunswick), Units 1 and 2, of the Carolina Power & Light Company (Licensee). The Petition requested that: the NRC Staff enter into a confidentiality agreement with NWC to facilitate the release of additional information; the NRC immediately require the Licensee to state whether it has, in fact, known about cracks in the reactor shroud since at least 1984; the NRC’s Office of Investigations (OI) determine whether Licensee management engaged in criminal wrongdoing, commencing in 1984, when Licensee management initially failed to report the existence of cracks in the core shroud to the NRC; and immediate suspension of the operating license for Brunswick pending the criminal investigation. The Petitioners alleged that the Licensee had falsely asserted to the NRC that cracks in the reactor shroud had been recently discovered, but that, in fact, the Licensee had discovered the cracks 9 years earlier and the Licensee’s management instructed the engineers who detected the cracks to prepare paperwork that would ensure that no report would be made to the NRC; the unwillingness to report a significant safety problem to the NRC demonstrates that the Licensee does not have the character or integrity to operate a nuclear facility; and the Licensee is willing to
take unreasonable risks with the public health and safety. After evaluation of the Petition and an OI investigation, the Director concluded that Petitioners failed to raise a substantial health or safety concern regarding either the presence of core shroud cracks or the Licensee's knowledge of and reporting of core shroud cracking at the Brunswick facility.

DIRECTOR'S DECISION UNDER 10 C.F.R. § 2.206

I. INTRODUCTION

On October 14, 1993, the National Whistleblower Center (NWC), the Coastal Alliance for a Safe Environment (CASE), and Charles A. Webb (Petitioners) filed a Petition with the U.S. Nuclear Regulatory Commission (NRC) requesting that action be taken regarding the Brunswick Steam Electric Plant (Brunswick), Units 1 and 2, of the Carolina Power & Light Company (CP&L or the Licensee). The Petition requested that (1) the NRC Staff enter into a confidentiality agreement with NWC to facilitate the release of additional information; (2) the NRC immediately require the Licensee to state whether it has, in fact, known about cracks in the reactor core shroud since at least 1984; and (3) the NRC's Office of Investigations (OI) determine whether CP&L management engaged in criminal wrongdoing, commencing in 1984, when CP&L initially failed to report the existence of cracks in the core shroud to the NRC. The Petitioners also requested an immediate suspension of the operating license for Brunswick pending the criminal investigation.

The Petitioners based their requests on allegations that (1) the Licensee falsely asserted to the NRC and to the public that cracks in the reactor shroud had just recently been discovered, but that, in fact, the Licensee had discovered the cracks 9 years earlier and the Licensee's management instructed the engineers who detected the cracks to prepare paperwork that would ensure that no report would be made to the NRC; (2) this unwillingness to report a significant safety problem to the NRC demonstrates that the Licensee does not have the character or integrity to operate a nuclear facility; and (3) the Licensee is willing to take unreasonable risks with the public health and safety.

By letter dated November 15, 1993, Dr. Thomas E. Murley, then Director of the Office of Nuclear Reactor Regulation (NRR), informed the Petitioners that the Petition was being evaluated in accordance with Title 10 of the Code of Federal Regulations, section 2.206 (10 C.F.R. § 2.206). Further, the letter stated that (1) the NRC would review the request for the NRC to immediately require the Licensee to state whether it knew of cracks in the Unit 1 shroud since 1984 and would take any action that the NRC may deem appropriate; (2)
a formal decision would be issued within a reasonable time; and (3) the request to suspend operation of the Brunswick plant pending criminal investigation was denied.

My Decision in this matter follows.

II. BACKGROUND

As a result of the Petitioners' allegations, the NRC Office of Investigations (OI) commenced an investigation into the possibility of misconduct by the Licensee in connection with the reporting of core shroud cracks at the Brunswick facility. On November 23, 1993, OI staff interviewed Mr. R. Shackleford, who had signed the Petition on behalf of the Coastal Alliance for a Safe Environment. Mr. Shackleford stated that he had first become aware of the core shroud cracking issue approximately 1 week before the Petition was filed with the NRC and that he had no personal knowledge regarding the allegations made in the Petition. Mr. Shackleford stated, however, that Mr. Charles Webb and another individual, whose name was known only to Mr. Webb and the National Whistleblower Center, had personal knowledge of the matters alleged in the Petition. Mr. Shackleford also stated that he personally knew of three other individuals who might have some first-hand knowledge of concerns with welds, although not specifically related to the core shroud matters expressed in the Petition. However, he declined to identify them because the individuals were not willing to come forward. At the request of OI staff, Mr. Shackleford agreed to contact these three individuals to determine the extent and nature of their knowledge concerning the core shroud issue and to advise OI of what he had learned. To date, Mr. Shackleford has not responded to this request or provided this information to OI. Furthermore, between January and March 1994, the OI staff attempted to contact Mr. Kohn, who signed the Petition on behalf of both the National Whistleblower Center and Mr. Charles Webb, in order to arrange an interview with Mr. Webb. To date, Mr. Kohn has not responded to three telephone messages or to a March 3, 1994 registered letter requesting his cooperation. The U.S. Post Office provided a return receipt for this registered letter indicating its proper delivery to the National Whistleblower Center.

In order to investigate whether there was wrongdoing on the part of the Licensee's management associated with the allegedly deliberate failure to report core shroud cracks as early as 1984, OI sought facts pertinent to the alleged discovery of cracks and the alleged coverup. The Petitioners' representatives, however, never responded to the OI requests for (1) the identity of individuals whom the Petitioners stated had personal knowledge of the matters alleged in the Petition and (2) assistance in contacting Mr. Webb and the other individuals.
OI concluded that it was unable to proceed with its investigation. Therefore, on April 26, 1994, OI closed its investigation.

Although OI terminated its investigation into the alleged wrongdoing, the NRC Staff independently evaluated the core shroud cracking issue at the Brunswick facility and the Licensee's corrective actions.

### III. DISCUSSION

In July 1993, the Licensee notified the NRC that cracks had been found in the core shroud of Brunswick Unit 1. The Licensee discovered the cracks through its in-vessel visual inspection of the core shroud during the unit's 1993 refueling outage. The inspection was performed in response to the recommendations contained in General Electric Company (GE) Rapid Information Communication Service Information Letter (RICSIL) 054, "Core Support Shroud Crack Indications," dated October 3, 1990 (GE is the manufacturer for the reactor used at Brunswick). In this RICSIL, GE advised the owners of boiling-water reactors (BWRs) that cracks had been discovered in the core shroud of a foreign-owned GE BWR and recommended visual inspection of the core shroud seam welds at accessible surfaces inside and outside the shroud. Although the RICSIL discussed the occurrence of cracks in the shroud at elevations surrounding the reactor core, the Licensee had elected to inspect additional shroud areas. The Licensee inspected the accessible core shroud welds between the top guide support plate and the core support plate.

The Licensee's 1993 in-vessel visual inspection of the Brunswick Unit 1 core shroud revealed a circumferential crack at horizontal weld H-3, which joins the top guide support ring to the lower shroud and other shorter axial and circumferential cracks around the horizontal welds, H-2, H-4, and H-5. On the basis of the information submitted by CP&L concerning its inspection findings at Brunswick, the Institute for Nuclear Power Operations, an industry association, issued Significant Event Notice SEN-103, "Circumferential Cracking of a Boiling Water Reactor Core Shroud," on September 13, 1993. The NRC also informed licensees of these conditions through the issuance of NRC Information Notice 93-79, "Core Shroud Cracking at Beltline Region Welds in Boiling Water Reactors," on September 30, 1993. Further, GE issued Service Information Letter (SIL) 572, "Core Shroud Cracks," that discussed factors that could contribute to core shroud cracking and recommended specific visual inspection methodology as developed by CP&L during the Brunswick inspections. This SIL was revised on October 4, 1993, to, in part, inform BWR owners about a recommended plant service time after which shroud inspections need to be performed.
Because cracks were seen in the Brunswick Unit 1 shroud during the 1993 outage and in-vessel examination, the Licensee reexamined the video tapes of a previous in-vessel visual inspection of the Unit 2 core shroud conducted during its 1991 refueling outage. After computer enhancement of the video images, the Licensee, on July 10, 1993, located three small (approximately 1-inch-long) indications at the outside diameter of the H-2 weld. The Licensee prepared an evaluation of these cracks and concluded that the cracks did not impair the structural integrity of the shroud.

During a meeting on October 22, 1993, with the Licensee to discuss the Brunswick Unit 1 inspection results, the draft crack evaluation methodology and acceptance criteria, and the proposed core shroud modification, the NRC asked the Licensee to submit the crack acceptance criteria and the core shroud modification design to the NRC for review. In a letter dated November 18, 1993, the Licensee submitted this information to the NRC. The NRC Staff reviewed the design and supporting analysis and concluded in an NRC safety evaluation dated January 14, 1994, that the proposed modification of the Unit 1 core shroud provides adequate structural integrity in the location of the H-2 and H-3 welds for the remaining life of the unit. The NRC Staff also concluded that, based on the structural integrity analyses, the flaws associated with the H-1, H-4, H-5, and H-6 welds would not adversely impact the structural integrity of the shroud during the next operating cycle. The NRC Staff will be reviewing the results of the Licensee's future shroud inspections and evaluations to verify that adequate structural integrity is maintained.

Prior to beginning the 1994 Brunswick Unit 2 refueling outage, the Licensee preliminarily decided to install the same modification on the Unit 2 core shroud that was used on Unit 1. The Licensee also performed in-vessel inspections of the core shroud welds and evaluated the observed flaws to the same acceptance criteria that were used on Brunswick Unit 1. The Licensee observed that the cracking at Brunswick Unit 2 was similar to that seen on Unit 1. On the basis of these in-vessel inspections, the Licensee made its final decision to install the modification at the H-2 and H-3 weld location. Since the degree of cracking of the H-1, H-4, H-5, and H-6 welds was within the acceptance criteria and since the modification was installed at the H-2 and H-3 weld location, the NRC Staff concludes that the structural integrity of the Brunswick Unit 2 core shroud is acceptable for the next operating cycle.

During the Licensee's 1993 in-vessel visual inspections of the Brunswick Unit 1 core shroud, the NRC conducted periodic inspections to review the Licensee's conformance to acceptable inspection and installation practices. The NRC Staff and its consultant from Pacific Northwest Laboratories also reviewed the process qualification and the performance of the ultrasonic testing used by the Licensee and GE to characterize the observed crack depths. The NRC documented its assessment of these activities in NRC Inspection Report Nos. 50-325, 324/93-
34, dated September 14, 1993; 50-325, 324/93-43, dated October 20, 1993; and 50-325, 324/93-51, dated November 18, 1993. The NRC also reviewed and inspected the qualification and mockup testing for the core shroud modification used to repair the shroud at the H-2 and H-3 welds. Although some problems related to bolt preloading and quality assurance documentation were observed and corrected, the NRC generally found the activities to be satisfactory, as documented in NRC Inspection Report No. 50-325, 324/93-58, dated January 14, 1994. When the Licensee inspected the shroud and installed the modification at Brunswick Unit 2, the NRC similarly assessed these activities and documented the results in NRC Inspection Report Nos. 50-325, 324/94-08, dated May 13, 1994; and 50-325, 324/94-10, dated May 16, 1994. On the basis of these inspections, the NRC found that the inspection and installation techniques were satisfactorily qualified and performed. Many of the process techniques, such as precleaning and lighting placement, identified by the Licensee to enhance the video image quality and success in observing potential cracks, were incorporated into recommendations provided by GE to other BWR owners.

As stated above, the NRC Staff issued NRC Information Notice 93-79 alerting other BWR owners of the shroud cracking at Brunswick and noting that GE had issued Revision 1 to RICSIL 054 on July 21, 1993, to update the information on the cracks and to provide revised interim recommendations for performance of visual examinations. On July 25, 1994, the NRC issued Generic Letter 94-03, "Intergranular Stress Corrosion Cracking of Core Shrouds in Boiling Water Reactors," to request that BWR owners (1) inspect the core shrouds no later than the next scheduled refueling outage, and perform an appropriate evaluation and/or repair based on the results of the inspection; (2) perform a safety analysis supporting continued operation of the facility until inspections are conducted; and (3) provide the NRC with the results of the core shroud inspections and the safety analysis. The NRC Staff is monitoring the results of the inspections and evaluating the designs for proposed shroud modifications. On August 24, 1994, CP&L submitted the requested information in response to Generic Letter 94-03. The NRC Staff's preliminary review of that response did not reveal information not already known to the Staff.

By letter dated November 24, 1993, CP&L forwarded to the NRC a report entitled "Brunswick Nuclear Plant Review Team Potential Shroud Cracking in 1984." On the basis of its independent investigation conducted in response to the allegations in the Petition, the CP&L report states that no shroud cracks had been observed in either Unit 1 or Unit 2 shrouds between 1983 and 1985, or at any other time before 1993. The Licensee also states that it found no evidence of a "coverup" or "papering over" of cracks in the core shroud of Unit 1 or Unit 2 at any time, either by concealment of an as-found condition or by failure to report an as-found condition to the NRC. In partial support of its conclusions, the Licensee also states that, between 1983 and 1985, GE conducted in-vessel
inspections at Brunswick and any attempt to conceal core shroud cracks would have required GE's participation. Furthermore, there was no NRC requirement during that period to inspect the core shrouds, and no inspections were planned or performed. Additionally, the Licensee states that there was no requirement to report core shroud cracks to the NRC until the Brunswick Unit 1 core shroud cracks were found in July 1993. The Licensee explains that the videographic records of the in-vessel visual inspection of the Brunswick Unit 2 shroud taken during the 1991 refueling outage did not reveal any cracking at the time of the inspection. When the videographic tapes were subsequently computer-enhanced in 1993 after cracks were discovered in the Unit 1 shroud, the Licensee observed three short crack-like indications in the H-2 weld of the Unit 2 shroud.

The Licensee is correct in stating that there was no basis to conduct inspections of the core shroud preceding the issuance of the GE RICSIL in 1990. A review of NRC inspection records between 1983 and 1985 did not indicate that any core shroud inspections were conducted by the Licensee, nor did any licensee report core shroud cracking. Considering the equipment staging, the necessary plant conditions, and the procedural aspects of performing in-vessel visual inspections with a remotely operated camera, it is unlikely that the NRC resident inspectors would have failed to notice these activities, if they had occurred at Brunswick. Therefore, on the basis of the above, the NRC has found no evidence to support a conclusion that the Licensee had knowledge of cracking in the Brunswick Units 1 and 2 core shrouds in the 1984 time frame, or at any time prior to 1993. Additionally, the 1993 discovery of the core shroud cracking in Brunswick Units 1 and 2 was promptly communicated to the NRC Staff. Because the core shroud cracking at Brunswick in this case did not constitute an emergency, significantly compromise plant safety, result in the plant being severely degraded, prevent fulfillment of safety functions, or constitute a substantial safety hazard, no report was required by 10 C.F.R. § 21.21, 50.72, or 50.73.

The NRC has been unable to meet the Petitioners' request that the NRC Staff enter into a confidentiality agreement with NWC to facilitate the release of additional information because the Petitioners have not provided access to their sources. The NRC was unable to obtain the full cooperation of the Petitioners in identifying those persons who might have had first-hand knowledge and in arranging interviews with them. The NRC had inadequate information to evaluate any need to grant confidentiality. The Licensee's voluntary submittal on November 24, 1993, of the report entitled "Brunswick Nuclear Plant Review Team Potential Shroud Cracking in 1984," which stated that no shroud cracks had been observed in either Unit 1 or Unit 2 between 1983 and 1985, or at any other time before 1993, mooted the Petitioners' request that the NRC immediately require the Licensee to state whether it has, in fact, known about cracks in the reactor core shroud since at least 1984. In response to the Petitioners' request
that the NRC’s Office of Investigations determine whether CP&L management engaged in criminal wrongdoing concerning reporting the existence of cracks in the core shroud to the NRC, the NRC OI commenced an investigation regarding this allegation. Since there is no evidence to suggest that the Licensee had any reason to inspect the core shroud before 1990 or that the Licensee in fact inspected the core shrouds before 1991, since the Licensee reported that cracking when it was found in 1993, and since the Petitioners provided no evidence to support their allegations, there is no need to conduct additional evaluations. If the Petitioners decide to make knowledgeable individuals or additional information available to the NRC Staff, the NRC Staff will evaluate the information obtained and further pursue the matter, as appropriate.

In view of the above, the Petitioners have failed to raise a substantial health or safety concern regarding either the presence of core shroud cracks or the Licensee’s knowledge of and reporting of core shroud cracking at the Brunswick facility.

IV. CONCLUSION

The Petitioners’ request for an investigation into the alleged misconduct regarding the Licensee’s reporting of core shroud cracking to the NRC was granted. The Petitioners’ request for confidentiality of their sources was incapable of being fulfilled because the Petitioners failed to provide access to those sources. The Petitioners’ request that the NRC require the Licensee to immediately state when it knew of core shroud cracking at the Brunswick facility became moot when the Licensee submitted the “Brunswick Nuclear Plant Report of Technical Review Team Potential Shroud Cracking in 1984.” In view of the foregoing actions in response to the Petitioners’ request and the NRC’s review of the Licensee’s actions in response to the core shroud cracking issue, no substantial health and safety issue remains that would warrant institution of further proceedings. 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). This standard has been applied to determine if any action is warranted in response to the Petition.

A copy of the Decision will be filed with the Secretary of the Commission for the Commission’s review in accordance with 10 C.F.R. § 2.206(c). The Decision will become the final action of the Commission 25 days after issuance.
unless the Commission, on its own motion, institutes a review of the Decision in that time.

FOR THE NUCLEAR REGULATORY COMMISSION

William T. Russell, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland, this 19th day of October 1994.
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

Ivan W. Smith, Chairman
Dr. Richard F. Cole
Dr. Charles N. Kelber

In the Matter of

Docket No. 30-29567-CivP
(ASLBP No. 94-686-01-CivP)
(Byproduct Material License No. 20-27908-01)
(EA 93-005)

CAMERO DIAGNOSTIC CENTRE, INC.

November 1, 1994

DECISION
(Granting NRC Staff Motion for Summary Disposition)

I. INTRODUCTION

The NRC Staff, pursuant to the Commission’s rule on summary disposition, 10 C.F.R. § 2.749(a), moves for disposition of all of the issues in this proceeding and a finding that the Staff’s November 24, 1993 “Order Imposing a Civil Monetary Penalty” (Order) issued to Cameo Diagnostic Centre, Inc. (the Licensee) should be sustained. In the Order below the Board grants the motion, thereby terminating the proceeding. In a separate Memorandum and Order, also issued today, we dispose of pending procedural motions.
II. BACKGROUND

On April 16, 1993, the Staff issued a “Notice of Violation and Proposed Imposition of Civil Penalty” (Notice of Violation) to the Licensee that set forth two violations of NRC requirements which were characterized as willful, and proposed a civil penalty.

Licensee responded by letters dated June 11, 1993, and July 23, 1993. Together the responses denied the allegations, especially the severity level of violation. On November 24, 1993, the Staff, taking into account the Licensee’s response to the Notice of Violation, issued its Order imposing a civil monetary penalty in the amount of $1750 to the Licensee.

On December 17, 1993, the Licensee requested a hearing on the Order, and, on December 30, 1993, this Board was established to preside over it.

During a prehearing conference of February 1, 1994, the Board requested the Staff to advise it on legal aspects of alleged Violation I.B. As a consequence, the Order and Notice of Violation were subsequently modified on February 15, 1994, to reflect more accurately the nature of Violation I.B.¹ Both originally and as modified the orders and notices charged that the Licensee changed the location of its operations without license authority to do so, and provided inaccurate information with respect to the change. The full text of the alleged violations, as modified, is stated below at pp. 172 and 173.

Because the issues to be heard would not be materially altered by the forthcoming modification, on February 14, 1994, the Board issued an order that established the issues for discovery and a hearing schedule.

Licensee answered the modified order and notice on March 14, 1994, again denying the alleged violations.

On March 22, 1994, the Staff served discovery demands. However, the proceeding was interrupted pending settlement negotiations before a settlement judge appointed for that purpose. On June 7, 1994, the settlement judge reported to the Board that the parties had failed to reach a settlement.


On August 9 and 10, 1994, the Board resolved the remaining discovery motions and prehearing matters. The Board ordered that the hearing schedule be resumed and provided that “[a]ny motion for summary disposition must be filed on or before September 12, 1994, and must be in careful compliance with the provisions of 10 C.F.R. § 2.749.” The Board also ruled that the Licensee’s answer to the motion was to be due no later than 20 days thereafter.²

² See Memorandum and Order (Following Prehearing Conference), dated August 11, 1994 (unpublished).
The NRC Staff filed the instant motion on September 12, 1994. The Licensee has not answered the motion.

III. LEGAL STANDARDS FOR SUMMARY DISPOSITION

The Commission's regulations at 10 C.F.R. § 2.749 provide that any party may move for a decision by the presiding officer in that party's favor as to all or any part of the matters involved in the proceeding. 10 C.F.R. § 2.749(a). Summary disposition is appropriate if the filings in the proceeding, including depositions, statements of the parties, and affidavits, show that there is no genuine issue as to any material fact and that the moving party is entitled to a decision as a matter of law. 10 C.F.R. § 2.749(d).

The party seeking summary judgment has the burden of proving the absence of genuine issues of material fact. Advanced Medical Systems, Inc. (One Factory Row, Geneva, Ohio 44041), CLI-93-22, 38 NRC 98, 102 (1993).

A party opposing a motion for summary disposition, however, must answer the motion,controverting it by showing that a genuine issue of material fact exists. If the opposing party fails to do so — or fails to show why it cannot — the material facts stated by the moving party (as to which no genuine dispute exists) will be deemed to be admitted. 10 C.F.R. § 2.749(a). If no answer is filed, as is the case here, the decision sought by the moving party, if appropriate, shall be rendered. 10 C.F.R. § 2.749(b).

IV. ISSUES OF MATERIAL FACT

A. Introduction

The Staff's motion is extensively and completely supported by affidavits of its cognizant officers, correspondence, the deposition of Cameo's president, and other exhibits. The underlying facts are deemed admitted. We accept them as set out in the motion, often without further examination or attribution.

Cameo is in default. We review the motion only as a part of our responsibility to see that the decision sought by the Staff is appropriate. Throughout this proceeding, Mr. Paul J. Rosenbaum, President of Cameo Diagnostics, has focused his defense on the issue of whether, given the facts alleged in the notice and order (but without admitting them), the Staff has improperly escalated the monetary penalty. We discuss the escalation issue in a separate section below, but an understanding of the factual bases for the penalty is necessary first.
B. Violation I.A

Violation I.A alleges:

10 C.F.R. 35.13(e) requires that a licensee apply for and must receive a license amendment before it adds to or changes the areas of use or address or addresses of use identified in the application or on the license.

Contrary to the above, as of November 3, 1992, the licensee changed the address and location at which byproduct material was used from 110 Maple Street, Springfield, Massachusetts to 155 Maple Street, Springfield, Massachusetts, and the licensee did not receive an amendment to authorize the change of location until January 12, 1993.

Cameo Diagnostic Centre, Inc., is the holder of an NRC byproduct material license. The license originally authorized the Licensee to use NRC-licensed materials at 110 Maple Street, Suite A, Springfield, Massachusetts.

On December 18, 1991, the Commission issued License Amendment No. 3 which authorized the Licensee to use NRC-licensed material at 3400 Main Street, Springfield, Massachusetts, in addition to 110 Maple Street. License Amendment No. 3 did not authorize any other locations of use. It was not until January 12, 1993, that the Commission issued the fourth license amendment to the Licensee which, for the first time, authorized the Licensee to use materials at 155 Maple Street.

Therefore, during November and December 1992, Licensee was authorized to use NRC-licensed material only at 110 Maple Street and 3400 Main Street. Use of the material at any other location during this time constituted a violation of 10 C.F.R. § 35.13(e).

On November 2, 1992, the Licensee changed the address and location at which byproduct material was used from 110 Maple Street to 155 Maple Street. As noted, the Licensee did not receive an amendment to authorize the change until January 12, 1993. Mr. Rosenbaum admitted that he began to use technetium-99m byproduct material at 155 Maple Street "[p]erhaps two or three days past November 2nd."

On December 17, 1992, the Staff issued a Demand for Information to the Licensee, which requested a complete list of dates on which NRC-licensed material was used at 155 Maple Street in violation of the Commission's requirements. On December 18, 1992, the Licensee responded by letter with an attachment representing "[a] complete list with dates, type and amount of radioactivity . . . ." The list of dates runs from November 3, 1992, through December 11, 1992, and includes every weekday during that period with the exception of November 24, 26, and 27, 1992.

There is no genuine issue of material fact in dispute with respect to the facts as they relate to Violation I.A. The Licensee was in violation of the Commission's regulations as set forth in Violation I.A of the Notice of Violation.
C. Violation I.B

Violation I.B, as modified, alleges:

10 C.F.R. 30.9(a) requires, in part, that information provided to the Commission by a licensee be complete and accurate in all material respects.

Contrary to the above, the Licensee did not provide to the Commission information that was complete and accurate in all material respects. Specifically, during a November 12, 1992 telephone conversation in response to a question from Region I as to whether the Licensee had licensed materials at its new address (155 Maple Street, Springfield, MA), the Licensee responded negatively. The licensee response was confirmed in a letter from NRC to the licensee dated November 13, 1992 which stated that it was the NRC "understanding that: . . . 2. You [Licensee] do not as yet possess any licensed radioactive material at this new facility." Therefore, the Licensee provided inaccurate information to the Commission in that it had possessed licensed materials at its new address. This information was material because, had the correct information been known, it would have resulted in action by the NRC to prohibit licensed activity at the new address until a license amendment had been granted.

The circumstances surrounding the violation are set forth below.

The October 21, 1992 Meeting

Mr. Rosenbaum met with NRC officers, Ms. Susan Shankman and Ms. Pamela Henderson at the NRC Region I offices on October 21, 1992. Ms. Henderson, a Health Physicist in Region I, was assigned to review the Licensee's pending license renewal application. The purpose of the meeting was to discuss outstanding issues.

Mr. Rosenbaum stated that he intended to move his facility to 155 Maple Street. Ms. Henderson informed Mr. Rosenbaum that the license renewal would take time to complete because he had requested exemptions from several regulations, which required review at NRC headquarters. Mr. Rosenbaum was told that if the Licensee chose to include its request to use licensed material at the new address in the renewal application, the Licensee could not use material at the new location until the renewal process was completed and the license renewal was issued. Ms. Henderson also explained to him that the Licensee could facilitate a change of address by submitting a separate amendment request, and that the amendment could be issued more quickly than the license renewal. Mr. Rosenbaum stated that he understood this, but would nonetheless like to include the request to add the new location in the license renewal in order to avoid paying a separate amendment fee.

There is no genuine issue with respect to the facts pertaining to the October 21, 1992 meeting.
The November 12, 1992 Telephone Conversation

Mr. Rosenbaum left a message for Ms. Henderson on November 10, 1992. He explained that he had moved, that his office was in disarray, and that he would get back to Ms. Henderson with information that she had requested. Ms. Henderson received Mr. Rosenbaum’s message on November 12, 1992, and, together with Ms. Shankman, contacted Mr. Rosenbaum by telephone to confirm that he had moved and to verify that he had not begun using NRC-licensed materials at the new location.

During the November 12, 1992 conversation, Ms. Henderson asked Mr. Rosenbaum whether he had NRC-licensed material at his new address at 155 Maple Street. Mr. Rosenbaum replied in the negative. The November 12, 1992 conversation is documented in a letter from Ms. Henderson to Mr. Rosenbaum, dated November 13, 1992. The purpose of the letter was to summarize the contents of the November 12, 1992 conversation. The letter states:

From the telephone conversation, it is our understanding that:

1. You have taken occupancy of a new facility.

2. You do not as yet possess any NRC licensed radioactive materials at this new facility.

Mr. Rosenbaum later admitted that, during the November 12, 1992 conversation, either Ms. Henderson or Ms. Shankman told him that he could not use the material at the address. The November 13, 1992 letter from Ms. Henderson to Mr. Rosenbaum also confirms that on November 12, 1992, Mr. Rosenbaum was “informed that in order to commence use of NRC licensed radioactive materials at [his] new facility that [he] must apply for and receive a license amendment or license renewal which identified the address where radioactive materials are used or possessed.” He was also advised of the merits of applying for license renewal compared with a license amendment.

There is no genuine issue of material fact in dispute with respect to the conversation that took place on November 12, 1992, or with respect to the content of the November 13, 1992 letter.

The November 19 and November 25 Telephone Conversations

On November 19, 1992, Ms. Henderson reminded Mr. Rosenbaum that he could not use NRC-licensed material at the new facility until the Licensee had a license that included the new location of use.

On November 25, 1992, Ms. Henderson left a message at Cameo’s office that Mr. Rosenbaum be reminded that the Licensee could not use NRC-licensed
materials at its new facility until it received a license that included the new
location of use.

There is no genuine issue of material fact with respect to the reminders to the
Licensee on November 19 and 25, 1992, that it could not use licensed material
at the new address until receiving a license amendment.

The Events of December 11, 1992

On December 11, 1992, Dr. Keith Brown, a Health Physicist, NRC Region I,
contacted a radiopharmaceutical licensee in the Springfield, Massachusetts area
and verified that it was shipping material to Licensee at 155 Maple Street and
that it had been regularly shipping doses of radiopharmaceuticals containing
technetium-99m to Cameo.

Later the same day, Ms. Shankman, during a telephone call, asked Mr.
Rosenbaum whether the Licensee was using NRC-licensed material at a location
other than the one authorized on its License. Mr. Rosenbaum replied in the
affirmative. Ms. Shankman informed Mr. Rosenbaum of the need to amend
the License prior to using licensed material at the new location and cited
the Commission's regulations at 10 C.F.R. § 35.13. Ms. Shankman asked
if Mr. Rosenbaum would agree to stop using NRC-licensed materials at the
unauthorized address, and Mr. Rosenbaum replied in the negative.

There is no dispute that Mr. Rosenbaum possessed and used NRC-licensed
material at the 155 Maple Street location during the time alleged in the notice
of violation and that Licensee provided inaccurate and incomplete information
about those facts to the NRC on November 12, 1992.3 Consequently, the Board
finds that Violation I.B, as set forth in the Notice of Violation, as modified on
February 15, 1994, did occur as stated therein.

V. AMOUNT OF MONETARY PENALTY

A. Introduction

The amount of the civil penalty was determined by assigning a severity level
to the violations, calculating the base penalty, and applying any adjustment
factors.

The Licensee initially objected to the characterization of Violations I.A and
I.B as willful and objected to the categorization of Violations I.A and I.B at
Severity Level III, because the change in location did not have radiological

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3 The events of November 19 and 25, and December 11, 1992, do not in themselves support Violation I.B.
Nevertheless, they are significant facts in determining the amount of the civil penalty. See Sections V.B and V.D,
infra.

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significance and because the Licensee informed the Staff on October 21, 1992, that the Licensee would be changing locations, and notified the Staff on November 10, 1992, that the move had taken place. The Licensee also stated that the $1750 civil penalty, being a 250% increase over the $500 base penalty, is entirely unjustified and completely based on personal animus. The issue of personal animus was later withdrawn from the proceeding by Licensee as noted in our Memorandum and Order of August 11, 1994.

Ms. Patricia A. Santiago, Assistant Director for Materials of the Office of Enforcement, explained how the Staff assigned the severity level to the two violations and assessed the amount of civil penalty for the violations. She explains that the Staff’s determination of the amount of the civil penalty was made in accordance with the Commission’s “General Statement of Policy and Procedure for NRC Enforcement Actions,” 10 C.F.R. Part 2, Appendix C. Ms. Santiago held her position on November 24, 1993, when the Staff issued the Order to the Licensee.

Ms. Santiago’s explanation is very detailed and complete. The Board can find no fault with it, and Licensee has not controverted her reasoning.

B. Severity Level

The Notice of Violation states that the two violations represent a Severity Level III problem, as illustrated by Supplements VI and VII of the “General Statement of Policy and Procedure for NRC Enforcement Actions.” 10 C.F.R. Part 2, Appendix C.

The Staff aggregated the two violations in assessing a severity level and determining the amount of the civil penalty. The aggregation was in accordance with section IV.A of the Enforcement Policy, which permits the Staff to evaluate a group of violations and to assign a single severity level if the violations stemmed from the same underlying cause or deficiency. The purpose of an aggregation is to focus a licensee’s attention on the problem. Both violations stemmed from the unauthorized use of NRC-licensed material at 155 Maple Street, and they were both willful.

The Staff assigned a severity level based on the most suitable examples provided in the Supplements to the Enforcement Policy. Licensee’s activity area corresponded with Supplement VI, “Fuel Cycle and Materials Operation.”

The Staff compared the Licensee’s violations to two examples in Supplement VI. The first example, an example of a Severity Level III violation, was:

10. A failure to receive required NRC approval prior to the implementation of a change in licensed activities that has radiological or programmatic significance, such as

... a change in the location where licensed activities are being conducted...
The second example, "[o]ther violations that have more than minor safety or environmental significance" (D.2) was an example of a Severity Level IV violation. In a lucky development for Licensee, the Staff determined that the Licensee's violations best corresponded with the Severity Level IV example based on the safety significance of the Licensee's program.

The Staff then increased the severity level to Severity Level III, in accordance with section IV.C of the Enforcement Policy, to reflect the regulatory significance of the willful nature of the violations. In evaluating willfulness, the Staff considered the responsibilities of the person involved in the violations; the significance of the underlying violations; the intent of the violator; and the economic or other advantage, if any, gained as a result of the violations. The Staff considered that Mr. Rosenbaum had been told many times that an amendment to the License was needed prior to using licensed material at any new location and he nevertheless continued to use material at the new location, and, thereby demonstrated, at a minimum, careless disregard for the Commission's requirements. He did it to save money associated with a fee for an amendment to the License.

The Staff was well within its discretion to increase the severity level from Level IV to Level III.

C. Calculation of the Base Civil Penalty

Once the severity level was assigned to the violations, the Staff derived the civil penalty amount using Tables 1A and 1B of the Enforcement Policy, section VI.B.

Table 1A shows the base civil penalty at Severity Level I for different classes of licensees. Item (j), "Other material licensees," provides the lowest base civil penalty. The base civil penalty for a violation under item (j) is $1000 for violations concerning "plant operations, construction, health physics, and emergency preparedness." This is the lowest penalty possible under the table.

Table 1B of the Enforcement Policy shows how to calculate the base civil penalty at various severity levels. The base civil penalty for Severity Level III violations is 50% of the amount listed in Table 1A. The Staff determined the base civil penalty to be $500.

D. Adjustment Factors

The base civil penalties shown in Tables 1A and 1B may be increased or decreased based on the civil penalty adjustment factors set forth in section VI.B.2 of the Enforcement Policy. The Enforcement Policy lists six adjustment factors: identification, corrective action, licensee performance, prior opportunity to
identify, multiple occurrences, and duration. The Staff applied three of the factors in determining the amount of the civil penalty.

The Staff first applied the "identification" factor, to the base civil penalty and escalated the penalty by 50% because the NRC, not Licensee, identified the violation.

The Staff did not escalate or mitigate the base civil penalty for the two violations with respect to the second adjustment factor, "Corrective action," or for the third adjustment factor, "Licensee performance."

Under factor (d), "Prior opportunity to identify," the base civil penalty may be increased by up to 100% in cases where the licensee should have identified the violation sooner as a result of prior opportunities such as "(2) through prior notice, i.e., specific NRC or industry notification; or (3) through other reasonable indication of a potential problem or violation" and others. The Staff escalated the base civil penalty by 100% based on the notices given to the Licensee.

The Staff also escalated the base civil penalty by 100% by applying the sixth adjustment factor, "Duration," which permits the Staff to escalate the base civil penalty as much as 100% for violations that continue or remain uncorrected for more than one day. This factor is normally applied in cases where a significant regulatory message is warranted. The Staff determined that 100% escalation of the civil penalty based on this factor is appropriate because the violations continued for approximately 1 month and that a significant regulatory message was warranted. We believe that this adjustment was a sound decision.

In summary, the Staff escalated the base civil penalty by 250% to $1750 based on three adjustment factors: identification (50%); prior opportunity to identify (100%); and duration (100%).

There exists no genuine issue with respect to whether, on the basis of the violations and the Enforcement Policy, the Order imposing a civil monetary penalty in the amount of $1750 should be sustained.

VI. CONCLUSION AND ORDER

The Licensee was in violation of the Commission’s regulations as set forth in Violation I.A and I.B of the Notice of Violation as modified. On the basis of the violations, and in accordance with the Enforcement Policy, the Order imposing a civil monetary penalty in the amount of $1750 is SUSTAINED.4

4 Judge Cole was not available to sign this Decision, but approved the result.
VII. RIGHT TO APPEAL

This Decision is effective immediately and, in accordance with 10 C.F.R. § 2.760, shall become the final action of the Commission forty (40) days from the date of issuance, unless any party petitions for Commission review in accordance with 10 C.F.R. § 2.786 or the Commission takes review sua sponte.

Within fifteen (15) days after service of this Decision, the Licensee may file a petition for review by the Commission on the grounds specified in 10 C.F.R. § 2.786(b)(4). The filing of a petition for review is mandatory for a party to exhaust its administrative remedies before seeking judicial review. A petition for review must be no longer than ten (10) pages and must contain the information specified by 10 C.F.R. § 2.786(b)(2). The NRC Staff may, within ten (10) days after service of a petition for review, file an answer supporting or opposing Commission review. The answer must be no longer than ten (10) pages and should concisely address the matters in 10 C.F.R. § 2.786(b)(2) to the extent appropriate.

THE ATOMIC SAFETY AND LICENSING BOARD

Charles K. Kelber
ADMINISTRATIVE JUDGE

Ivan W. Smith, Chairman
ADMINISTRATIVE JUDGE

Rockville, Maryland
November 1, 1994
The Licensing Board issues an Initial Decision that approves operating license amendments extending the Unit 1 operating license for approximately 13 years and the Unit 2 license for almost 15 years, representing recapture of periods of construction of the reactors. In approving the amendments, the Licensing Board issued three directives to the Applicant with respect to the maintenance and surveillance program. The Board also rejected claims that PG&E's implementation of Thermo-Lag compensatory measures was inadequate. Finally, the Board ruled against the Intervenor's second Motion to Reopen the Record, on the ground that reopening could not change the result the Board was otherwise reaching.
OPERATING LICENSE AMENDMENT: SIGNIFICANCE

An operating license amendment that does not modify any systems, structures, or components (SSCs) but which extends the license term to recapture time lost during construction represents a significant amendment and not merely a ministerial administrative change, notwithstanding prior review during the operating license proceeding of such SSCs.

MAINTENANCE AND SURVEILLANCE PROGRAM: STANDARDS

Absent any currently effective regulatory standards for maintenance and surveillance programs, those programs must be judged in terms of the "reasonable assurance" of public health and safety appearing in the Atomic Energy Act. The guidance provided by INPO 90-008, Rev. 01 (March 1990) is also useful in looking at the elements of a comprehensive program.

MAINTENANCE AND SURVEILLANCE PROGRAM: STANDARDS

Perfection in implementation of a maintenance and surveillance program is not required, given the "reasonable assurance" standards of the Atomic Energy Act.

MAINTENANCE AND SURVEILLANCE PROGRAM: SCOPE

A maintenance program must be deemed to include maintenance-type activities and supporting functions performed by employees outside the Maintenance Department.

MAINTENANCE AND SURVEILLANCE PROGRAM: STANDARDS

"Fundamental flaw" and "failure of an essential element" are not appropriate criteria by which to judge the effect of maintenance deficiencies or the adequacy of a maintenance and surveillance program. Those criteria were developed by the Commission to deal with a particular problem under defined circumstances and are not applicable where, as here, circumstances differ markedly. With respect to implementation of a maintenance and surveillance program, numerous or repetitive incidents may coalesce to indicate a significant deficiency in a program.
RULES OF PRACTICE: CROSS-EXAMINATION

An intervenor may present its case through cross-examination of other parties' witnesses and by use of documents offered through those witnesses.

RULES OF PRACTICE: PROPOSED FINDINGS

Even though a party presents no expert testimony, it may advance proposed findings that include technical analyses, opinions, and conclusions, as long as the facts on which they are based are matters of record. The Licensing Board must do more than act as an umpire blandly calling balls and strikes for adversaries appearing before it. The Board includes experts who can evaluate the factual material in the record and reach their own judgment as to its significance.

RULES OF PRACTICE: CROSS-EXAMINATION PLANS

The Rules of Practice require parties generally to submit cross-examination plans to the Licensing Board (although not to other parties) but they do not require parties to provide other parties with advance notice of exhibits they plan to use in cross-examination.

RULES OF PRACTICE: REOPENING OF PROCEEDINGS

Motions to reopen a record are governed by 10 C.F.R. § 2.734, which requires that a motion to reopen a closed record be timely, that it address a significant safety or environmental issue, and that it demonstrate that a materially different result would be or would have been likely had the newly proffered evidence been considered initially.

TECHNICAL ISSUES DISCUSSED

The following technical issues are discussed: Maintenance/surveillance; Thermo-Lag Interim Compensatory Measures.

APPEARANCES

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This is an initial decision on Pacific Gas and Electric Company's (PG&E or Applicant) application to amend the operating licenses for its Diablo Canyon Nuclear Power Plant, Units 1 and 2 (DCPP or Diablo Canyon), located near San Luis Obispo, California, to allow for 40 years of operation dated from the issuance of its operating licenses. For the reasons set forth herein, we conclude that, to the extent challenged in this proceeding, PG&E satisfactorily justified the license extensions it seeks and, subject to certain directions, as well as normal NRC Staff review, should be granted those extensions.

II. BACKGROUND

On July 9, 1992, PG&E submitted a license amendment request by which it sought to extend the life of its operating licenses for the DCPP by more than 13 years (for Unit 1) and almost 15 years (for Unit 2) by "recapturing" the period spent in constructing the plants. The licenses, which are limited to a term of 40 years by section 103c of the Atomic Energy Act, 42 U.S.C. § 2133(c), were issued consistent with a then-extant Commission policy under which that 40-year life extended from the date of issuance of the construction permit for a particular unit — for Unit 1, a term running from April 23, 1968, to April 23, 2008, and for Unit 2, a term running from December 9, 1970, to December 9, 2010.
In 1982, the Commission began issuing the 40-year operating licenses measured from the date of issuance of the operating license. It has also approved license amendments for many reactors conforming the earlier licenses to this new policy. The Applicant is here seeking to amend its operating licenses to take advantage of the newer practice. As proposed, the extended expiration dates for DCPP would be September 22, 2021, for Unit 1 and April 26, 2025, for Unit 2.

In response to a notice of opportunity for hearing on the proposed amendments, 57 Fed. Reg. 32,575 (July 22, 1992), San Luis Obispo Mothers for Peace (MFP) timely filed a request for a hearing/petition for leave to intervene. This Licensing Board was established to rule on the request/petition and to preside over the proceeding in the event that a hearing were to be ordered. 57 Fed. Reg. 43,035 (Sept. 17, 1992).

After a prehearing conference held in San Luis Obispo, California, on December 10, 1992, at which we heard argument concerning MFP's petition and the Supplement in which MFP set forth its proposed contentions, together with PG&E's and the NRC Staff's responses each opposing admission of any of the contentions, we granted MFP's petition for leave to intervene and request for a hearing. LBP-93-1, 37 NRC 5 (1993) (LBP-93-1); see also LBP-92-27, 36 NRC 196 (1992). We determined that MFP had standing and, of the eleven contentions proffered, we admitted portions of two of them: Contention I, challenging the adequacy of PG&E's maintenance and surveillance program, and Contention V, challenging the adequacy of PG&E's interim fire protection measures to compensate for defective "Thermo-Lag" passive fire barriers manufactured by Thermal Science, Inc.

Thereafter, MFP submitted three late-filed contentions. Following a prehearing conference held on May 11-12, 1993, in NRC's then-Region V office at Walnut Creek, California, we rejected all three contentions. But we determined that portions of two of them could be litigated under the previously admitted maintenance and surveillance program contention, and that portions of another dealing with fire protection had become moot as a result of steps already taken or planned by PG&E. LBP-93-9, 37 NRC 433 (1993).

We held evidentiary hearings in San Luis Obispo, California on seven days, August 17-21, 23-24, 1993. The record was closed on August 24, 1993 (Tr. 2295). PG&E and the Staff presented their cases through expert witnesses and documents. MFP put on no witnesses but presented its case through cross-examination, based in large part on numerous PG&E and NRC documents that
MFP offered into evidence. Thereafter all parties submitted timely proposed findings of fact and conclusions of law,¹ and PG&E submitted a timely reply.²

On February 25, 1994, MFP filed a motion to reopen the record, based on material appearing in an NRC inspection report provided to PG&E by the NRC Staff on January 12, 1994.³ PG&E and the NRC Staff filed responses on March 7 and 14, 1994, respectively. By Memorandum and Order dated March 23, 1994, LBP-94-9, 39 NRC 122, we denied that motion, primarily because the matters in the inspection report relied on by MFP were at that stage no more than "unresolved items" and because an affidavit of the NRC inspector involved in the inspection (one of the Staff's witnesses in this proceeding) stated that nothing in the inspection report was contrary to or inconsistent with his prior testimony. Our denial, however, was without prejudice to a later motion to reopen based on any of the unresolved items demonstrated to be significant and to possess substantive implications for implementation of the maintenance and surveillance program.

On August 8, 1994, MFP filed such a motion.⁴ PG&E and the Staff each opposed the reopening.⁵ We are denying the motion for reasons spelled out in Part V of this Decision.

The Board addresses the contested issues below. We have divided the remainder of this opinion into six parts. First, we describe the applicable legal standards for resolving the issues before us (Part III). Next, we address the contested issues in two parts, the first (Part IV) addressing Contention I (Maintenance and Surveillance Program) and the second (Part VI) addressing Contention V (Thermo-Lag Interim Compensatory Measures). These portions of the opinion include various findings of fact necessary to our conclusions on the respective issues. In Part V, we spell out our reasons for denying the Renewed Motion, which relates to the maintenance/surveillance issue immediately preceding it. In Part VII, we set forth conclusions of law, and, in Part VIII, our resulting Order.

¹ PG&E’s Proposed Findings of Fact and Conclusions of Law in the Form of an Initial Decision, dated October 8, 1993 (PG&E FOF); MFP’s Proposed Findings of Fact and Conclusions of Law Regarding PG&E’s Application for a License Amendment to Extend the Term of the Operating License for the DCNPP, dated November 19, 1993 (MFP FOF); NRC Staff’s Findings of Fact and Conclusions of Law in the Form of an Initial Decision, dated December 22, 1993 (Staff FOF).
³ This report was entered into the NRC’s NUDOCS document storage and retrieval system on February 2, 1994, and hence became a publicly available document no later than that date.
⁴ San Luis Obispo Mothers for Peace’s Renewed Motion to Reopen the Record Regarding Pacific Gas and Electric Company’s Application for a License Amendment to Extend the Term of the Operating License for the Diablo Canyon Nuclear Power Plant, dated August 8, 1994 (Renewed Motion).
⁵ PG&E’s Opposition to San Luis Obispo Mothers for Peace Renewed Motion to Reopen the Record, dated August 23, 1994; NRC Staff Response to San Luis Obispo Mothers for Peace’s Renewed Motion to Reopen the Record, dated August 29, 1994.
III. STANDARD OF REVIEW

A. General Requirements

Since its change in policy in 1982, when it began measuring the term of operating licenses from the commencement of operation, the Commission has approved more than sixty recapture amendment requests. PG&E FOF at 3; Tr. 2274 (Peterson). PG&E characterizes NRC's approval of recapture amendments as "routine" and "administrative in nature" inasmuch as it does not involve any alterations in plant design or operation, or any new environmental impacts not previously evaluated. PG&E FOF at 3. In fact, that description may be more reflective of the number of challenges to such approvals than to the nature of the approval itself: only one such comparable amendment request has been challenged. The only contention accepted in that proceeding concerned the adequacy of the surveillance and maintenance program, and it was finally settled (with some additional obligations attached to the extension). See Vermont Yankee Nuclear Power Corp. (Vermont Yankee Nuclear Power Station), LBP-90-6, 31 NRC 85 (1990).

In LBP-93-1, however, we in effect rejected PG&E's "administrative change" designation. In the context of determining MFP's standing to participate, we noted that the "risk of an accident with offsite consequences for an additional 13 to 15 years" represented injury in fact (notwithstanding the prior analyses of such accidents) and in substance undercut PG&E's claim that the proposed amendments were not "significant" but virtually ministerial. 37 NRC at 10-11. Our evaluation of the record evidence in this proceeding reinforces our view of the significance of the amendments.

In seeking denial of the license amendments here in issue because of asserted deficiencies in the maintenance/surveillance program (Contention I), MFP points out that there are currently no detailed regulatory requirements prescribing conditions for such programs. Similarly, it notes that there are no regulations for evaluating the adequacy of implementation of a maintenance/surveillance program in terms of past performance. MFP FOF ¶ 13. The Staff essentially agrees, pointing out that the NRC's maintenance rule, 10 C.F.R. § 50.65, does not become effective until 1996. Staff FOF ¶I-6.

Normally, in evaluating the adequacy of a program such as the maintenance/surveillance program, a Board would look to standards appearing in regulations. Absent such regulations, MFP would rely generally on section 182a of the Atomic Energy Act (AEA) of 1954, as amended, 42 U.S.C. § 2232(a), which provides that an applicant for a reactor operating license must submit sufficient information for the NRC to find that the facility will "provide adequate protec-

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6The Staff makes no attempt to characterize the significance of the recapture proceeding.
tion to the health and safety of the public." Further, MFP references section 103d of the Act, 42 U.S.C. § 2133(d), providing that the NRC may not issue a license that would be "inimical to the . . . health and safety of the public." These statutory standards are reflected in 10 C.F.R. § 50.57(a)(3) and (6), which specify in pertinent part that NRC may issue operating licenses upon finding that there is "reasonable assurance (i) that the activities authorized by the operating license can be conducted without endangering the health and safety of the public, and (ii) that such activities will be conducted in compliance with [NRC] regulations" and that issuance of the license "will not be inimical to the . . . health and safety of the public." MFP adds that, although absolute perfection is not required, "reasonable assurance" may not be tainted by cost or risk-benefit considerations, citing Union of Concerned Scientists v. NRC, 824 F.2d 108 (D.C. Cir. 1987). MFP FOF ¶12.

For its part, PG&E relies generally upon the "reasonable assurance" standard. PG&E FOF at 10. Both it and the Staff further cite various codes, standards, regulatory guides, and technical specifications dealing with the maintenance of particular equipment.

These standards do not, however, define an adequate maintenance/surveillance program, although the degree to which they are achieved may constitute a reasonable measure of program adequacy. As the Commission observed (in adopting the section 50.65 requirements to be effective in the future):

[the Commission's current regulations, regulatory guidance, and licensing practice do not clearly define the Commission's expectations with regard to ensuring the continued effectiveness of maintenance programs at nuclear power plants.]

56 Fed. Reg. 31,306, 31,308 (July 10, 1991). Thus, we will refer to such standards as guidelines to determine whether the maintenance/surveillance program is performing its intended function.

MFP further references the guidance provided by INPO 90-008, Rev. 01, Maintenance Programs in the Nuclear Power Industry (March 1990) (MFP Exh. 4), as helpful in defining the scope of issues that a maintenance program must address in order to provide adequate protection to the public health and safety. MFP FOF ¶14. PG&E agrees, claiming that the evidence supports PG&E's compliance with those guidelines. PG&E Reply FOF ¶R9. The Staff points out that, in declining to adopt regulations defining a maintenance program, the Commission specifically declined to adopt INPO 90-008. Staff FOF ¶1-8, referencing 54 Fed. Reg. 50,611 (Dec. 8, 1989). The Staff acknowledges, however, the usefulness of the INPO 90-008 standards in looking at the elements of a comprehensive maintenance program.

The general safety provisions of the Atomic Energy Act and implementing general regulations are the ultimate standards against which to evaluate the
amendments. The standards of INPO 90-008 and the other material cited by various parties are useful as guidance. In determining the adequacy of PG&E’s program, we will refer to all these standards to determine what appears to us to constitute an adequate program sufficient to provide reasonable assurance of public health and safety for the extended operation period of the proposed amendments.

With respect to the maintenance and surveillance program, the Applicant has maintained that the Commission’s specific criteria for dealing with emergency preparedness exercise issues are germane and that we might give weight only to maintenance deficiencies that indicate a “fundamental flaw” or “failure of an essential element” of the maintenance/surveillance program. PG&E FOF at 7. We earlier disagreed in essence with that conclusion and we still do. As we have held, numerous or repetitive incidents may coalesce to indicate a significant deficiency in the program. LBP-93-1, 37 NRC at 19-21.

“Fundamental flaw” was promulgated to deal with a specific circumstance involving an emergency planning exercise that would occur only at the time a plant was ready for operation. Litigation of the results of such an exercise could delay operation, and the concept of “fundamental flaw” was developed to keep delay to a minimum by limiting the scope of litigation. Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), CLI-86-11, 23 NRC 577 (1986). Here, the additional time needed for thorough consideration will not delay operation — technically, the extension is not needed until at least 2008.

For all of these reasons, we have declined to follow the criteria favored by PG&E. Our decision will consider each of the alleged deficiencies propounded by MFP and give it the weight that we consider it deserves.

With respect to the issue of interim compensatory measures for Thermo-Lag (Contention V), MFP relies on a series of Information Notices issued by the Staff. It also cites several NRC Bulletins. MFP FOF ¶¶ 786-787. We see no reason not to rely on this material, interpreted in accord with the “reasonable assurance” standard that also governs this issue.

MFP contends (and we agree) that the burden of proof falls on the Applicant. MFP further asserts that PG&E has not satisfied that burden. MFP claims the asserted deficiencies in the maintenance/surveillance program that it has demonstrated (as well as asserted deficiencies in PG&E’s implementation of interim Thermo-Lag corrective actions) require denial of the proposed amendments. Id. ¶¶ 2, 839.

PG&E and the NRC Staff assert, to the contrary, that the maintenance/surveillance program is adequate — indeed, exemplary — and that the statutory and regulatory standards referenced by MFP are perforce satisfied. PG&E and the Staff claim, and MFP concedes (id. ¶12), that perfection in a program is not required, given the “reasonable assurance” standards of the Atomic Energy Act.
Although acknowledging that the ultimate burden of proof falls on PG&E, the Staff (and to a lesser extent, PG&E) further claim that MFP has the burden of going forward with evidence, which (in their view) it has failed to do. Both PG&E and the Staff also find PG&E's implementation of Thermo-Lag interim corrective measures to be adequate.

B. Method of Proof

PG&E and the Staff each presented witnesses on both the maintenance/surveillance and the Thermo-Lag issues. MFP did not sponsor any witnesses but, instead, developed its case (as is permissible7) through cross-examination of PG&E and Staff witnesses and documents offered through them.

The NRC Staff takes the position that the portions of MFP's proposed findings that include technical analyses, opinions, and conclusions may not be "adopted" by us, inasmuch as "technical analyses, opinions, and conclusions in NRC proceedings must be sponsored by experts who can testify to the soundness of the conclusions set forth." Staff FOF ¶2. The Staff relies primarily on Duke Power Co. (William B. McGuire Nuclear Station, Units 1 and 2), ALAB-669, 15 NRC 453, 477 (1982), and Southern California Edison Co. (San Onofre Nuclear Generating Station, Units 2 and 3), ALAB-717, 17 NRC 346, 367 (1983).

However, neither of these cases supports the Staff's position. In McGuire, the Appeal Board ruled that a Licensing Board had not erred in declining to admit documents into evidence when there was no competent expert witness to sponsor them. 15 NRC at 477. Similarly, in San Onofre, the Appeal Board would not allow portions of an applicant's Final Safety Analysis Report to be considered as substantive evidence when the applicant provided no witnesses for cross-examination on the document. In so ruling, the Appeal Board concluded that there was "no basis for allowing applicants to avoid cross-examination on a document of central importance that they themselves prepared." 17 NRC at 366.

Both of these cases dealt with document reliability and the need for documents to be verified by competent witnesses before they can be admitted into evidence. In contrast, in this case the documents relied on by MFP were accepted into evidence after being introduced through PG&E's or the Staff's expert witnesses. Once admitted into evidence, MFP was entitled to use them in its proposed findings.8

7Tennessee Valley Authority (Hartsville Nuclear Plant, Units 1A, 2A, 1B, and 2B), ALAB-463, 7 NRC 341, 356 (1978); Commonwealth Edison Co. (Zion Station, Units 1 and 2), ALAB-226, 8 AEC 381, 389 (1974); Wisconsin Electric Power Co. (Point Beach Nuclear Plant, Unit 2), ALAB-137, 6 AEC 491, 504-05 (1973).

8The Staff also cites Louisiana Power and Light Co. (Waterford Steam Electric Station, Unit 3), ALAB-732, 17 NRC 1076, 1088 n.13 (1983), involving prepared direct testimony of an expert, which is distinguishable on the same basis.
The result of adopting the Staff’s argument would be that, in reaching technical conclusions, the Board would be limited to relying on expert testimony of witnesses — all sponsored by PG&E or the Staff and essentially reaching the same conclusion. This would eliminate or seriously abrogate the right of MFP to present its case through cross-examination. We do not read the Commission’s rules or decisions as either requiring or even permitting this result. Federal agencies, and this Board as the delegatee of such an agency, are required to do more than act as an “umpire blandly calling balls and strikes for adversaries appearing before it.” Scenic Hudson Preservation Conference v. Federal Power Commission, 354 F.2d 608, 620 (2d Cir. 1965). This Board includes technical experts who can evaluate the factual material in the record and reach their own judgment as to its significance.

Early during the hearing, PG&E objected generally to MFP’s introduction of documents intended to show deficiencies in PG&E’s maintenance/surveillance program, on the ground that the “uncontroverted evidence in the direct testimony” affirmed the adequacy of such program. Tr. 597. We overruled that general objection on the basis that we should have the opportunity to evaluate the significance of the documents and the adequacy of the program. Tr. 597-99. We permitted PG&E to offer objections to specific documents on grounds such as relevance to the operation of the maintenance/surveillance program. Tr. 600.

C. Asserted Procedural Deficiencies

The NRC Staff raises a question concerning the advance notice it received of exhibits that MFP intended to introduce. The Staff points to the requirement that written testimony be provided the parties fifteen (15) days prior to the commencement of the hearing (10 C.F.R. § 2.743(b)) and would extend that requirement to apply as well to the identification of exhibits. It faults MFP for not adhering to these standards and concludes that documents that other parties have not had an adequate opportunity to examine, and cross-examination based thereon, may not serve as a basis for our findings. Staff FOF ¶¶ 5-6.

We recognize the difficulties faced by the Staff in attempting to formulate its position in the absence of adequate notice from other parties of their position on issues. The 15-day testimony rule reflects, in part, the Staff’s needs in this regard. Nonetheless, we decline to adopt the Staff’s suggested approach to the record. No such extension of the testimony-filing rule to documents appears in the rules, either expressly or by implication. Indeed, where credibility of witnesses is at stake (as it was in certain instances in this proceeding, at least one of which was the subject of the Staff’s complaint), it would undercut the

9See also Texas Utilities Generating Co. (Comanche Peak Steam Electric Station, Units 1 and 2), LBP-82-87, 16 NRC 1195, 1199 (1982).
utility of the cross-examination were the documents to be revealed in advance to the opposing party. (That is the rationale for revealing cross-examination plans only to the Board prior to cross-examination. 10 C.F.R. § 2.743(b)(2).)

In addition, we recognize, of course, that MFP's actions in this regard were driven not by any intent to ignore procedural requirements or make it difficult for the parties (or Board) to become adequately familiar with MFP's case. MFP was merely forced because of inadequate financial resources to present its case as best it could. A review of the procedural developments in this case will place in context the Staff's complaints.

It appears that, until shortly before the start of the evidentiary hearing, MFP had planned to present one or more witnesses. Our early scheduling orders, and MFP's early discovery responses, all anticipated that MFP would provide witnesses and file direct testimony. See, e.g., Memorandum and Order (Discovery and Hearing Schedules), dated February 9, 1993 (unpublished), at 5; [MFP] Responses to First Set of Interrogatories and Request for Production of Documents Filed by [PG&E] and Motion for Protective Order, dated March 22, 1993; Prehearing Conference Order (Late-Filed Contentions and Discovery), LBP-93-9, 37 NRC 433, 453 n.42 (1993).

Indeed, during the course of discovery, MFP made use of several technical consultants, whom it identified. See, e.g., letter from Jill Zamek, MFP, to Licensing Board, dated April 2, 1993. As late as May 6, 1993, it advised that it was "working with limited resources" and "would expect to be able to identify its expert witnesses" in the near future. [MFP] Reply to [PG&E's] Motion to Impose Duty on MFP to Supplement Responses to Interrogatories and Requests for Production of Documents.

Not until June 21, 1993, when we established the final filing date for testimony as August 2, 1993 (see Memorandum and Order (Notice of Prehearing Conference and Evidentiary Hearing), dated July 8, 1993, 58 Fed. Reg. 58,974 (July 14, 1993)) did MFP advise that it had "no commitment from any person to appear as an expert witness at the hearing." [MFP] Supplemental Response to First and Second Sets of Interrogatories and Requests for Production of Documents Filed by [PG&E]. It then agreed to provide a list of documents on which it would rely and, as a part of that filing, provided a listing that identified many of them.10

During the foregoing phases of the proceeding, MFP had not been represented by counsel. On July 28, 1993, counsel representing MFP filed a "Notice of Appearance" (which was provided to the Board and parties by telefax). In a telephone conference call on July 29, 1993, the Board, as provided by 10 C.F.R. § 2.743(b), directed the parties to provide the Board cross-examination plans.

10 Although the list was provided as a partial response to PG&E discovery, the Staff was on the service list of the response.
MFP's cross-examination plan indicated that MFP was still in the process of reviewing documents and that its plan would be amended to reflect any additional documentation. Simultaneously, on August 16, 1993, MFP distributed (to all parties and the Board) a document — termed a "road map" (Tr. 578) — that in effect supplemented the cross-examination plan and identified 219 exhibits that MFP intended to introduce concerning Contention I, grouped in accordance with specified topics. (During the hearing, MFP determined not to offer certain of these documents, and further offered a few additional documents that it had not earlier been able to identify. Moreover, at least one series of documents bore on the credibility of certain PG&E witnesses and could not have been revealed in advance to other parties without undermining their utility.)

For a party proceeding by cross-examination only, the "road map" would represent a fair substitute for the 15-day filing requirement. Such a document, however, could not have been submitted at the same time as other parties' prepared testimony inasmuch as its formulation depends upon the content of the other parties' direct testimony. Because we heard no objection to our ruling of simultaneous submission of prepared testimony, we in effect made it impossible for MFP to observe the 15-day time frame for filing. In fact, given the change in MFP's representative, the filing on the date prior to the hearing was about as timely as could reasonably be effected. Additionally, we made it clear that we would afford parties (or the Board) additional time within which to examine documents offered into evidence that they had not previously had an adequate time to examine. Tr. 581-82 (Licensing Board). To the extent that additional time for reviewing documents may have been sought, we made every attempt to grant such requests.

Given this history, we are declining to take the course of action sought by the Staff. Although it may have been more difficult for the Staff to prepare its case, we do not believe that the Staff was prejudiced by the late identification of certain documents, particularly in view of our offer to provide sufficient time to review the documents and the circumstance that Staff witnesses were not called upon to testify until late in the hearing, giving them time to review documents presented earlier. See, e.g., Tr. 2183-89 (re: MFP Exh. 5); Tr. 2226 (re: MFP Exhs. 105-108). Moreover, we would prefer to base our rulings on the potential

11 In accordance with 10 C.F.R. § 2.743(b)(2), the cross-examination plans were submitted only to the Licensing Board and not made available to opposing parties. In accord with that same regulation, we are providing the various plans to the Commission's Secretary for inclusion in the record of the proceeding.

12 MFP further described the "road map" at an August 17, 1993 prehearing conference immediately preceding the evidentiary hearing. See Tr. 578-82. The topics in the "road map" were not co-extensive with those identified in MFP's June 21, 1993 discovery response.
safety significance of the case MFP presented, not on procedural technicalities that would eliminate from the record essentially all information contrary to the virtually single view being espoused by PG&E and the Staff.

We turn now to the two contentions before us.

IV. CONTENTION I (Maintenance/Surveillance Program)

Contention I reads as follows:

The San Luis Obispo Mothers for Peace contends that Pacific Gas and Electric Company's proposal to extend the life of the Diablo Canyon Nuclear Power Plant for more than 13 years (Unit 1) and almost 15 years (Unit 2) should be denied because PG&E lacks a sufficiently effective and comprehensive surveillance and maintenance program.

LBP-93-1, 37 NRC at 14-15.

This contention was addressed by a panel of witnesses from PG&E consisting of: Bryant W. Giffin, Manager of Maintenance Services (DCPP); William G. Crockett, Manager of Technical and Support Services (DCPP); David A. Vosburg, Director of the Work Planning Section, Maintenance Services Department (DCPP); Steven R. Ortore, Director of the Electrical Maintenance Section, Maintenance Services Department (DCPP); Tedd Dillard, Supervisor of Component Programs for the Nuclear Division of Florida Power & Light Company; and David B. Miklush, Manager of Operational Services (DCPP).13 The NRC Staff presented testimony of a panel consisting of: Paul P. Narbut, Regional Team Leader, Region V, Division of Reactor Safety and Projects; Mary H. Miller, Senior Resident Inspector (DCPP), Region V; and Sheri R. Peterson, Senior Project Manager (DCPP), Office of Nuclear Reactor Regulation.14 All of the foregoing Applicant and Staff witnesses were qualified for their particular testimony.

As described earlier, MFP presented no witnesses but instead chose to rely on numerous exhibits (and cross-examination based thereon) consisting of PG&E's internal Nonconformance Reports (NCRs), Licensee Event Reports (LERs) filed with the NRC, PG&E correspondence with the NRC, and NRC Staff Inspection Reports (IRs) and Notices of Violation (NOVs). See Tr. 576-79.

13 Testimony of Pacific Gas and Electric Company Addressing Contention I: Maintenance and Surveillance, admitted but not bound in, Tr. 590 (PG&E Test.).
14 NRC Staff Testimony of Paul P. Narbut, Mary H. Miller, and Sheri R. Peterson Regarding Contention 1: The Surveillance and Maintenance Program at Diablo Canyon, ff. Tr. 2159 (Staff Test.). As a result of a recent NRC reorganization, Region V has become a part of Region IV.
A. Scope of Contention

In evaluating the adequacy of the maintenance and surveillance program, we initially consider the appropriate scope of the program to be evaluated. Here the parties differ significantly.

PG&E defines "maintenance" as those activities which are performed to assure that structures, systems and components ("SSCs") will continue to operate as designed, as well as those activities necessary to repair or replace SSCs that are degraded or cannot perform the intended function. Maintenance is considered to be the aggregate of actions at DCPP that (1) minimizes the degradation or failure of SSCs, and (2) promptly restores the intended function of SSCs if they experience operability or functional problems.

PG&E Test. at 4; PG&E FOF ¶M3.

It defines "surveillance" as the aggregate of periodic tests and/or inspections that verify that SSCs continue to function in accordance with predetermined specifications or are in a state of readiness to perform their particular safety functions. Surveillance activities can trigger maintenance activities based upon the results of the particular tests or inspections.

PG&E Test. at 5; PG&E FOF ¶M3.

For its part, the NRC Staff defines "maintenance" and "surveillance" collectively, as the work of keeping something in suitable condition. There are basically two kinds of maintenance, preventive and corrective. Preventive maintenance is regularly scheduled work performed on structures, systems or components that keeps failures from occurring due to predicted component degradation. Industry-wide operating experience is often taken into account in determining what type preventive maintenance is necessary and how often it should be performed. Corrective maintenance is performed after a failure occurs, or a component exhibits degraded capability. The surveillance tests are conducted to identify failures or degraded performance that needs to be corrected prior to a system being called upon to perform a safety function.

NRC Staff Test., ff. Tr. 2159, at 2; Staff FOF ¶I-5.

On the other hand, MFP urges that the somewhat broader definition set forth in INPO 90-008 would be helpful in defining the scope of issues that a maintenance program must address. That definition reads:

the aggregate of those actions that prevent the degradation or failure of, and that promptly restore the intended functions of, structures, systems, and components. As such, maintenance includes not only the activities traditionally associated with identifying and correcting actual or potential degraded conditions (that is repair, surveillance, and other preventive measures), but also extends to supporting functions for the conduct of these activities. Examples of these
functions include engineering support of maintenance; operator identification of material deficiencies; and some aspects of chemistry control, radiological protection, and training.

MFP Exh. 4, INPO 90-008, Section 1 ("Elements of Maintenance"), at 1.

Given the current lack of any prescribed regulatory definition of maintenance or surveillance, we have considered (against the background of both the witnesses' testimony and the various activities and incidents advanced by MFP) the appropriate scope of maintenance and surveillance in achieving the public health and safety goals set forth in the AEA and NRC regulations. We conclude that the INPO 90-008 definition most suitably defines the scope of a program likely to achieve these results — with some limited exceptions necessitated by the somewhat ambiguous INPO 90-008 definition. Our use of INPO 90-008 in this manner appears to be consistent with the acknowledgment by PG&E and the Staff that the INPO 90-008 guidance is useful in outlining the subject areas that a program should encompass. As stated by PG&E, "the nuclear industry and the NRC have generally agreed that [INPO 90-008, Rev. 1, March 1990] identifies the requisite elements for a comprehensive maintenance program." PG&E Test. at 23 (Giffin).

The INPO 90-008 definition, by including supporting functions, appears to encompass many of the activities and programs not falling within the other definitions but actually employed at DCPP for maintenance or surveillance purposes, as described below. The INPO definition thus counters the tendency expressed in certain instances by PG&E and the Staff to "write off" maintenance-type failures or deficiencies as the responsibility of, e.g., engineering or operations and hence not attributable as a deficiency in maintenance or surveillance. In other words, by defining the "maintenance/surveillance" function narrowly, failures can be allocated to some other "box." The resulting maintenance/surveillance record will thus necessarily appear better than it really might be. By including supporting functions, however, we are only including those aspects of the function (such as operations) directly encompassing maintenance and surveillance type activities.

That the Commission earlier declined to adopt the INPO 90-008 standard is of no moment, for the Commission declined to adopt any particular standard. It explicitly pointed to the INPO 90-008 standard because that was one of the few reasonably well-defined standards that the Commission had considered adopting. It referred generally to other standards. The Commission also explained its lack of adoption of INPO 90-008 on the basis not of any disagreement with the standard but rather on its desire to de-emphasize programmatic elements and to require all licensees to monitor the effectiveness of maintenance activities. 56 Fed. Reg. 31,306, 31,308, 31,312 (July 10, 1991). By using the INPO 90-008 definition, we are not endorsing any or all of the programmatic elements but only considering it in terms of program scope, for which it seems reasonable.
guidance. Given the current lack of regulatory definition of a maintenance and surveillance program, the INPO 90-008 definition appears to provide a meaningful standard for ascertaining the appropriate scope (i.e., degree of coverage) of such a program.15

B. Description of Maintenance/Surveillance Program

To understand the significance of the various incidents to which MFP refers, we first describe the scope and extent of maintenance- and surveillance-type activities at DCPP. Based on the summary provided by the Staff in its proposed findings (Staff FOF ¶¶1-11 through I-27), which essentially is not challenged by MFP or PG&E, the maintenance and surveillance program at DCPP encompasses aspects of several activities, including (1) surveillance required by Technical Specifications; (2) equipment surveillance not required by the operating license; (3) Inservice Inspection (ISI) and Inservice Testing (IST) Programs; (4) the Environmental Qualification (EQ) Program; and (5) the Maintenance Program. Surveillance testing required by DCPP Technical Specifications has been developed and implemented by PG&E in accordance with the industry standard ANSI N18.7-1976/ANS 3.2, "Administrative Controls and Quality Assurance for the Operation Phase of Nuclear Power Plants." Such surveillance testing is administratively controlled in accordance with PG&E procedure NPAP-C3, "Conduct of Plant and Equipment Tests." Technical Specification surveillance testing at DCPP is done to ensure that safety-related equipment failures or sub-standard equipment performance will not remain undetected. PG&E Test. at 10-12 (Giffin, Crockett).

In addition, there are additional plant activities intended to provide current information about the condition of SSCs at DCPP, such as routine plant operator equipment inspections or walkdowns, predictive maintenance program testing, preventive maintenance program inspections, procedure functional checks, performance tests of equipment not controlled by Technical Specifications, erosion/corrosion monitoring, post-maintenance testing, and system engineer walkdowns. These are activities clearly falling within the INPO 90-008 definition, although not necessarily within the definitions advanced by other parties. Main-

15 No party brought to our attention in this proceeding NRC Regulatory Guide 1.160, "Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" (June 1993). That Guide is intended to assist utilities in implementing the requirements of NRC's maintenance rule. Use of the guide is currently permitted to determine methods to comply with maintenance requirements. The Guide incorporates by reference the definition of maintenance set forth in NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" (May 1993), at Appendix B. That definition closely parallels the INPO-90-008 standard that we are using as a guideline, particularly insofar as it incorporates supporting functions. NUMARC 93-01 directly states (at 6) that its scope includes "SSCs that directly affect plant operations, regardless of what organization actually performs the maintenance activities." That neither the Applicant nor Staff may approve of such standard (as reflected in their positions in this proceeding) is not a valid reason for their failing to advise us why its inclusion of supporting functions has not been followed by them.
tenance tasks are scheduled and performed on the basis of information derived from these activities in order to maintain equipment performance at the required level for the life of the plant. *Id.* at 12-14 (Crockett, Giffin).

The ISI and IST programs are designed to meet the requirements of 10 C.F.R. § 50.55a(b)(2) and 50.55a(g), as well as plant Technical Specifications, and include inspection, testing, and maintenance of pressure-retaining components as required by the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel (B&PV) codes. Commission regulations (10 C.F.R. § 50.55a(g)) require revision of ISI and IST Programs as necessary to comply (to the extent practical within the limitations of design, geometry, and materials for construction of components) with the edition of the ASME B&PV Code and Addenda in effect and adopted by the NRC 12 months prior to the start of each 10-year inspection interval. These programs are in place to ensure that pressure-retaining components will be adequately inspected, tested, and maintained throughout the term of the operating license. PG&E Test. at 14-16 (Crockett).

Post-maintenance and post-modification testing (PMT) also is encompassed within the scope of PG&E’s maintenance program. The primary objective of PMT is to ensure that all plant equipment that has undergone maintenance or modification has been demonstrated to be fully functional or operable prior to being returned to service. PMT at DCPP consists of two types of testing: (1) Maintenance or Modification Verification Tests performed by the implementing organization without actually operating the equipment; and (2) Operability Verification Tests to prove Technical Specification operability. Documented completion of the required PMT is an essential element of the equipment control process used by the Operations Department when returning equipment to service. *Id.* at 51-53 (Crockett, Vosburg).

The planning and scheduling of maintenance tasks at DCPP is part of a work control process to enable maintenance activities (including both preventive and corrective maintenance tasks) to be planned and performed in a safe, timely, efficient, and controlled manner. Administrative controls for the work control process at DCPP are integrated into the computerized Plant Information Management System (PIMS), thereby making the data available on a plantwide basis and ensuring that maintenance tasks receive appropriate levels of review and are tracked through final resolution. *Id.* at 43-45 (Vosburg).

PIMS provides integrated access to up-to-date information on plant component history, maintenance task instructions and history, problem reports and status, inventory control, and radiation exposure tracking. *Id.* at 20-21 (Crockett). It also provides a means by which all personnel working at DCPP can document plant equipment problems and request interdepartmental support. *Id.* at 44-45 (Vosburg).

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PG&E uses a reporting system to document failures or degradation of SSCs consisting of Nonconformance Reports (NCRs), which are a mechanism for personnel to document certain deficiencies at Diablo Canyon, initiate corrective action, and establish a completion schedule for resolution of a nonconformance. In Diablo Canyon procedure OM7.ID3, PG&E defines a nonconformance as: “A quality problem that constitutes a significant condition adverse to quality.” Staff Test., ff. Tr. 2159, at 3 (Peterson).

To be classified as a nonconformance, the quality problem must satisfy one or more of eight criteria outlined in the procedure. The criteria include NRC violations, programmatic or implementation breakdowns, design deficiencies, defects, frequently recurring events, and NRC-reportable events. If the problem identified is determined to be a nonconformance, the NCR documents the event description, root-cause determination, safety analysis, and action taken to correct the nonconformance and prevent recurrence. Id.

A detailed root-cause analysis program provides for the systematic analysis of unplanned occurrences pertaining to maintenance. This root-cause analysis program is controlled by Procedure NPAP C-26, “Root Cause Analysis,” and provides guidance in several techniques including cause-and-effect analysis, change analysis, event-and-causal-factors analysis, barrier analysis, and human factors surveys. PG&E also tracks component histories as part of root-cause analysis and component failure trending at DCPP. PG&E Test. at 59-60 (Giffin). There are approximately 187,000 components in the DCPP Component Data Base, each with its own maintenance history available in PIMS. Component experience also is available from an industrywide database, the Nuclear Plant Reliability Data System (NPRDS), maintained by INPO. Id. at 60-61 (Crockett).

Licensee Event Reports (LERs) are submitted to the NRC pursuant to 10 C.F.R. §50.73. The threshold for requiring an LER is higher than for an NCR. Typically, the Applicant issues anywhere from 60 to over 100 NCRs each year compared to 20 to 30 LERs each year. Whereas NCRs are used internally at Diablo Canyon, LERs are placed in the Applicant’s public docket and used by the NRC for trending purposes and identifying significant events. Both reports are means for licensees to document self-identified problems. Staff Test., ff. Tr. 2159, at 3 (Peterson).

Management of equipment aging is inherent in many of the maintenance and surveillance activities discussed above. However, PG&E has also initiated other programs expressly directed at aging management issues. Those programs and activities include the preventive, predictive, and corrective maintenance programs; surveillance test programs; fatigue monitoring; the Environmental Qualification (EQ) program; the Reactor Vessel Embrittlement Management Plan; the Motor-Operated Valve (MOV) testing and evaluation program; the Steam Generator Strategic Management Plan; the erosion/corrosion program; and the structural monitoring program. Each of these programs and activities produces
specific results or corrective actions to maintain and/or restore equipment to its required performance level whether the aging occurred prior to or during plant operation. PG&E Test. at 62-64 (Giffin).

Since beginning plant operation, PG&E has also made a number of major plant modifications to improve reliability or upgrade safety-related equipment that also help minimize the effects of age-related degradation on the plant over its 40-year design operating life. Among these modifications are copper removal, including replacement of all feedwater heaters and retubing of all moisture separator reheaters; addition of a Condensate Polisher System; steam generator blowdown rate increase; fuel design improvements; removal of Boron Injection Tanks; reduction of the boron concentration in the Boric Acid System; installation of a digital Feedwater Control System; Chlorination System modifications; and installation of an on-line fatigue monitoring system. Id. at 65-69 (Giffin).

PG&E also has established an aging management program pursuant to Program Directive TSI, “Plant Aging Management,” that addresses age-related degradation over the course of the plant’s operating life. This program collects data from new research findings, industry operating experience, the NRC, the Electric Power Research Institute (EPRI), and vendors, for inclusion in appropriate programs. Id. at 70 (Giffin).

PG&E’s aging management activities also include several special maintenance programs which have been established to monitor and manage certain critical components subject to complex aging mechanisms, as well as certain designated components with a limited life. For example, steam generator tube degradation is monitored and managed by careful chemistry control during operation and by an extensive cleaning and inspection program during each refueling outage. Id. at 72 (Giffin).

The reactor pressure vessels at DCPP are also addressed by special maintenance programs. The DCPP Reactor Vessel Radiation Surveillance Program is designed to monitor changes in material and mechanical properties of DCPP reactor pressure vessels (RPVs) in order to ensure their continued safe operation throughout the operating life of the plant. Compliance with all NRC regulations governing RPV integrity was documented in PG&E’s response to Generic Letter 92-01. PG&E Test. at 75-76 (Giffin, Crockett).

Erosion/Corrosion (E/C), which refers to the process of wall thinning in susceptible piping or other pressure boundary components caused by the flow of water or wet steam, is a normal part of the nuclear power plant aging process. The management of E/C is an integral part of maintenance at DCPP. Measures to control E/C include the replacement of certain piping with E/C-resistant material such as stainless or chrome-moly steel. Id. at 77-78 (Crockett).

PG&E’s testimony also indicates that it has a program for managing the aging of passive, long-lived structural concrete and steel at DCPP. Conditions such as spalling or cracking of concrete, corrosive or caustic attacks from leaks, spills,
or exposure to the environment, mechanical damage, and rust are routinely identified and reported by plant personnel. *Id.* at 81-82 (Giffin). PG&E's maintenance work at the intake structure is an example of this process. Tr. 1737-38 (Giffin). This type of maintenance is meant to ensure that these structures will perform their intended functions for the life of the plant. Tr. 1741-42 (Giffin). For safety-related structures, functional surveillance requirements are specified in Technical Specifications. Periodic surveillance testing verifies the operability of these structures. PG&E Test. at 82 (Giffin).

C. Evaluation of Evidence

Turning to the merits of the contention, we find that all of the expert witnesses — both PG&E and the Staff — testified as to the adequacy and indeed the excellence of PG&E's maintenance/surveillance program. As summed up by the Staff:

The performance of maintenance and surveillance at Diablo is considered to be superior and clearly supportive of safe facility operation. Their performance has been, at worst, good and has improved over the years. Gradual trends over the past seven years show a reduction in the number of equipment failures, reduction of significant safety problems, increased management involvement in maintenance issues, and more timely identification and resolution of problems. Some examples of poor performance in each of these areas continue to be identified. However, these examples have been of decreasing frequency and safety significance.

Staff Test., ff. Tr. 2159, at 5-6 (Narbut, Miller).

MFP challenges the adequacy of the maintenance and surveillance program by claiming that the program fails to satisfy a number of broad standards necessary for a satisfactory program. It cites numerous particular incidents to demonstrate how the program fails to satisfy these standards (some incidents are relevant to more than one of the broad standards).

The broad standards set forth by MFP, in outline form, are as follows: 16

I. Failure or unreliability of important safety systems.

A. Reduction in safety margins. Most of PG&E's maintenance problems in the past several years have disabled or threatened essential safety systems.

B. Inadequate and incorrect analyses of safety significance. PG&E wrongly discounts the safety significance of many of its maintenance deficiencies. This not only results in an incorrect evaluation for purposes of evaluating the significance of the incident

16 MFP FOF ¶ 20-61 at 11-29. Later in the text of this Decision, we shall refer to various outline topics by the paragraph numbers set forth herein.
that occurred, but it also raises general questions about the adequacy of PG&E’s judgment with respect to safety matters.

II. Untimely or Ineffective Response to Maintenance Problems.
   A. Untimely Response. PG&E has shown a pattern of responding to maintenance problems in a lax and untimely manner.
   B. Previous Corrective Action Failed to Prevent Recurrence. In many cases, PG&E had the same or similar problem recur after PG&E had attempted to resolve it. This shows an ineffectual maintenance program that is unable to take timely and effective corrective action with respect to maintenance problems.
   C. Untimely Detection and Correction of Aging Effects.

III. Breakdown of Multiple Barriers.

IV. Repetitive Patterns of Failure.
   A. Lack of Communication and/or Coordination. PG&E’s maintenance and surveillance program is deficient in its communication and coordination between different groups of individuals and/or departments. Examples are provided for insufficient communication, insufficient coordination between multiple groups, and insufficient management involvement.
   B. Previous Maintenance Errors Caused Undetectable Problems. PG&E has demonstrated a pattern of creating undetectable failures through improper maintenance.
   C. Inadequate/Improper Surveillance. Routine surveillances, tests, and inspections at DCNPP are inadequate to ensure the continued safe operation of the plant.
   D. Personnel Errors. PG&E has demonstrated a repetitive pattern of personnel errors which jeopardize the safety of the plant. Examples are cited dealing with personnel errors due to inattention to detail, personnel errors due to failure to follow procedures, and personnel failure to self-verify.
   E. Inadequate Procedures. Procedures or work instructions for personnel are not adequate to ensure that work activities are performed adequately.
   F. Manufacturing/Vendor Deficiencies and Internal Defects. PG&E does not have an effective program for detecting manufacturing deficiencies or internal defects.
   G. Financial Considerations. PG&E’s decisions regarding what is needed to maintain the plant in a safe condition have been unduly influenced by economic considerations.

We will individually discuss each of the particular incidents set forth by MFP in its proposed findings and relate them to the broader standards outlined by MFP. We will discuss them in the order presented by MFP in its specific
proposed findings, and will relate them to all the broad standards to which MFP claims they are relevant.

1. Maintenance of Environmental Qualification of Electrical Equipment

MFP asserts that PG&E's maintenance program for the environmental qualification of electrical equipment is fatally flawed because of imperfections in the so-called “telatemp” sticker program.¹⁷ MFP categorizes this claim as an example of a maintenance problem that has disabled or threatened essential safety systems (outline ¶1.A).

In support of this claim, MFP questioned PG&E witnesses on the basis of MFP Exhibits T-1 through T-4. T-1 is a copy of NRC Information Notice 89-30, High Temperature Environments at Nuclear Power Plants, dated March 15, 1989.¹⁸ T-2 is a copy of PG&E implementing procedures, dated April 22, 1992. T-3 is a consultant’s report to PG&E, dated February 27, 1990, concerning “Effect of Localized High Temperatures Upon EQ Components.” T-4 consists of numerous sheets recording data from telatemp stickers.¹⁹

MFP asserts that maintenance of the EQ of electrical equipment that is important to safety is fundamentally important to the safe operation of DCPP, that the qualified life of such equipment is partially determined by assumptions about the normal operating temperatures to which the equipment will be exposed, and that if the normal operating temperature exceeds the assumed normal operating temperature, the qualified life “must” be shortened. MFP FOF ¶65. MFP contends that, as a result of PG&E’s poor management of the telatemp sticker system, the temperatures in many locales are unknown and, for conservatism, the qualified life on many components must be shortened.

The Applicant describes its EQ maintenance/surveillance system as a portion of its program designed to comply with the requirements of 10 C.F.R. § 50.49, which sets forth substantive requirements for an EQ system and defines equipment to be included (but sets no special standards for a maintenance and surveillance program applicable to such equipment). The EQ program is designed to ensure that electrical equipment that would be relied on in the event of an accident will be capable of performing its design safety functions to achieve safe reactor shutdown, despite exposure to the harsh environment that

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¹⁷ In the transcript and in MFP’s FOF, the term is spelled “teletemp.” In MFP Exh. T-2 (a PG&E document) and the Applicant’s and Staff’s FOF, the term is spelled “telatemp.” We will use the latter spelling in this Decision.
¹⁸ This document was identified and extensively discussed at the hearing by a PG&E witness but was never formally admitted into evidence. We believe that this omission was due to inadvertence, as claimed by MFP: MFP’s questions were directed at a PG&E witness but, because Exh. T-1 is a Staff document, MFP deferred formally introducing it until Staff witnesses were testifying. MFP neglected to introduce it when Staff witnesses appeared several days later. In any event, the PG&E witness’s responses to questions provide an adequate basis for referencing the document herein. See, e.g., Tr. 1844-45, 1861-62 (Otorc).
¹⁹ MFP Exhs. T-2 through T-4 were admitted into evidence at Tr. 2051.
could result from an accident. Among other matters, the EQ program includes
the determination of a "qualified life" based on expected service conditions and
identifying and implementing appropriate surveillance, maintenance, and pro-
curement requirements to ensure that EQ is maintained. PG&E Test. at 16-18,
79-81 (Ortore).

At DCPP, the qualified life of a safety component is based on the bulk
ambient temperature of the area in which the component is located. However,
localized temperatures may be higher than ambient temperatures as defined in the
"binders" that document the basis for the qualified life of each safety component.
Tr. 1856-57 (Ortore).

In 1986-87, the Maintenance Department initiated the telatemp program,
a proceduraiized temperature monitoring program for EQ equipment. This
predated NRC generic correspondence (Information Notice 89-30, proposed
MFP Exh. T-1) that raised an issue regarding the potential impact of operating
temperatures on equipment performance and qualification. Tr. 2043 (Ortore).

As a result of this program, PG&E identified particular "hot spots" at
DCPP. It then contracted with Sargent and Lundy for a report to address
"hot spots" and the effects of localized temperatures on the qualified life of
EQ equipment. Through these activities, various "hot spots" were identified,
allowing calculation of a qualified life for EQ components based on observed
environmental conditions. Tr. 1853, 2043 (Ortore); MFP Exh. T-3.

The telatemp monitoring procedure is used principally by the Electrical
Maintenance Section at DCPP to monitor electrical equipment and hot spots.
PG&E has issued a procedure for implementing that program, MP E-57.8A,
MFP Exh. T-2. Tr. 1845, 2045 (Ortore); PG&E Test. at 81 (Ortore). The
procedure was last revised in 1992 (Tr. 1891 (Giffin)).

The list of components subject to the monitoring procedure does not include
all instrument and control (I&C) EQ equipment at DCPP. PG&E testified,
however, that most I&C equipment is, by design, located in areas that are low
in containment or outside the bioshield. Furthermore, most I&C components
are low-voltage, low-current equipment that does not generate significant heat.
As a result, most I&C equipment is subject to temperatures well below 120°
and need not be included in the temperature monitoring program. Tr. 1875,
2045-46 (Ortore). Further, DCPP is a very large and uncongested plant and
this factor, along with other design features (e.g., ventilation, routing of power
cables), reduces the likelihood of hot spots. PG&E Test. at 80 (Ortore).

The Maintenance Department utilizes telatemp stickers to monitor local
ambient temperature at EQ components. Id. at 80-81 (Ortore). These stickers are
tabs with mylar faces that include squares with temperature-sensitive chemicals
which turn color when they are exposed to certain temperatures. The squares
record momentary peak temperatures at the point of installation. During
refueling outages, maintenance personnel read and record the data provided by
the telatemp stickers, remove the stickers, affix them to data sheets, and apply new stickers at each location. The temperature is recorded on a form. Tr. 1846-47, 1855, 2041, 2043 (Ortore); MFP Exh. T-2.

MFP asserts that the telatemp stickers generally give readings in 10° intervals, and that when a window changes color, that means the component experienced a temperature that was between the degree of the window and 9° higher. MFP cites PG&E's testimony of the importance of applying conservatism in using the telatemp readings and would have us assume that the safety component being evaluated experienced the highest possible temperature that is indicated by the changed telatemp sticker window. Thus, if the 150° window changed color, MFP would assume that the component experienced a temperature as high as 159°. Tr. 1861 (Ortore). PG&E's witness was not certain exactly how these data would be used but agreed that conservative assumptions would require such an interpretation (Tr. 1855, 1861 (Ortore)).

The Staff initially would have us ignore the documents on which MFP relies, because of lack of adequate advance notice of MFP's intent to use them. Beyond that, the Staff perceives no merit to MFP's claims premised thereon. For the reasons outlined earlier, we are declining to ignore these documents. In particular, we regard as sound MFP's claims that the documents have potential safety significance that could have a material bearing on the adequacy of the maintenance and surveillance program.

The temperature monitoring program provides PG&E with a system to identify any localized areas in which EQ equipment might be exposed to temperatures in excess of the operating temperature previously assumed in the qualified life calculations for that component. If monitored operating temperature exceeds that previously assumed, it may be necessary to reduce the component's qualified life. The qualified life of an installed component is then based on the highest temperature data, unless there is reason to believe that a high temperature was only transitory. Moreover, in performing the qualified life calculation, PG&E generally assumes that the highest temperature registered on the telatemp sticker has been and will be the constant temperature over the service life of the component. Tr. 1842-43, 2042-43 (Ortore).

The data gathered by the Maintenance Department are provided to the Engineering Department, which, in turn, analyzes such data and determines whether it is necessary to change the qualified life of EQ equipment. Information resulting from engineering analyses is sent back to the Maintenance Department, which has the responsibility to change out such equipment prior to the end of its qualified life as part of the preventive maintenance program. Thus, calculation of the qualified life of EQ equipment is not a Maintenance Department function, although ordering the repair or replacement of EQ equipment based on recalculated qualified life is such a function. Tr. 1850-51, 2041-42 (Ortore).
PG&E describes the telatemp monitoring program as confirmatory in nature. In other words, it is not the principal means employed by PG&E to ascertain localized peak temperatures. PG&E indicated that, since the original hot spots were identified, it has seen very few changes in normal operating conditions. Tr. 2043 (Ortore).

MFP attempts to disprove this testimony by the telatemp data in MFP Exh. T-4. For example, it claims that readings for selected valves and conduits had temperature variations over a period of years as much as 69° (MFP FOF, Tables A and B). MFP also introduced numerous data sheets into the record, to demonstrate that telatemp stickers are sometimes destroyed upon removal, hard to read, otherwise unavailable, or where there either were no telatemp measurements or measurements were incomplete (Tr. 1882-84 (Ortore); MFP Exh. T-4).

It demonstrated that there were no telatemp readings for certain components or general plant areas, that readings of “N/A” or “NA” appeared on many data sheets possibly indicating, according to the PG&E witness, that only one sticker was found (when two were required), that a sticker was illegible, that there was no sticker below, that a sticker could not be moved without damaging it, and that many stickers could not be found (Tr. 1887 (Ortore); MFP FOF, Tables A and B).

MFP went on to assert that, although MP E57.8A generally requires stickers for both the top and bottom of components, many of those dual stickers were not present. It emphasized the importance of the dual-sticker requirement by demonstrating the considerable temperature variation that could occur between the top and bottom of components. MFP claims that the problem dates from 1988, when the first telatemp measurements were recorded, to the most recent refueling outages for each unit. In addition, MFP claims that an adequate range of temperatures on stickers is not present, setting forth certain components where four rather than two stickers should be used and others where the highest temperatures recorded were not the peak temperatures, only the highest that the stickers could record.

Finally, MFP claims that the procedures for telatemp measurements are confusing and hence inadequate. It cites the incomplete lists of equipment to which the program applies (or is intended to apply), the limitation of the procedure to instructions for installation and removal of stickers, without sufficient guidance on how to record the data from the stickers onto the data sheets. Indeed, one of the data sheets contains an explicit complaint that “procedure should explain how to read stickers.”

In short, some of MFP’s claims are well founded. The Board finds that PG&E’s procedures for telatemp sticker installation are confusing, and that as a result it is difficult to determine exactly where stickers should be installed and monitored. The requisite terminology on data sheets is also confusing — e.g.,
N/A or NA may refer to the fact that a new piece of equipment was installed, or to the fact that a telatemp sticker was not found or could not be read. N/A or NA on data sheets could also apparently mean either “not available” or “not applicable.” Tr. 1886-87 (Ortore). The list of equipment in the applicable procedure to which stickers are to be affixed is also not representative of all the equipment to which stickers are attached (Tr. 1882 (Ortore)). A failure to list a temperature could mean either an erroneous listing or a failure of the temperature to be high enough to warrant a listing (Tr. 1885-86 (Giffin)). Occasionally the PG&E witness was not certain what a particular recorded number meant (Tr. 1889 (Ortore)).

We are also concerned about the level of accuracy of the telatemp measurements, given the many instances in which PG&E recorded only one measurement rather than the required two or, indeed, the four that should perhaps be available. This pattern leads us to believe that, to the extent PG&E relies on the telatemp program, systemic improvements should be made to reduce or eliminate such inconsistencies.

In sum, it is fundamentally important that PG&E have an adequate program for maintaining environmentally qualified safety equipment. This includes monitoring equipment where temperatures are known to be high, to ensure that the normal operating temperature is not higher than the conditions to which the equipment was originally qualified. If it is, the qualified life may have to be reduced and the equipment replaced. The Board recognizes that the telatemp program is confirmatory only. But to the extent it is used in monitoring these localized high temperatures, it is deficient in that it is not being carried out in a consistent and accurate manner and PG&E does not have adequate procedures to ensure that it can be carried out properly. To the extent of that deficiency, MFP’s assertion that PG&E’s telatemp sticker program reflects a reduction in contemplated safety margins and a potential threat to essential safety systems is well founded.

The documents relied on by MFP do not, however, constitute a sufficient basis upon which to conclude that there is an overall programmatic deficiency in the maintenance of EQ equipment at DCPP. As noted, the temperature monitoring program is confirmatory in nature; i.e., it continually confirms the validity of the input data used in qualified life calculations. The significance of any imperfections in the data collection process will, to that extent, be alleviated. Moreover, the exhibits are replete with examples where more than one telatemp sticker is used on an EQ component. See MFP Exh. T-4. Where more than one is required by procedures, however, those examples do not serve to ameliorate the deficiencies outlined.

In conclusion, although the telatemp procedure is not per se required for PG&E to conform to the EQ requirements of 10 C.F.R. §50.49, we believe that where, as here, PG&E elects to utilize such a program as part of its
maintenance/surveillance program, it must have adequate procedures (1) that define all the equipment on which the stickers are to be utilized, (2) that set forth the number and location of the stickers to be used for each piece of designated equipment, (3) that specify the time, method, and precise nomenclature for recording the temperature data, and (4) that ensure that the information utilized is not erroneous or misleading. To the extent PG&E places any reliance on such a program (even if only confirmatory, as claimed), it should revise its procedures to incorporate these changes. We are imposing orders for correction to this effect.20

2. Check Valves/IST Deficiency

MFP introduced several NCRs and LERs to demonstrate that PG&E's in-service testing (IST) of check valves is deficient (MFP Exhs. 6-11, 13). It claims that, as a result, safety systems have been disabled or threatened (outline ¶I.A), that routine surveillances, tests, and inspections at DCNPP are inadequate to ensure the continued safe operation of the plant (outline ¶IV.C) and that procedures or work instructions for personnel are not adequate to ensure that work activities are performed adequately (outline ¶IV.E).

For many years, the ASME code did not require testing of leaktightness of check valves if their position was normally closed (Tr. 602 (Crockett)). However, on August 29, 1988, the NRC issued IN 88-70, "Check Valve Inservice Testing Program Deficiencies," to notify licensees of potential problems with check valve IST. NRC Generic Letter 89-04, "Guidance on Developing Acceptable Inservice Testing Programs," dated April 3, 1989, identified similar generic concerns and required that implementing test procedures be reviewed and revised as necessary within 6 months. The NRC was concerned that check valves included in the IST program were not always tested in both the open and closed positions and that no reverse-flow operability tests were being performed on check valves other than those used for containment isolation and reactor coolant system pressure boundary isolation. MFP Exh. 11 at 2. PG&E initiated the review required by the Generic Letter (MFP Exh. 13 at 2).

MFP claims — accurately — that, as a result of PG&E's review, a multitude of deficiencies in the check valve IST program have been (and continue to be) identified. MFP FOF ¶98. The finding of these deficiencies does not, however, denominate a current breakdown or failing in PG&E's maintenance program. Rather, the NCRs and LERs cited by MFP demonstrate PG&E's attempts to bring its own maintenance and surveillance procedures in line with recently evolving Staff policy. As characterized by PG&E, the issue is generic. Tr. 603

20 We are here imposing no conditions or guidelines as to whether or how the Engineering Department uses the telatemp data.
Moreover, valves added to the list for testing had never been found to be leaking. Tr. 608 (Crockett). Thus, PG&E’s performance in this regard appears to be adequate and cannot serve as a basis for either license denial or conditions.

3. Cable Failures

MFP introduced evidence to the effect that there were five medium-voltage cable failures at DCPP between October 1989 and March 1993 — three of which were on 4 kV cable and two on 12 kV cable — and it claims that PG&E’s maintenance and surveillance program was not adequate to detect the degradation of this cable (outline ¶ IV.C). MFP FOF ¶¶ 50, 108, 112. One of these failures was detected only by smoke occurring as a result of the failure. MFP Exh. 15 at 5. According to MFP, an essential safety system is thus threatened (outline ¶ I.A).

MFP further asserts that PG&E has not identified the cause of the three 4 kV failures and cannot justifiably claim that they are random occurrences. MFP FOF ¶ 115. MFP also faults PG&E for delay in replacing certain of these cables and for replacing them with the same construction material, as to which it asserts there is some question of acceptability for the conditions under which it is operating. Id. ¶¶ 119, 126. These failures thus also represent an untimely response to a maintenance problem (outline ¶ II.A) and untimely detection and correction of aging effects (outline ¶ II.C).

The five failures occurred in two separate sets of underground duct bank conduits, between the turbine building and the intake structure. MFP Exh. 15 at 3. The Applicant asserts first that there is no connection between the failures of the 4 kV and 12 kV cables. See MFP Exh. 21 at 1-2. (Two of the three 4 kV cables are safety-related, whereas one 4 kV cable and both of the 12 kV cables are not. MFP Exh. 15 at 3; PG&E Test. at 108 (Ortore); Tr. 624 (Ortore).) It testified that two of the 4 kV failures were random in nature and time of occurrence (October 29, 1989, and May 3, 1992), whereas one occurred during a routine high-potential test during a refueling outage (October 31, 1992). PG&E Test. at 108 (Ortore).

PG&E conceded that, at the time of the hearing, it had not yet completed its root-cause analysis of the 4 kV cable failures. But, it had ruled out certain possible causes, including the chemical attack and degradation that had been determined to have caused the 12 kV cable failures. Tr. 625 (Ortore); MFP Exh. 15 at 9. It also determined that the failed cables were of acceptable quality and design for their specific applications and service conditions. Both the failed and certain unfailed sections of these cables have been replaced. PG&E Test. at 110. In addition, because of defense-in-depth redundancy, the ultimate safety significance of a 4 kV cable failure is likely not to be great.
The 12 kV failures occurred, respectively, in February and March 1993. PG&E testified that both were the result of external cable degradation, caused initially by exposure to an unidentified contaminant, probably a cleaning agent, present in the underground conduits for the 12 kV cable. The contaminant was carried within the conduit by water, which degraded the outer jacket of the cable, exposing the copper shielding. The shielding was then attacked by chlorides in saltwater present in the conduit, creating uneven electrical stresses on the cable and thus causing a fault. PG&E Test. at 109 (Ortore); Tr. 649, 671 (Ortore).

The failed 12 kV cables and certain other sections have likewise been replaced. In addition, PG&E found a contributory cause of these failures to be inoperable sump pumps in the cable vaults. Prior to the 1993 failures, these pumps were not included in the formal maintenance program. The pumps have now been repaired and are included in the preventive maintenance program. PG&E Test. at 110; MFP Exh. 15 at 11.

With respect to the 4 kV failures, the Staff concluded that PG&E's responsive actions were adequate and reasonably thorough. The Staff further concluded that plant safety had not been significantly reduced by these failures, because of the presence of other, unaffected cables for redundant safety-related pumps. Staff Test., ff. Tr. 2159, at 10 (Narbut). With respect to the 12 kV failures, an NRC inspection verified the repair of inoperable pumps, the initiation of preventive maintenance for such pumps, and the replacement of all failed cable. The Staff would have us find that, with the sump pump added to the maintenance program and the cable replaced, it is unlikely that such a cable failure will recur. Staff FOF ¶1-84.

We find that PG&E's responses to these failures were reasonable and effective. Even though not on safety-related cable, however, the fire resulting from one 12 kV failure appears significant, if for no other reason than that fires are per se hazardous. PG&E's corrective actions, approved by the Staff, appear adequate.

4. Wrong Size Motor Installed

Premised on a PG&E draft NCR dated July 28, 1993, MFP Exh. 24, NCR DC2-93-EM-N031, together with related testimony, MFP asserts that, during a refueling outage, a 10 ft-lb motor was installed on a motor-operated valve (MOV) rather than the required 15 ft-lb motor, that this mistake was caused by multiple personnel errors, and that barriers designed to prevent such errors were ineffective, evidencing a programmatic deficiency. MFP stresses that, although installation of the wrong motor may be attributable to an isolated personnel error, the failure of "not less than three other individuals" responsible for checking the correctness of the installation cannot properly be so designated and, rather, is an indication of a programmatic deficiency in the maintenance/surveillance
program. MFP further describes what it perceives to be the safety significance of the erroneous installation. MFP FOF ¶¶ 144-51. It categorizes the erroneous installation as threatening an essential safety system (outline ¶ I.A), as a series of personnel errors resulting in a breakdown of multiple barriers (outline ¶ III), and as an example of a repetitive pattern of personnel errors which jeopardize the safety of the plant (outline ¶ IV.D).

PG&E acknowledges the erroneous installation, claiming that an individual preparing a work order to replace the motor on an actuator for a MOV made an error in reading the motor size from a table and hence specified on the work order an erroneous motor, which was later installed. Tr. 689-90 (Giffin). It characterizes the incident as an isolated personnel error. PG&E FOF ¶ M-A21. The Applicant as well as the NRC Staff, however, deny the incident’s actual or potential safety significance. Based on the NCR, they assert that, even with the undersized motor, the MOV was able to shut under design-basis conditions and thus would have performed its intended safety function. 21

As for corrective action, PG&E replaced the incorrect motor and checked other similar motors to verify their correctness. It also counseled the work planner and the QC inspector involved with this event, communicated the importance of self-verification to incoming persons through the electrical maintenance bulletin, and held meetings with electrical maintenance engineers to discuss the importance of the engineer’s responsibilities and expectations when they sponsor design control notices. MFP Exh. 24 at 1, 6-8; Tr. 690-91 (Giffin, Vosburg).

It is clear to us that PG&E took appropriate action to replace the hardware involved, and to ensure that incorrect motors had not been installed elsewhere. More important, the Applicant also took significant steps to alleviate the maintenance deficiencies. That three individuals were responsible for four personnel errors is not, however, reassuring. 22

For these reasons, license conditions would not be appropriate. Nonetheless, because similar incidents might well have safety significance given the wide variety of parts in a nuclear facility that conceivably could be incorrectly utilized, PG&E may wish to explore whether some systemic improvements could be made in this area. Improvement might be particularly appropriate with respect to the process of self-verification by installers. For example, perhaps the self-verification process could require a second look by the installer at the design change document, as well as at the installed part.

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21 MFP Exh. 24 at 11; Staff FOF ¶1-86. The NCR adds, however, that “[i]t is not likely that the valve would trip the torque switch at reduced voltage and with the Thermal Overload Device (TOLD) sized for a 15 ft-lb motor, once it goes closed it would probably burn out the motor. This would happen only after the valve had performed its safety function.”

22 MFP’s identification of four separate individuals (MFP FOF ¶147) appears erroneous — the worker who failed the self-identification appears to be the same as the installer, resulting in errors by three individuals.
5. Storage and Handling of Lubricants

Relying on two NCRs, MFP asserts that failure to control lubricants is a recurrent problem at DCPP and demonstrates a deficient maintenance and surveillance program. MFP FOF ¶162. MFP categorizes the alleged deficiency as an example of a previous corrective action that failed to prevent recurrence (outline ¶II.B) and as a repetitive pattern of personnel errors due to inattention to detail (outline ¶IV.D).

Specifically, MFP cites “unlabelled and mislabelled grease guns and oil pumps; cross contamination of greases and oils; the use of wrong oils; and failure to maintain log books.” MFP FOF ¶152, citing MFP Exhs. 27 and 28. MFP notes that the issue was first identified in 1987, that additional problems occurred in 1991, and that, despite corrective actions, similar problems occurred in 1993.

MFP asserts that PG&E received an NOV in 1987 for failure to comply with the procedure governing control of lubricants. In 1990, the wrong oil was added to the “heater 2 drain tank pump 2-1.” In 1991, the wrong oil was added to a motor bearing. Also, PG&E wrote an NCR considering other discrepancies in lubrication storage and handling. MFP further claims that, in 1993, an incompatible oil was used to lubricate the auxiliary saltwater pumps and that the oil log book did not indicate where or when this oil was obtained. MFP Exh. 27. MFP attributes all these deficiencies to the maintenance and surveillance program.

The Applicant characterizes the problem (citing the same MFP exhibits) as involving several minor lubrication control issues widely separated in time and dissimilar in nature. It claims that corrective actions have been adequate and existing procedures sufficient. PG&E FOF ¶R-A32. The Staff takes a similar position. Staff FOF ¶¶I-91 through I-93. PG&E further disputes MFP’s claims of safety significance, terming them as based on extra-record speculation, inasmuch as only small amounts of oil or lubricants were involved, with no impact on equipment operability. The Applicant further points out that existing preventive maintenance tasks ensure that oil is periodically changed and sampled and that equipment is monitored for excessive wear. PG&E FOF ¶R-A33. The Staff concurs. Staff FOF ¶I-94.

The Board here supports the position taken by PG&E and the Staff, to the effect that the incidents are essentially isolated and reflect no systemic deficiency in the maintenance and surveillance program. They represent neither a recurrence of a previously corrected problem nor a repetitive personnel error. Given that finding, as well as the circumstance that the amounts of oil or lubricants involved were small and could cause no operational impacts, we agree that the incidents lack current or potential safety significance.
6. Fuel Handling Building

In order to ensure that all potential releases from the spent fuel pool are exhausted through fuel handling building (FHB) exhaust filters, the fuel pool area must be maintained at a negative pressure. MFP Exh. 39 (LER-89-019-00) at 4; MFP FOF ¶167. MFP has cited several instances in which the negative pressure was not maintained adequately, and it attributes these instances to inadequate maintenance or surveillance. MFP FOF ¶¶ 170, 173, 177, 181, 184. MFP categorizes these examples as ones where safety systems were disabled or threatened (outline ¶I.A), as an untimely detection and correction of aging effects (outline ¶II.C) and as an inadequate or improper surveillance (outline ¶IV.C).

Two instances in particular, both in 1991, were identified. The first was discovered on January 18, 1991, when the FHB ventilation system was declared inoperable after failing to meet the negative 1/8-inch water gauge pressure requirements specified in surveillance test procedure (STP) M-41. The STP M-41 had last successfully been performed on September 18, 1989, and the January 18, 1991 surveillance was the routine 18-month followup surveillance. MFP Exh. 39 (LER-89-019-00) at 2. The second occurred on August 7, 1991, when the Unit 2 FHB failed to pass STP M-41. MFP Exh. 38.

The root cause of the first of these events was determined to be “the degradation of the FHB.” Contributory causes were “dirty exhaust fan ducts, failure to maintain a flow difference between the exhaust and supply flows of 19.8 percent, and blocking of a FHB exhaust duct.” The root cause of the second event was “an improper understanding of the required calibration frequency of the supply fan inlet vane controller.” MFP Exh. 38 at 1, 11-12.

PG&E took corrective action for each of these deficiencies. Id. at 1. No issue appears to be raised concerning the adequacy of any particular corrective action. MFP, however, attributes the deficiencies to lack of an effective preventive-maintenance program for the FHB. MFP FOF ¶170.

PG&E points out that in each instance the pressure was negative, although not as negative as required, thus reducing (in its opinion) the safety significance of the incidents. PG&E FOF ¶M-A41, citing MFP Exh. 38 at 2-3, 13-14. The Staff agrees. Staff FOF ¶1-95. However, PG&E acknowledged that its preventive-maintenance program covered FHB doors and ventilation system components but not the building as a whole.

With respect to the first instance, PG&E promptly investigated the situation, determined the root cause, and implemented corrective actions. PG&E Test. at 104-05 (Crockett). It determined that the cause of the deficient negative

23 MFP Exh. 38. Documents relating to other FHB incidents were not admitted, because they bore no relationship to maintenance or surveillance. See Tr. 827-28.
pressure was the existence of small leakage paths into the building, resulting from degradation of building siding and seals. This was an example of structural degradation that was identified by PG&E and corrected. Tr. 807-08 (Giffin).

Corrective actions included sealing the leaks and re-siding both FHBs. Most significantly, surveillance is now performed within 7 days of any fuel movement, rather than at the previously prescribed 18-month intervals. Tr. 812 (Crockett).

The second instance of reduced negative pressure resulted from drifting of the setpoint for the controller, increasing the supply flow into the FHB. MFP Exh. 38 at 3. The drift was identified through surveillance and later corrected.

Although the Applicant and Staff deny that these instances reflect any deficiencies in the surveillance program — indeed, they credit the program for detecting the instances of negative pressure — we find it significant that an important corrective action was to increase the frequency of surveillances. To that extent, the previous surveillance program did result in the untimely detection and correction of aging effects (as claimed by MFP) and hence warranted improvement. The prompt modification, however, demonstrates the strength of PG&E’s overall program. We find no evidence that would permit us to question (as MFP does, at MFP FOF ¶181) the adequacy of the current surveillance program for the FHB.

7. Tests of Containment Personnel Airlock

MFP has identified what it describes as several missed surveillances of the airlock door seals and portrays them as failures of the surveillance system. It categorizes them as disabling or threatening safety systems (outline ¶1.A) and as examples of a repeat pattern of inadequate performance of routine surveillances, tests and monitoring activities (outline ¶IV.C). MFP also faults PG&E for minimizing the significance of the missed surveillances. MFP FOF ¶52.

The first two occurred on September 20 and 21, 1990; another occurred on April 25, 1993. In each case, a personnel airlock gauge was removed (for maintenance) and later reinstalled, but required post-maintenance leak rate testing within the period specified by the Technical Specifications was not performed. MFP Exh. 42 (NCR DC2-93-WP-N025); MFP Exh. 43 (LER 2-90-011-00); Tr. 830-32 (Vosburg).

MFP also cites a final missed surveillance that occurred on June 11, 1991 (but was not discovered and reported until September 27, 1991). The LER states that "[a] review determined that an acceptable leak rate test was not performed following 17 containment entries during the period from June 11, 1991, to September 27, 1991." MFP Exh. 44 (LER 1-91-016-00) at page numbered 1 (2 of exhibit). The immediate cause of the missed surveillance was a faulty solenoid valve, with root cause attributed to personnel error caused by inadequate knowledge of the leak-rate monitor operation.
The Applicant and Staff each treat the 1990 and 1993 incidents as separate and apart from the 1991 incident (which, as indicated above, was attributed to personnel error). Analytically, however, there appear to be more interrelationships among all of the four separate incidents.

Thus, PG&E initially believed that the 1990 and 1993 incidents were also the result of personnel error. It changed its opinion when it discovered what it deemed to be faulty instructions to the workers who were servicing the gauge. Tr. 830 (Vosburg). And the 1991 incident, although attributed to personnel error, resulted in fact from deficient documentation — i.e., an inadequately documented clearance to take the leak-rate monitor out of service for calibration. MFP Exh. 44 at 3 of LER (fourth page of exhibit).

Collectively, therefore, it appears to us that all of the incidents in question may be properly perceived as resulting, not from individual personnel errors but, rather, from less than complete instructional material for those performing the maintenance-related servicing or calibration. Improvement in the procedures and associated instructions seems to be the proper corrective action and, indeed, has already been implemented. MFP Exh. 42 at 9-10; MFP Exh. 43 at 1, 6 of LER (pp. 2, 7 of exhibit); MFP Exh. 44 at 1, 7-8 of LER (pp. 2, 8-9 of exhibit).

Although these incidents all seem to have a bearing on the adequacy of the maintenance and surveillance program, and although they have safety significance, they do not appear analytically to cast any strong adverse inferences about the program. In particular, corrective action apparently has countermanded the seeming deficiencies that were brought to our attention. We thus decline to include these instances among adverse information that would detract from the sought extensions of the operating licenses.

One comment on “numbers” is, however, in order. The Applicant has characterized these missed surveillances as among sixty-five missed surveillances throughout the 10-year history of the facility and has compared that number to the over 10,000 total tech-spec surveillances that take place annually. PG&E adds that in 1992 it missed only three surveillances and in 1993, up to August, it had missed only one. Tr. 836 (Crockett).

PG&E witnesses were questioned about the accuracy of these numbers, given the statement in MFP Exh. 44 (quoted above) that a single missed surveillance had resulted in 17 containment entries, each of which would require a surveillance. They explained that missed surveillances were grouped by root causes and that all stemming from the same root cause were considered the same missed surveillance. Tr. 834, 836, 845, 848-53 (Crockett, Vosburg, Giffin).

MFP considers these statistics to be misleading. Tr. 853 (Curran); MFP FOF ¶¶52, 190. On the other hand, PG&E supported its methodology by explaining that it helped it to gauge the effectiveness of its program, as well as to correct the root cause of a missed surveillance. Tr. 846-47 (Vosburg). The Staff adds
that industry and the NRC accept this practice as appropriate. Staff FOF ¶I-108, citing Tr. 1149 (Crockett).

We agree that PG&E's methodology for counting missed surveillances is appropriate, given the common industry practice. However, it might be wise for PG&E to add, in the context of statements to other than industry or the Staff, some explanatory preface to avoid the appearance of manipulating statistics to make the record appear advantageous.

8. Component Cooling Water (CCW) Heat Exchanger

The CCW system removes heat generated by various plant systems without releasing radioactive material to the environment. The DCPP has four CCW heat exchangers, two for each unit. Each CCW heat exchanger has 1237 tubes approximately 35 feet long.

In March 1993, during a Unit 2 refueling outage, testing was conducted on tubes in both Unit 2 heat exchangers. The testing was part of the ISI program that looks at performance to identify and predict early if there is any degradation of equipment. Tr. 857 (Crockett). Fretting was found on the outside diameter of certain tubes, at the baffle plates. Tubes with damage greater than 20% were plugged (i.e., removed from service), including ten on one Unit 2 heat exchanger and several on the other. PG&E determined the root cause to be flow-induced vibration on the tubes, and accordingly it also revised operating procedures to address maximum flow limits. MFP Exh. 47 (NCR DC2-93-TS-N017, Rev. 00, June 15, 1993).

MFP claims that testing is not being conducted with sufficient frequency, that the ability of maintenance and surveillance activities to ensure the efficiency of the CCW heat exchangers is questionable, and that the corrective actions, maintenance, and design changes may have violated the original design criteria by improperly extending the original design flow rate. MFP FOF ¶¶ 203, 206, 211. MFP portrays this incident as representative of a maintenance problem that has threatened or disabled essential safety systems (outline ¶I.A) and as an example of inadequate routine surveillances (outline ¶IV.C).

PG&E counters that the fretting was indeed detected through the surveillance program, that frequency of inspection, which is determined on the basis of expected wear and service life, is sufficient, and, in any event, PG&E is studying whether increased inspections are warranted. Tr. 858 (Crockett). PG&E adds that it incorporated the design-basis maximum flow limits into its operating procedures. PG&E FOF ¶R-A43, citing MFP Exh. 47 at 1. The Staff stresses that PG&E identified the problem through its surveillance program, took appropriate maintenance action, and is further studying the appropriate testing interval. It regards the incident not as a weakness but a strength of the ISI program. Staff FOF ¶¶I-109 through I-111.
In evaluating this incident, we find no basis for suggesting that the surveillance program was not properly implemented. The CCW heat exchanger tubes were inspected when they were scheduled to be inspected. Indeed, there had been no previous finding of fretting on inspection of the Unit 1 tubes. Tr. 863-64 (Crockett). We express no opinion, however, as to whether the inspection interval was or is appropriate. The evidence of record does not suggest that more frequent surveillances are clearly necessary (or, for that matter, clearly not necessary).

Finally, no safety system appears to have been compromised — the regularly scheduled testing is designed to detect this type of condition so it can be corrected before tube failure (MFP Exh. 47 at 6) and it did so here. PG&E is appropriately studying whether the frequency of testing should be increased. Given the existing schedular surveillance requirements, we find no undue delay — the condition was discovered 5 months before the hearing, with no indication that it had occurred earlier. In short, this incident does not reflect adversely on PG&E's surveillance program.

9. **Auxiliary Building Ventilation System Inoperable**

On March 2, 1993, maintenance personnel were preparing to perform a preventive maintenance task relating to the Unit 2 Auxiliary Building Ventilation System (ABVS), and a clearance was placed on the system. In subsequently revising the clearance and implementing the work order, however, personnel improperly closed the wrong damper, activating the ABVS logic to shut down the only operable ABVS fan (the redundant fan was already out of service for maintenance). PG&E prepared an NCR and a LER concerning this reportable event. MFP Exhs. 49 (NCR DC2-93-MM-N012 Rev. 00, dated June 11, 1993) and 50 (LER 2-93-002-00, dated April 5, 1993); Tr. 881-83 (Giffin).

MFP claims that this incident demonstrates inadequate maintenance instructions and poor communication between maintenance and operations staff, creating an unacceptable safety risk (MFP FOF ¶220). MFP designates the incident as one that disabled or threatened an essential safety system (outline ¶I.A), as indicative of insufficient communication between groups or departments (outline ¶IV.A), and as an example of inadequate or improper surveillance (outline ¶IV.C).

PG&E and the Staff regard this incident as an isolated personnel error with no safety significance. This latter conclusion is based primarily on the circumstances that limits set forth in 10 C.F.R. Part 50, Appendix A, General Design Criterion 19, would not be exceeded within the time (2 hours) needed to restore system operations, and that 24 hours is needed before any safety-related equipment would be affected (the ABVS was out of service for only 15 minutes). MFP Exh. 49 at 8.
We agree with MFP that the incident threatened a safety system, irrespective of the circumstance that it did not last long enough to have immediate safety significance. We also agree that the incident does to some degree represent an inadequacy in communications between maintenance personnel and others. It also reflects a personnel error, caused in part by insufficient instructions. We note that corrective action to improve such instructions is being proposed. Given these factors, we do not consider the incident to have sufficient significance to undermine the effectiveness of the maintenance program. Nevertheless, given the number of incidents reflecting inadequate communications between maintenance personnel and other PG&E departments concerning maintenance-related activities, we are directing PG&E to perform a study of this problem and provide it to the Staff. In addition, although not warranting a license condition, PG&E might also consider certain general improvements in the preparation of instructions to maintenance personnel.

10. Restoration of Electrical Panels

MFP points to two incidents in 1993 (one in April, the other in May) involving failures to return electrical panels to their original configuration following work-related activities within the panels.24 On April 1, 1993, the rear hinged panel of the Unit 1 RHF panel was observed with no fasteners installed to secure the hinged panel to the main panel. The fasteners were in a plastic bag in the bottom of the RHF panel. The preliminary safety evaluation was "a potential loss of seismic qualification that could have impacted the operability of vital 4 kV bus F and its associated diesel generator during a seismic event." A preliminary root cause was that responsibility for panel restoration was not assigned to any of the groups performing concurrent work on the panel. The NCR referred to several "previous similar events," one of which was a 1989 event to which MFP alluded. MFP Exh. 52 at 1, 3, 9.

The second event was reported on June 7, 1993, but occurred earlier (i.e., investigative followups were under way as early as a TRG meeting on May 25, 1993). Covers were found not to have been installed on the hot shutdown panel for both Units 1 and 2. The covers were observed to be lying in the bottom of the back of the panel, and the mounting screws "were nowhere [sic] to be found." MFP Exh. 51 at 1, 2, 7. The specified root cause was merely a cross-reference to the other NCR and, thus, must be considered by us to be identical.

24 MFP Exhs. 51 and 52; Tr. 888-90 (Giffin). Because of the similarity of the incidents (in PG&E's view), the Applicant is cancelling Exh. 51 and taking action under Exh. 52. Nonetheless, two separate incidents did occur, and the cancellation of one of the NCRs represents only a bookkeeping convenience for PG&E, not a lowering of the significance of either incident (or of both considered collectively).
Immediate corrective actions included (for the first event) replacing the fasteners the same day they were discovered uninstalled and checking fasteners in similar panels and (for the second event) reinstallation of the internal hot shutdown panels. Further investigative actions were undertaken but not yet complete at the time of the hearing. MFP Exhs. 51 and 52; Tr. 898 (Giffin).

MFP asserts that PG&E’s previous corrective action failed to prevent recurrence of a similar event and that PG&E’s safety analysis shows a misunderstanding of or disregard for the safety principles underlying its maintenance responsibilities. MFP FOF ¶¶ 227, 231. MFP categorizes these incidents as involving safety systems being disabled or threatened (outline ¶I.A), inadequate or incorrect analyses of safety significance (outline ¶I.B) and previous corrective action failing to prevent recurrence (outline ¶II.B), and as an example of insufficient coordination between multiple groups (outline ¶IV.A).

PG&E determined that both incidents had no safety significance — the first, because the bus and associated diesel would in any event have been operable before and after a postulated seismic event, and because of redundancy, and the second because the as-found condition did not impact safety given other fire-protection features of the plant. PG&E FOF ¶¶ M-A61 and M-A62, citing MFP Exhs. 51 and 52. PG&E acknowledges that corrective action is still ongoing. Tr. 898 (Giffin). The Staff asserts that the incidents do not rise to the level of a fundamental flaw in the maintenance program and, in addition, would discount MFP’s findings in this regard as speculative and not supported by expert testimony. The Staff also observes that PG&E’s root-cause analysis and corrective actions are ongoing. Staff FOF ¶¶ I-119 through I-121.

In our opinion, there is no basis for concluding that a safety system was disabled or threatened, even though the practice of failing to restore equipment being serviced to use could analytically be deemed significant. Further, this is not an example of an inadequate or incorrect analysis of safety significance — the analysis is still under way, and no evidence suggests that final resolution has been unduly delayed. Finally, the 1989 and 1993 incidents are too disparate in time for us to conclude that the 1993 incidents resulted from a failure in the 1989 corrective action.

We agree with MFP, however, that the incidents are examples of insufficient coordination between multiple groups. This deficiency has appeared in several other cited incidents. Although not sufficient to undermine the adequacy of the maintenance system, this is an area calling for additional corrective action. We are encouraged that PG&E is studying this problem, but we nonetheless are directing that this general area be included as part of PG&E’s communications study that we are directing, with a report to be furnished to the Staff.
11. Containment Equipment Hatch

On March 12, 1993, the Unit 2 equipment hatch was observed to be not fully closed, during a core offload, thus violating a technical specification. PG&E submitted an LER to the Staff, as required. MFP Exh. 54 (LER 2-93-003-00, dated April 5, 1993). The Applicant also prepared an NCR recording the event, its significance, and corrective action. MFP Exh. 53 (NCR DC2-93-MMN013 00, dated May 28, 1993).

MFP claims that, despite a previous event and an NRC information notice, the maintenance procedure and personnel preparation were not adequate for the hatch closure activity. MFP FOF ¶238. MFP categorizes this incident as one where safety systems were threatened or disabled (outline ¶I.A), where previous corrective action failed to prevent recurrence (outline ¶I.B) and as an example of personnel error resulting from inadequate procedures (outline ¶IV.E). The Applicant and Staff each regard the incident as an example of isolated personnel error not reflecting any systemic maintenance problem. PG&E FOF ¶M-A66; Staff FOF ¶I-125.

We agree with MFP that the incident had safety significance: the gap in the cover could, during fuel movement, permit a gaseous release of radioactive material to the atmosphere if an assembly were dropped. Tr. 903 (Giffin). We also perceive the incident to represent, as claimed by the Applicant and Staff, an isolated personnel error. We disagree with MFP’s characterization of the incident as reflecting previous corrective action that failed to prevent recurrence. Although a previous similar event had occurred 10 years earlier (in 1983), the lapse of time is sufficient to assume that the two personnel errors are unrelated.

Finally, there is some ambiguity in the record as to whether the 1993 error resulted from inadequate procedures. PG&E states that “[t]he procedure was adequate, the journeyman did not follow it.” Tr. 904 (Giffin). But PG&E is modifying the procedures to require independent inspections of the closure from both inside and outside the containment. Tr. 904-05 (Vosburg). This appears to us to represent an improvement to already adequate procedures and not a reason to fault the maintenance program.

We note that we believe that it would be impossible to eliminate all personnel errors, as highly desirable as such a result might be. We here find not that personnel can never commit errors with significant safety consequences, or that PG&E did not commit such an error here, but only that there appears to be no programmatic reason at DCPP for errors such as this to have occurred. We offer no magic solution to this endemic problem.
12. **Manual Reactor Trip Caused by Failure of a Fuse for the Rod Control System**

As set forth in NCR DC1-91-EM-N046, dated June 10, 1991 (MFP Exh. 56), on April 24, 1991, plant operators initiated a manual reactor trip to terminate an increase in reactor power, caused by a failure of the rod control system which rendered manual control rod movement inoperable. The immediate cause was failure of a fuse in the bus duct disconnect to the rod control power supply cabinet. Investigation disclosed that twelve of fifteen fuses in similar locations were of the wrong type. All such fuses were to have been replaced with newer-design fuses. PG&E had submitted an LER to report this event to the Staff. MFP Exh. 55 (LER 1-91-008-00, dated May 23, 1991).

MFP asserts that PG&E’s previous corrective actions were ineffective and failed to prevent this event. MFP FOF ¶1245. It categorizes the event as one where safety systems were disabled or threatened (outline ¶I.A), where previous corrective action failed to prevent occurrence (outline ¶II.B), and as a personnel error due to failure to follow procedures (outline ¶IV.D.)

PG&E acknowledged that the failed fuse was of an old style with known reliability problems that was to have been replaced in 1989. It also acknowledged a personnel error in that the wrong fuses had been replaced. Following the trip, PG&E took steps to replace all of the bus duct fuses for the Unit 1 rod drive control cabinets, as well as other corrective actions. It considers the matter resolved, with no recurring maintenance problems indicated. PG&E FOF ¶MA68, citing MFP Exh. 56 at 1, 4, 7, 10. The Staff essentially agrees, perceiving no matter generally relevant to PG&E’s surveillance and maintenance program. Staff FOF ¶I-127.

In our view, MFP is correct in its characterization of this event. The failed fuse had safety significance, it was supposed to have been changed and was not, and, predictably, it failed. Indeed, the wrong fuse had been changed. Although these errors were eventually corrected, the situation does constitute poor maintenance performance. Nonetheless, adverse circumstances do not appear to be recurring with sufficient frequency to disqualify the maintenance program or suggest a readily apparent remedy. We thus merely observe that continuous vigilance and attention to detail is a worthwhile goal that management should strive for in implementing its maintenance and surveillance program.

13. **Limitorque 2-FCV-37 Failed to Close**

During a routine surveillance procedure in January 1993, one Limitorque motor-operated valve (2-FCV-37) failed to close on demand from the control room. MFP Exh. 57 at 3-4. The cause of the failure was determined by PG&E to be a quad ring incorrectly installed during a 1990 maintenance overhaul of
the operator, caused by an installation procedure that did not give adequate
guidance to the workman. Tr. 913-14 (Giffin); MFP Exh. 57.

MFP would have us find that PG&E failed to perform adequate maintenance
on two valves and did not identify the problem in a timely way. MFP FOF ¶260. It categorizes the incident as a pattern of responding to maintenance
problems in a lax manner (outline ¶II.A), as untimely detection and correction of
aging effects (outline ¶II.C), as demonstrating a pattern of creating undetectable
failures through improper maintenance (outline ¶IV.B), and as an example of
inadequate procedures or work instructions (outline ¶IV.E).

In contrast, PG&E and the Staff portray the incident as an example of the
IST/ISI test program performing as intended. PG&E FOF ¶M-A69; Staff
FOF ¶I-128. They stress that PG&E, in developing its NCR, determined the
root cause of the error and thereafter instituted corrective action, returning
the component to service and revising the maintenance procedure to provide
additional guidance. PG&E FOF ¶M-A71. In addition, they note that the other
“similar” incident referenced by MFP was not related to maintenance and had
a different root cause.

We agree with PG&E’s description of this incident as only a “single isolated
event.” Id. Both the problem and its resolution appear to be adequately
covered by the NCR. This does not significantly detract from the adequacy
of the maintenance program. We are somewhat concerned, however, about
the adequacy of work instructions, a problem that is repeated in several of
the incidents before us. In our opinion, but only as a suggestion because no
Board order would be warranted here, PG&E should consider whether improved
systemic procedures could generally improve the adequacy of work instructions.

14. Safety Injection Emergency Core Cooling System (ECCS)
Accumulator Tanks

This incident concerns the discovery by PG&E of indications of intergranular
stress corrosion cracking (ISCC) in the Safety Injection ECCS accumulator
tanks in both Units 1 and 2. Relying on a 1993 Staff Inspection Report (MFP
Exh. 59, IR 93-08), together with a voluntary LER and a report of PG&E’s
Onsite Safety Review Group (OSRG) (MFP Exhs. 60 and 61), MFP claims
that PG&E’s response to NRC Information Notice 91-05 was untimely and
inadequate, that PG&E is not certain about the nozzle material used, and that
financial considerations influenced PG&E’s decision to delete its corrective
action to replace all possible nozzle devices and piping in Unit 2 during its
5th refueling outage (2R5). MFP FOF ¶¶267, 272, and 276.

The LER relied on by MFP lists three instances in 1985 when ISCC in the
Unit 2 accumulator nozzles was detected, two instances in 1986 and one in
1991, also in Unit 2, where ISCC was detected, and one in 1992 where ISCC
was detected in Unit 1. MFP Exh. 60 (LER 2-87-023-01) at 4 (of LER). The record also reveals that all the defective nozzles were replaced but, because of cost considerations and schedule impact, PG&E elected not to replace all such nozzles. MFP Exh. 61 at 2.

MFP characterizes the deficiencies as disabling or threatening safety systems (outline ¶1.A), as representing untimely corrective action (outline ¶II.A), as examples of previous corrective action that failed to prevent recurrence and of untimely detection and correction of aging effects (outline ¶II.B, II.C), and as an example of PG&E decisions regarding what is needed to maintain the plant in a safe condition being unduly influenced by financial considerations (outline ¶IV.G). For their parts, PG&E and the Staff portray the incidents as a maintenance program performing as it should — in PG&E’s terms, “an operating experience that was thoroughly addressed by PG&E.” PG&E FOF ¶M-A72. See also Staff FOF ¶¶I-132 through I-135.

As stressed by the Staff and as reflected in the record, when small nozzle leaks were first detected in 1985-87, PG&E identified and successfully repaired or replaced all leaking nozzles. The frequency of surveillance inspections was also increased. PG&E further cut out several nozzles for metallurgical analysis. Analysis demonstrated that crack propagation was from the inside and thus not from exterior corrosion. Staff FOF ¶I-133, citing MFP Exh. 60 at 3 and Tr. 934 (Crockett). Thereafter, following Staff issuance of Information Notice 91-05, concerning the possibility of ISCC in accumulator tanks, PG&E performed further inspections and discovered several other indications of cracking, which were repaired.

With respect to this incident, we agree with the Applicant and Staff that the maintenance and surveillance program performed appropriately. As the Staff asserts, PG&E has been investigating the issue since its initial identification and has implemented appropriate corrective maintenance and increased surveillance. It has committed to an enhanced periodic inspection program for accumulator nozzles. Staff FOF ¶I-135, citing Tr. 939-41 (Crockett) and MFP Exh. 60 at 8. Although the matter does have safety significance, as claimed by MFP, there is no evidence supporting the claims that PG&E was slow to initiate corrective action, that its attempted corrective action was unsuccessful, or that PG&E fails to know the composition of the nozzles.

Further, the financial claim (MFP FOF ¶¶276-278), based on assertions that PG&E elected to repair or replace defective nozzles rather than replace all of them (as it had considered doing) because of cost and the structure of California’s rate system in dealing with maintenance costs, is not appropriate for us to consider at this point. No systemic compromise of safety standards has been demonstrated, and there is no evidence that, because of California’s rate
system, PG&E is cutting corners on appropriate maintenance or surveillance activities.\(^{25}\)

In short, we concur with the Staff assessment of the examination program for the accumulator tanks, "not only was it acceptable, it was considered very good work to be looking this hard and finding these things and fixing them." Tr. 2178 (Miller).

15. Corrosion of ASW Annubar, DFO, and CO\(_2\) Piping

This issue concerns corrosion in three types of underground piping: the diesel fuel oil (DFO) line for Unit 2; fire protection carbon dioxide (cardox) piping in Unit 2; and ASW annubar piping (in the form of a 1 1/2-inch hole). Corrosion on the DFO piping was first observed in 1990; on the ASW annubar piping in June 1992; and on the cardox piping in January 1993. The corrosion on these three different pieces of equipment is related because of the similar location of the pipes — all of them are located below ground in a concrete trench on the west end or sea side of the turbine building. After each discovery, PG&E initiated corrective action. MFP Exhs. 62, 63, 64, 64A; PG&E Test. at 99 (Crockett); Tr. 1059 (Crockett).

MFP claims that corrective actions taken after discovery of corrosion in the DFO piping in 1990 were ineffective and failed to prevent further degradation; that PG&E's maintenance and surveillance program was not adequate to detect and sufficiently control the extensive corrosion that has occurred in the pipe trench/pipeway; that there was inadequate initial application and maintenance of the coal tar protective coating that was intended to prevent corrosion on the piping in the trench/pipeway; that the trench/pipeway was not maintained in an adequate manner to prevent the accumulation of water; that PG&E has been unacceptably slow to respond with corrective actions to alleviate the corrosion of pipes in the pipe trench/pipeway; and that PG&E's proposed corrective actions are unsubstantiated and should not be considered in this process.

MFP goes on to assert that PG&E determined that the DFO and ASW annubar piping remained operable despite the corrosion; that PG&E instituted compensatory measures to compensate for the inoperable cardox system; and that PG&E's operability/compensatory determination, however, is not an indication of an effective maintenance and surveillance program but rather an indication that PG&E was lucky this time. Further, MFP asserts that PG&E's failure to prevent the accumulation of water in the trench/pipeway contributed  

\(^{25}\) We also note that PG&E testified that "We don't put off required maintenance. This was evaluated, it was determined that we didn't have to do this [full replacement] at that time and we didn't. . . . instead of going with a plan that would automatically just replace all the nozzles we had preparations to inspect . . . all of the nozzles, and replace them if necessary." Tr. 940 (Giffin, Crockett).
to the development of corrosion on the various pipes and is similar to its failure to maintain sump pumps in the vaults; and the submergence of the cables contributed to the severe degradation and eventual failure of the 12 kV cables (see item 3, above). Finally, MFP portrays these developments as an example of inadequate coordination between maintenance and operations personnel.

MFP categorizes these claims and assertions concerning underground corrosion of piping as disabling or threatening safety systems (outline § I.A), as an example of responding to maintenance problems in a lax and untimely manner (outline § II.A), as an example where previous corrective action failed to prevent recurrence (outline § II.B) and of untimely detection and correction of aging effects (outline § II.C), and as an example of deficient communication and coordination between different groups of individuals and/or departments (outline § IV.A). Finally, the corrosion is attributed to inadequate procedures or work instructions (outline § IV.E).

PG&E characterizes these incidents as “operational experience with equipment that is well within the scope of PG&E’s maintenance and surveillance capabilities.” It goes on to observe that the maintenance and surveillance program “functioned to find deteriorating piping and then to replace the piping with upgraded design, materials or construction techniques.” PG&E FOF ¶M-A76. It acknowledges, however, that its 1990 corrective actions with respect to the DFO piping corrosion may not have been adequate. “If we had done more then, . . . we may have been able to do something to alleviate the situation.” Tr. 1070 (Giffin). The Staff stressed that the 1990 actions were “not sufficiently comprehensive or conservative to prevent recurrence” but added that, “while further actions arguably could have been taken in 1990, in the vast majority of cases in which a problem has been identified, PG&E has taken prompt action commensurate with safety significance.” Staff FOF ¶I-145, citing Staff Test., ff. Tr. 2159, at 13.

Discovery of the DFO corrosion in 1990 arose from normal surveillance. As corrective action, PG&E repaired the pipe coating and increased the frequency of surveillance. Later inspections, however, revealed further corrosion in the DFO lines as well as the other piping. Eventually, PG&E instituted a corrosion task force, comprising a multidisciplined organization from engineering to review the material condition throughout the plant of any piping that may be susceptible to corrosion. Tr. 1062 (Crockett). PG&E is also looking at the design of the trench in which all three types of pipes were located and is changing the location of the DFO piping in the trench to minimize its exposure to standing water. The cardox piping is being removed from the trench completely and routed within the turbine building. Tr. 1084 (Giffin, Vosburg).

26 See also MFP Exh. 64A at 1-3 (“the previous corrective actions were ineffective,” at 3).
We here find no fault with the surveillance program — it discovered the problems and none of the pipes were ever inoperable (although conservatively some of the ASW piping was declared inoperable pending further review). Tr. 1085-86 (Vosburg). The maintenance program for repairing the DFO pipe in 1990 fell short but now appears to be addressing the corrosion problem adequately — i.e., the broad-based task force, which is studying the "big picture" (Tr. 1088 (Crockett)), appears to be an acceptable approach to the overall problem. Improvements in surveillance procedures have also been implemented, to facilitate discovery of corrosion in underground piping. Tr. 1076-77 (Giffin).

Thus, we agree with MFP that the corrosion has safety significance and that PG&E's initial corrective action (for the DFO piping) fell short. We also agree that communications between various departments could have been improved. But the current program appears to be following a technically acceptable approach and is likely to represent a permissible means for developing an appropriate program for dealing with underground pipe corrosion for the extended terms of operation. Upgraded surveillance procedures have already been instituted, and one type of piping is being moved to another location. In short, we will not disqualify the maintenance program for past shortcomings that appear to have been recognized and, in our view as well as that of the Applicant and Staff, corrected. We are, however, including this incident as one of those that requires PG&E to perform a study, to be provided the Staff, concerning upgrading of interdepartmental communications for maintenance-related activities.

16. Control of Measuring and Test Equipment (M&TE)

Technical specifications for the DCPP provide that there be appropriate procedures to ensure that tools, gauges, and other measuring and testing devices be properly controlled, calibrated, and adjusted at specified periods to maintain accuracy. MFP Exh. 66, Enclosure 1, at 1. PG&E has established such procedures.

In a February 1991 inspection, the Staff found both deficiencies in the M&TE programs and that PG&E had previously identified deficiencies but had not aggressively corrected them. MFP Exh. 69; PG&E Test. at 102 (Giffin). These deficiencies resulted in a single (non-escalated) NRC enforcement action (Severity Level IV violation). MFP Exh. 71.

MFP asserts that the identified M&TE problems are longstanding, recurring, and continuing, that PG&E's maintenance and surveillance organization failed to respond promptly to the deficiencies, that corrective actions taken by PG&E were ineffective to prevent recurrence, that PG&E management was insufficiently involved in the resolution of the M&TE deficiencies, and that the recurring deficiencies have safety significance. MFP FOF ¶¶ 318, 323, 329, 338, 345.
MFP categorizes the activities as disabling or threatening safety systems (outline ¶1.I.A), as indicating a pattern of responding to maintenance problems in a lax and untimely manner (outline ¶II.A), as previous corrective action that failed to prevent recurrence (outline ¶II.B) and as insufficient management involvement (outline ¶IV.A), and of personnel error due to inattention to detail and to failure to follow procedures (outline ¶IV.D).

PG&E acknowledges the previous enforcement action and the failure of certain of the corrective actions previously taken. But it maintains that it has taken further corrective action, as to which MFP has not indicated any deficiencies. It suggests that current deficiencies are minor paperwork discrepancies that must be differentiated from the earlier, more serious problems. The Staff similarly believes that the ongoing corrective actions will be effective. The current NRC Staff senior resident inspector testified that she is satisfied with the current M&TE program based on her own in-depth inspections. Tr. 2192-94 (Miller).

It seems clear that, in the past, there were both problems with the M&TE program and with maintenance activities designed to alleviate those problems. The record also establishes that the ongoing program appears to be working satisfactorily. That being so, it cannot conclusively be asserted that it casts doubt on the current or future maintenance program. Indeed, it may perhaps be validly claimed that the Staff’s enforcement action is producing its intended result. In any event, the evidence of record concerning M&TE problems fails to establish significant weaknesses in PG&E’s current maintenance program.

17. Centrifugal Charging Pump 2-1; Degraded Coupling

On June 30, 1992, an increase in vibration on centrifugal charging pump (CCP) 2-1 was identified by PG&E Predictive Maintenance (PM) personnel. Investigation into the cause included taking a gear lube sample from the motor-to-speed increaser coupling. During the sampling process, the coupling sleeve on the speed increaser side of the pump was found to be stiff due to hardened lubricant. The sleeve was subsequently freed and a work order was issued to replace the coupling prior to any failure of the equipment. The maintenance organization initiated an NCR on July 1, 1992. MFP Exh. 73.

The Technical Review Group (TRG) for this NCR concluded that the root cause of the problem was inadequate motor alignment criteria stemming from ambiguous vendor information. Contributing causes related to inadequate lubrication were also identified. This was the third occurrence involving vibration of CCP 2-1. (However the NCR reviewed only one previous incident involving excessive coupling wear that occurred in 1989.) The cause of excessive coupling wear in the 1989 incident was misalignment of the motor with respect to the speed increaser. The role of inaccurate vendor information as
a root cause was not recognized in the analysis of the 1989 event. Tr. 1120-24 (Ortore).

The TRG met five times in the year following the issuance of the NCR. The Group addressed such matters as corrective actions, investigative actions, actions to prevent recurrence, and additional prudent actions. The TRG also considered previous similar events and operating experience at other plants. Closure of the NCR was achieved on July 7, 1993.

The foregoing facts are not in dispute and the parties differ only as to the inference about the predictive maintenance program that should be drawn from this incident. MFP urges the Board to find that the maintenance program is deficient because previous corrective actions should have prevented recurrence of this event, but failed to do so (outline ¶II.B) because the program includes deficient procedures or work instructions (outline ¶IV.E) and because the program for detecting manufacturing deficiencies or internal defects did so only by chance and should have identified the deficiencies before they became self-evident (outline ¶IV.F). MFP FOF ¶¶350-353. PG&E and the Staff argue that this incident is evidence of the effectiveness of the company's predictive maintenance program because the degraded condition of the coupling was found before any pump failure occurred. Tr. 1120-21 (Giffin; Ortore); PG&E FOF ¶¶M-A88-89; PG&E Reply FOF ¶¶R-A63-64; Staff FOF ¶¶I-154 through I-156.

The Board concludes that the degraded condition of the coupling was found and repaired before any equipment failure occurred and that the inspection was conducted as part of the company's systematic preventive maintenance program (PG&E Test. at 38-40 (Ortore); Tr. 1121 (Ortore)), which we further conclude functioned effectively in this instance. We base our conclusion not only on the circumstances of detection and correction of the degraded condition but also on the systematic efforts of the Technical Review Group (TRG) to investigate the incident, find root causes, and develop remedies that could prevent future occurrences. MFP Exh. 73 at 9.

The TRG investigation revealed that similar degradation had occurred in 1989 on the same pump and that corrective actions for that event had not prevented recurrence. In both cases the root causes were attributed to inadequate alignment criteria; however, in the earlier case it was not recognized that inadequate vendor information contributed to the problem. We have no record basis that might show that the 1989 analysis was lacking in diligence or that it resulted from some weakness in the PG&E maintenance program. The self-critical disclosure of the 1989 results indicates strength in the program because it contributed to a deeper analysis of root causes in the later analysis.

The discovery and correction of the latest pump problem together with the analyses made by the TRG over a period of nearly 1 year to identify root causes and preventative measures appear to the Board to have been both reasonable
and effective. We rely on the NCR itself for this conclusion since there is no evidence of record to support a finding of weakness in the maintenance program. MFP's assertion (FOF ¶¶350-351) that the company should have done better based on prior experience is therefore unsupported and we reject it. We find that PG&E's detection, correction, and technical analysis of the degraded coupling on the centrifugal charging pump is substantial evidence of a properly functioning maintenance program at the plant.

18. Unit Shutdown Due to Inoperable High-Pressure Turbine Stop Valve

Circumstances related to the failed turbine stop valve are set forth in LER 2-92-003-01 (MFP Exh. 74). MFP relies on the LER and testimony of PG&E witnesses to support its allegation of improper maintenance. There is no controversy among the parties regarding the facts of the valve failure, however. Accordingly, we adopt, with minor modifications, MFP FOF ¶¶354, 355, and 356 in the following paragraph as an accurate factual summary of the event.

On March 22, 1992, a manual shutdown was commenced for Unit 2 when PG&E determined that one high-pressure turbine stop valve (FCV-144) was inoperable. FCV-144 is a hydraulically actuated swing check valve that protects the high-pressure turbine from overspeed. PG&E disassembled FCV-144 and determined that "the nut that retains the valve disc to the valve swing arm had disengaged from the disc stem, allowing the valve disc to become separated from the valve swing arm." When the valve separated from the swing arm it caused a partial blockage of steam flow through the Main Steam Lead. PG&E has been unable to identify the root cause of this equipment failure. It postulates two modes of failure: (1) unscrewing of the nut off the stem; or (2) a failure of the nut/disc stem threaded joint. MFP FOF ¶¶354-356.

MFP requests the Board to find that "PG&E may have caused an undetectable failure through improper maintenance." PG&E responded that the immediate cause of the inoperable valve was equipment failure, and that neither the LER nor the testimony of record attributes this problem to a maintenance deficiency. MFP Exh. 74; Tr. 1126-27 (Vosburg). The NRC Staff sees no programmatic deficiency. NRC Staff FOF ¶¶1-159.

In our view, the record does not support MFP's belief that the valve failure was caused by a maintenance deficiency. The root-cause analysis points either to unscrewing of the nut off the stem holding the disc, or to stripping of the threaded joint possibly due to buffeting of the disc in the steam flow. MFP Exh. 74 at 3; Tr. 1133-34 (Giffin). Moreover, no "undetectable failure" occurred.\footnote{MFP has not made clear how a maintenance program could be improved to permit the detection of "undetectable failures."}
valve failure was detected by a rapid load reduction in power of approximately 10%. Thus the valve failure was self-disclosing.

The root causes of failure are likely traceable to manufacture or original installation of the valve. Tr. 1133-34 (Giffin). Prior maintenance and inspection of the valve, however, did not disclose any abnormalities that might have warned of potential failure. Had degraded conditions stemming from either possible root cause been present on inspections prior to the failure, they could have (and should have) been detected. Although the valve was manufactured and set up by Westinghouse, which performed at least one prior inspection during an outage, degraded conditions were not discovered prior to failure. Tr. 1131-32; 1134-36 (Giffin). The record does not disclose whether degraded conditions were present but not observed on initial installation or on a prior inspection or whether they developed during subsequent operation. However, PG&E has now established enhanced inspection programs specifically to detect possible failures stemming from either of the root causes that have been identified from this event. Tr. 1134-35 (Giffin).

There are eight such valves in the two units at Diablo Canyon. The failure described herein is the first of its kind in the life of the plant. Inspection of the seven valves that did not fail did not disclose any abnormal conditions. Tr. 1128-29 (Vosburg). The Board concludes that this failure was isolated and that no adverse inference about the PG&E maintenance program can be drawn from it.

For all of the foregoing reasons, we reject MFP's assertion (outline ¶IV.B) that this failure supports a general conclusion that maintenance activities may cause undetectable failures and future safety problems. We also reject MFP's assertion (outline ¶IV.F) that PG&E generally lacks an effective program for detecting manufacturing deficiencies or internal defects for the same reasons. MFP FOF ¶¶47-48, 57-59.

19. Diesel Generator 2-2 Failure to Achieve Rated Voltage

On December 29, 1992, diesel generator (DG) 2-2 was subject to a post-maintenance test. The DG started but did not load because the generator did not achieve rated voltage. MFP Exh. 75 at 1; MFP Exh. 76 at 1; Staff FOF ¶1-160. PG&E determined that the failure to load occurred because all four generator slip ring brushes were out of position after maintenance had been performed. PG&E found that the mispositioning occurred inadvertently when a mechanical maintenance worker loosened some mounting bolts to conduct an inspection of the generator shaft, rotated the shaft manually, and then retightened the bolts without inspection of the position of the brushes. MFP Exhs. 75, 76; Tr. 1139-40 (Giffin). The immediate cause for this event was personnel error. Tr. 1139-40 (Giffin). The root cause was inadequate electrical information.
being supplied to the mechanical technician. MFP Exhs. 75, 76; Tr. 1141-43 (Giffin). Corrective action was taken to revise the maintenance manual for the DGs to advise technicians on how to prevent recurrence of the error. When the generators are involved in maintenance, procedures will also be revised to involve electrical technicians. Tr. 1144 (Giffin).

MFP requests the Board to find the maintenance program defective because the error outlined herein demonstrates inadequate procedures and a lack of communication or supervision among electrical and mechanical maintenance personnel. MFP FOI ¶¶362-368. The Applicant asserts that this incident is an example of how a maintenance program should work and that MFP’s conclusion that the program is globally defective because procedures had to be improved is unwarranted. PG&E FOI ¶M-A94. The Staff sees no programmatic defect because, even though the error occurred, it was found by surveillance and PG&E took corrective actions. Staff FOI ¶¶I-162, I-163, I-164.

Errors in maintenance and communication occurred as asserted by MFP; however, its exhibits and PG&E testimony show that PG&E’s surveillance was effective, that it analyzed the problem, and that it took corrective action which appears reasonable and effective. MFP Exhs. 75, 76; Tr. 1142-44 (Giffin). MFP has not controverted this aspect of the exhibits and testimony. Because the errors found here have been effectively analyzed and corrected, this incident cannot serve as cumulative evidence in support of MFP’s assertion (outline ¶¶I.A, IV.B, and IV.E) of general deficiency in the surveillance and maintenance program. The Applicant has carried its burden of proof with respect to the diesel incident.

20. Missed Alert Frequency STP for Auxiliary Saltwater Pump 1-2 and Component Cooling Water Valve CCW-2-RCV-16

MFP introduced three exhibits that addressed two separate incidents of personnel error and missed surveillance tests: one on a component cooling water (CCW) valve and the others on an auxiliary saltwater (ASW) pump. MFP Exh. 77 (NCR DC2-93-TS-N005 Rev. 00); MFP Exh. 78 (NCR DC1-92-TP-N052 Rev. 00); MFP Exh. 79 (LER 1-92-024-00). There is no dispute that the required surveillance tests were missed and that personnel error was responsible. Missed surveillance tests are the only common factors in the otherwise unrelated incidents involving the valve and pump. The Board is called upon to decide whether the missed surveillance tests are indicative of a general deficiency in the PG&E maintenance and surveillance program, as claimed by MFP (outline ¶¶I.A, III, IV.C, IV.D), or are simply examples of isolated personnel errors that do not suggest a pervasive programmatic breakdown, as claimed by PG&E and the NRC Staff (PG&E FOI ¶M-A99; Staff FOI ¶¶I-167, I-168).
Details of the missed surveillance tests and other error are given in MFP Exhs. 77, 78, and 79. There being no factual dispute, only a brief summary of the incidents need be set forth here:

**Incident 1.** In the first incident, the CCW valve was stroke tested in October 1992 and, based on results, was placed on alert that required the test frequency to be changed from once every 92 days to once every 31 days. The new test frequency was lost from the plant computer system at the time of entry because of personnel error, so the next test was performed on the regular 92-day schedule rather than the 31-day schedule. The required surveillance test was missed twice in the interim. The error was discovered during the 92-day surveillance. PG&E FOF ¶M-A96; Staff FOF ¶1-165; MFP FOF ¶¶375-377.

**Incident 2.** This incident involved two instances of personnel errors during surveillance testing of an ASW pump. In the surveillance test of August 21, 1991, the reviewer used an incorrect pump curve to determine the required differential pressure and failed to recognize that the ASW pump should have been declared inoperable. This was later found to be a reportable violation of applicable technical specifications. In the surveillance test of the same pump on November 14, 1991, the reviewer wrongly determined that the differential pressure test was satisfactory when it actually was within the alert range. The pump should have been placed on alert which would have required surveillance on a 46-day testing frequency. The test was missed on January 29, 1992, and PG&E was, on that date, in violation of applicable technical specifications. The error was discovered on October 15, 1992, during review of a similar test that had been performed on October 7, 1992. MFP Exhs. 78, 79; PG&E FOF ¶¶M-A97, M-A98; Staff FOF ¶¶1-165, I-166; MFP FOF ¶¶369-370, 372-373.

MFP requests the Board to find that these examples of personnel error constitute cumulative evidence in support of their broad assertions of programmatic deficiency in the Diablo Canyon maintenance and surveillance program (outline ¶¶I.A, III, IV.B, D).

Although the personnel errors occurred as described by MFP, the Board rejects MFP’s view that the errors are contributing evidence to an inference of programmatic breakdown. The view expressed by MFP is contrary to uncontroverted direct testimony of the Applicant. In each case, the testimony describes both preventative and corrective actions within the maintenance program. PG&E’s direct testimony elaborates at length on that portion of the PG&E program that provides for root-cause analysis, failure trending, and correction of equipment and personnel failures. PG&E Test. at 58-62 (Giffin). The Board finds that systematic provision in a maintenance program for the analysis and correction of degraded conditions is an integral part of the overall program and must be considered in determining the quality of the program.

Each of MFP Exhs. 77, 78, and 79 contains analyses not only of the circumstances of equipment and personnel failure but also of the root-cause analyses
and corrective actions that were recommended by the respective technical review
groups. None of the corrective actions were explored or controverted by MFP
on cross-examination. The Board finds from its own inspection of the exhibits
that the analyses and recommended corrective actions in each case appear to be
reasonable. They are indicators of a properly functioning program.

There is no support anywhere for MFP's apparent belief that the worth
of the overall maintenance program can be determined by counting unrelated
equipment or personnel failures. There is no objective standard for such
determinations and MFP ignores the integral role of root-cause analyses and
corrective actions in such programs. If these actions are effective, we cannot
say that the program itself is generally defective even though equipment and
personnel failures occur. We find that the examples of failure cited in MFP Exhs.
77, 78, and 79 do not constitute contributing evidence that PG&E's maintenance
program is generally defective.

21. In-Service Prompt Test Data Questionable

MFP offered Exhibits 81 and 82 as examples of errors in a surveillance
test procedure (STP). MFP Exh. 81 (NCR DCO-92-TN-N055 Rev. 00, 3/1/93);
MFP Exh. 82 (PG&E Letter No. DCL-92-262, 11/25/92). The STP contained
a diagram showing an erroneous location for taking vibration measurements
on Auxiliary Feedwater Pumps (AFW). The diagram showed an arrow wrongly
pointing to the pump housing instead of the correct location on the pump bearing
caps. A PG&E engineer discovered and corrected the error in the diagram after
several months but did not initiate an Action Request (AR) to track the matter
and to ensure that tests conducted while the diagram error was in place were
done correctly. NRC issued a Severity Level IV NOV for failure to issue an AR
which was required by procedure. PG&E agreed with the violation. There is
no dispute that the erroneous diagram existed and was used in many inspections
before the error was found and corrected.

There is no evidence that incorrect data were taken because of the diagram.
Tr. 1154-57, 1159 (Crockett). Even if measurements had been taken from the
pump housing instead of the pump bearing cap, abnormal vibration would have
been detected. MFP Exh. 81 at 7. We adopt the factual description of the NRC
Staff as an accurate summary of events leading to the NOV. Staff FOF ¶¶1-169,
I-170, I-171.

MFP calls upon the Board to find that this incident indicates a weakness in
PG&E's surveillance testing program (outline, ¶¶ III, IV.C). MFP FOF ¶¶ 387-
389; 42 (failed checks and balances or multiple barriers); 49-50 (repetitive
pattern of inadequate surveillance). The Applicant and NRC Staff see the error
as minor, in the nature of a typographical error. PG&E FOF ¶¶ M-A101, M-
A102; Staff FOF ¶I-172.
The Board finds that this minor incident had virtually no safety significance and does not support an adverse inference on the overall quality or effectiveness of the surveillance program. The Diablo Canyon maintenance and surveillance program is premised on the need for both preventive maintenance (including surveillance) and corrective maintenance. Corrective activity is an integral part of the program because preventive maintenance (and surveillance) cannot avoid all corrective maintenance. PG&E Test. at 11-14 (Crockett, Giffin); at 38-42 (Ortore, Giffin, Vosburg).

MFP's own exhibits show that, even for the minor error described here, PG&E undertook a substantial corrective effort that included internal review of its procedures leading to the discovery of the diagram error and review by a technical review group that analyzed the event, identified the root cause, and considered whether dots painted on equipment to guide vibration measurements should be programmatically controlled. The corrective actions appear reasonable; there is no contrary evidence. The Board concludes that this event does not contribute to an inference of programmatic deficiency in PG&E's maintenance and surveillance program.

22. Hold-Down Motor Bolts on Centrifugal Charging Pumps

MFP Exh. 83 is a PG&E NCR that reports several discrepancies in Centrifugal Charging Pump (CCP) 2-1 hold-down motor bolts found by PG&E during preventive maintenance in July 1992. Further investigation by PG&E subsequently revealed hold-down bolt discrepancies on other CCPs as well. The discrepancies were attributed to flaws in the original procurement specifications and vendor-supplied information during plant construction in the 1970s. Some of the conditions now regarded as discrepant such as machined hold-down bolts, elongated bolt holes, and stacked washers were done for motor alignment purposes and were accepted field practice during plant construction. MFP Exh. 83 at 1-5; Tr. 1161-62 (Giffin).

MFP requests the Board to find that PG&E's maintenance program is defective because it failed to identify the hold-down bolt discrepancies in a timely manner and it has given inadequate attention to identification of discrepancies related to initial installation. MFP FOF ¶¶393-401. It claims that this issue contributes to a showing that most of PG&E's past maintenance problems have threatened or disabled essential safety systems (outline ¶1.A). MFP FOF ¶¶25-27.

28 MFP urges adoption of FOF ¶385, alleging that guide dots missing from equipment are an additional indicator of program weakness. We reject this view because the dots were neither regulatory nor plant requirements and served only as informal aids to technicians. They had no safety significance.
PG&E argues that MFP's exhibit shows the preventive maintenance program working as it should in finding manufacturing discrepancies that had existed since original procurement. No defect in the maintenance program is shown by this occurrence. The Staff agrees that it does not show any defect in the maintenance program. Neither does it show any current problem in procurement which is, in any event, outside the scope of the admitted contention according to both the Applicant and the Staff. PG&E FOF ¶M-A103; Staff FOF ¶¶I-173 through I-176.

The Board finds that this occurrence had no public health and safety effects and does not support MFP FOF ¶¶25-27, which allege a general deficiency in maintenance of safety systems. We also find that any flaws existing in the original procurement program are outside the scope of Contention I and need not be considered further.

MFP's concern for timely discovery of flaws in hold-down bolts is supported by its exhibit which shows that PG&E had not implemented a Westinghouse technical bulletin and thus did not find the problem earlier. MFP Exh. 83 at 5. We adopt MFP's FOF ¶¶393-396 which assert that the problem could have been found earlier.

The truth of MFP's proposed findings applies to this particular incident but does not assist it in proving programmatic deficiency in PG&E's maintenance program. We know of the missed opportunity to discover the problem earlier from the self-critical analysis of the PG&E Technical Review Group. Self-critical analysis is an indicator of integrity in the program. The scope of TRG investigation included consideration of similar problems on other components and the formation of a hold-down bolt "hit team" to track corrective actions and ensure completion of inspections of all components identified as a result of this TRG. MFP Exh. 83 at 8, 9. The analyses and corrective actions of the TRG appear reasonable; there is no contrary evidence.

We find that root-cause analysis and broadly based corrective action are indicators of strength in the maintenance program. The deficiencies described herein could have been discovered earlier; however, that has no implication for the safety of future operations because the lessons from this occurrence were learned and incorporated into the maintenance program. The Board finds that MFP Exh. 83 demonstrates a now-properly-functioning maintenance program and is not now supportive of an adverse conclusion on that program.

23. Reactor Coolant System Leakage

MFP Exhs. 84 and 85 are an NCR and LER, respectively, that describe an incident of excessive reactor coolant system (RCS) leakage that occurred at Diablo Canyon Unit 2 on August 13, 1991. MFP Exh. 84 (DC2-91-MM-N069 D14, 2/2/93); MFP Exh. 85 (LER 2-91-004-00, 9/16/91). There is no dispute
among the parties that excessive RCS leak rates existed; that the leakage was not promptly detected because of personnel error in calculation of leak rates; that the error resulted in a violation of a Technical Specification (reported to NRC in the LER); and that the leakage occurred in the body-to-bonnet joint of check valves in the Chemical Volume Control System (CVCS). The valves had degraded studs from boric acid corrosion. The full description of this event is given in MFP Exhs. 84 and 85 and the Board adopts MFP FOF ¶¶402-408 as uncontested findings of fact that summarize the foregoing occurrences.

MFP asserts that PG&E failed to establish an effective surveillance program that would have prevented or detected the degradation and leakage despite prior industry communications on this subject. It asserts further that PG&E’s corrective action is of questionable effectiveness, vague, indefinite, and lacking in commitment. MFP FOF ¶¶409-420. It also claims that this incident is contributing evidence to a general conclusion of programmatic deficiency in the surveillance and maintenance program because safety systems were threatened; there was untimely detection and correction of aging effects; and there was generally inadequate surveillance and testing (outline ¶¶I.A, II.C, IV.C). MFP FOF ¶¶26-27, 36-37, 49-50.

MFP filed no proposed findings on the personnel error that led to failure to meet a Technical Specification as set forth in MFP Exh. 85, and we treat that issue as abandoned.

PG&E asserts that its corrective actions were effective and its existing surveillance procedures are adequate to detect leakage. PG&E FOF ¶M-A109. The Staff asserts that this occurrence does not evidence a breakdown in the overall program. Staff FOF ¶I-181.

The Board finds that prior to this incident PG&E had effective procedures for detection of leaks from the RCS but did not have a preventive maintenance program for the inspection and retorquing of valve bolts or for inspection of gaskets or for the detection of boric acid corrosion on bolts. MFP Exh. 84 at 2-5, 9; Tr. 1185-86 (Giffin, Vosburg).

As a result of this incident PG&E inspected and maintained seventeen additional Unit 2 valves and developed additional corrective actions to replace nuts and studs showing corrosion and to retorque all nuts on valves. A “hit team” program was developed for replacing bolting on valves that have carbon steel (B7) bolts that are exposed to boric acid with stainless steel bolts. The bolt replacement has been accomplished. This eliminated the problem of bolt corrosion from boric acid because stainless steel bolts are resistant to corrosion. Tr. 1184 (Giffin).

The Board rejects for lack of evidence MFP’s assertions that the corrective actions adopted by PG&E are vague, indefinite, or lacking commitment. The corrective actions summarized above and set forth in detail in MFP Exh. 84 and in PG&E testimony appear to the Board to be clear and understandable.
Contrary to MFP FOF ¶¶418-420, we find it commendable rather than sinister that PG&E took “prudent actions” in addition to “corrective actions to prevent recurrence” as a result of this incident. There is no evidence that “prudent actions” will not be implemented.

Although MFP is correct in its assertion that PG&E had no preventive maintenance program that would have directly prevented or detected degradation of bolts prior to the incident described herein, the Board rejects MFP’s assertion of PG&E negligence (MFP FOF ¶¶409-411). Industry and regulatory documents cited only by title in support of that assertion are not before us and, without Board knowledge of their contents, are not adequate evidence to support such a finding. We also reject MFP’s assertion that no information exists on the condition of Unit 1 valves (MFP FOF ¶412). They have been inspected for leakage. Tr. 1182 (Giffin). Moreover, MFP’s exhibit is an account of events that took place at Unit 2; it is neither alarming nor significant that it contains no information on the condition of valves in Unit 1.

There is no basis for concluding that a preventive maintenance program targeting valve bolts and gaskets should have been in place earlier. Reasonable minds may well have decided initially that leak detection was adequate to protect the reactor from excessive loss of coolant, as proved to be the case here. Staff FOF ¶I-180. MFP simply disagrees; however, the dispute is academic. PG&E has now adopted the additional inspection and maintenance procedures for retorquing of bolts, and for detection and prevention of corrosion as advocated by MFP. These actions resulted in improvements in the effectiveness of the maintenance and surveillance program. The Board does not find the prior program defective simply because it was later improved as a result of operating experience. The program improvements adopted by PG&E in this case contribute to a finding of reasonable assurance of safety in future operations. The Board rejects as unsupported MFP’s assertion that this incident is evidence of a generally defective surveillance and maintenance program.

24. Reactor Cavity Sump Wide-Range Level Channel 942A Inoperable

The issue of inoperable channel 942A requires the Board to decide whether the particular failures of equipment and personnel that occurred are also evidence supporting a general finding of programmatic deficiency in the PG&E surveillance and maintenance program.

MFP Exhs. 86-89 describe events related to two occurrences of an inoperable reactor cavity sump wide-range level channel. MFP Exhs. 86 (DC2-91-TINO96 D8); 87 (PG&E Letter No. DCL-92-090, 4/20/92); 88 (NRC Letter to PG&E with NOV attached, 2/28/92); 89 (PG&E letter No. DCL-92-071, 3/30/92). These channels are instruments used to provide post-accident water-level data inside containment. The data are used to verify the occurrence of
a loss-of-coolant accident (LOCA). Two channels are required by Technical Specifications to be operational when the reactor is in one of several specified operational modes. MFP Exh. 89 at 1. The channels are not the only way of detecting a LOCA; other redundant means for doing so exist at DCPP. Tr. 1200-01 (Vosburg).

The first equipment malfunctions occurred in 1990 when two channels became inoperable and were not detected by operators from August 21, 1990, to November 6, 1990. The failure to detect the malfunctions resulted in a violation of a Technical Specification which was reported to NRC in an LER. The second incident began with a channel instrument malfunction on October 10, 1991, that went undetected until October 22, 1991, when an NRC Inspector found it by reviewing the Safety Parameter Display System (SPDS). The failure to detect the malfunction for more than 7 days with the reactor in mode 2 (startup) or mode 3 (hot standby) was a violation of a Technical Specification and NRC issued a Severity Level IV NOV. PG&E acknowledged the violation in its response to the NOV. MFP FOF ¶¶ 421, 423, 424; MFP Exh. 89 at 1.

NRC's cover letter with the NOV was critical of PG&E for taking inadequate corrective actions in the 1990 event that failed to preclude the 1991 undetected failure. MFP Exh. 88. NRC's main concern was for inadequacy of the operator surveillance program that resulted in failure to detect equipment malfunction. NRC has only minor concern for the equipment failure itself, which it regards as a common occurrence. Tr. 2199 (Narbut).

MFP requests the Board to find with respect to this incident that PG&E's corrective actions to train operators after the 1990 event were inadequate to prevent recurrence of undetected equipment failure. MFP FOF ¶¶ 425-427, 429-430, 431-433. It also asserts that the SPDS system is not maintained adequately. Finally it argues that this issue is relevant to maintenance and surveillance even though the personnel failure that led to the NOV was by control room operators rather than maintenance personnel. MFP also asserts that this incident supports a conclusion of general deficiency in the PG&E surveillance and maintenance program because it is part of a more general pattern: it involved safety systems; PG&E's response was lax and untimely; the problem recurred; and surveillance was inadequate (outline ¶¶ I.A, II.A, II.B, IV.C).

PG&E minimized the significance of the equipment and personnel failure because the incident is isolated and now resolved; it involved operator failure which does not reflect on PG&E's ability to maintain equipment; failed indicators are not uncommon; and the majority of its corrective actions are effective. The NRC Staff sees no general deficiency in the maintenance program because operator knowledge problems are not widespread and subsequent corrective actions were effective.

The Board finds that MFP's assertion of inadequate corrective action in 1990 that permitted recurrence of equipment malfunction and operator failure to detect
a malfunctioning channel in 1991 is true and uncontested in this case. No root cause was found for the equipment failures in 1990 or 1991, and correction was finally achieved by replacing the affected equipment and cables. Cause for the operators’ failure was their reliance on a misleading chart record and their failure to understand indications of failed channels shown on the SPDS despite instructions issued in 1990. Tr. 1191-96 (Vosburg, Crockett). However, corrective actions on equipment have been effective and there have been no channel failures since the 1991 incident. Tr. 1199 (Crockett). Surveillance of the SPDS by control room personnel is now adequate. The issue is closed. Tr. 2200-01 (Miller).

Corrective action is an integral part of the surveillance and maintenance program. Even though equipment and personnel failures occurred, the program cannot be found generally deficient if corrective action was prompt and effective. The fact that correction took two tries in this case was not unreasonable under the circumstances. Resolution of the intermittent equipment problem was difficult but there was no evidence of laxness, lack of diligence, or lack of commitment in addressing it. Between the 1990 and 1991 incidents, four 942A channel failures occurred but none exceeded the 7-day technical-specification action statement. These failures did not go undetected and there is no evidence of prior warning of deficient surveillance by operators during that period. The issue is now closed and there is nothing left of it that undermines reasonable assurance of safe operation during the recapture period.

The Board rejects for lack of evidence all of MFP’s assertions alleging that the SPDS system is unreliable. No record exists to support a conclusion about the reliability of the SPDS system. MFP cites unrelated equipment failures that do not support its proposed findings on the reliability of the SPDS. Contrary to MFP’s claim, there is no regulatory requirement for the SPDS to be seismically qualified (Tr. 1197 (Giffin)). Allegations of unreliability in the SPDS are without merit.

Contrary to MFP’s claim, the failure of control room operators to perform adequate surveillance in this case has no general adverse implication for the adequacy of the surveillance and maintenance program which is the subject of the admitted contention.

The Board concludes that the particular failures of equipment and personnel occurred as alleged by MFP but these failures do not support an inference of programmatic deficiency in the PG&E surveillance and maintenance program.

25. Design Criterion Memorandum (DCM) Requirements

The issue raised by MFP based on Exh. 90, MFP FOF ¶¶446, 450, requires the Board to decide whether the review of design documentation undertaken by PG&E shows a programmatic weakness in the surveillance and maintenance
PG&E conducted an audit (as part of an upgrade project) to determine the adherence of its maintenance program to its administrative requirements (Design Criterion Memorandum Category I (DCM)). The purpose of the audit is to remove discrepancies between design documents and the surveillance and maintenance program. PG&E regards this as an important purpose, as does NRC. The upgrade program for category I devices was expected to be completed by the end of 1993. Tr. 1204-09 (Crockett).

In the course of the audit, PG&E encountered a discrepancy wherein no test exists to provide verification of the emergency diesel generator fuel oil day-tank low-level switch transfer pump start signal actuation. MFP Exh. 90 at 2. Although the equipment discrepancy in this instance should be removed, the finding itself is of minor significance because, when the diesels start automatically, operators start the pumps manually and do not rely on the switch. Tr. 1203-04 (Crockett).

MFP FOF ¶¶448-449 appear to agree with PG&E as to the necessity for the design document review, the necessity for it to be completed, and the need to make changes that result from it. There is no controversy in those assertions in need of resolution inasmuch as PG&E testimony shows that that is its intent. We reject, for lack of evidence, MFP's assertion that the review should be extended to include "Class 2" equipment. There is no mention of that matter anywhere in the record and the Board has no basis to decide it. We also reject MFP's concern that there is uncertainty as to PG&E's commitments to NRC. No record was developed on that matter at the hearing, and NRC has not addressed it.

The Board concludes that there is no evidence at all related to the DCM issue that contributes to a finding of general programmatic weakness in the surveillance and maintenance program. Critical self-assessment, voluntarily undertaken by PG&E, indicates program strength, not weakness. The Board rejects any possible implication by MFP that voluntary program improvement by PG&E, per se, supports an inference of prior program deficiency. MFP's assertions in the DCM issue are without merit and are rejected in their entirety.

26. Pipe Support Snubber Damage

The issue raised by MFP based on Exhs. 91 and 92 calls upon the Board to decide whether an incident involving a damaged pipe support snubber is evidence of a generally deficient surveillance and maintenance program at DCPP.

[29 See also PG&E Exh. 23 (DCO-93-TN-N006, August 23, 1993), which is an updated version of MFP Exh. 90.]
MFP Exh. 91 (NCR DC1-92-MM-N021, Rev. 00, February 12, 1993); MFP Exh. 92 (PG&E Letter No. DCL-92-264).

MFP claims that the snubber failure contributes to a conclusion of general programmatic deficiency because it shows that PG&E lacks a program to detect manufacturing deficiencies or internal defects and it thereby did not prevent the snubber failure (outline ¶IV.F). MFP FOF ¶¶57, 58, 59, 454, 455. PG&E claims that the failure is due to a manufacturing defect that does not implicate maintenance and that the defect could not be detected absent disassembly of the snubber. PG&E FOF ¶M-124. The Staff agrees with PG&E. Staff FOF ¶1-196.

PG&E found the damaged snubber during a system walkdown in May 1992. The snubber was locked and buckled. Root-cause analysis showed that the failure was due to an out-of-tolerance condition on the interior stainless steel verge wheel combined with stress and chloride exposure from salt air at an outdoor location. The out-of-tolerance condition resulted from a manufacturing defect that led in turn to excessive stress in service. The wheel failed under excessive tensile stress due to stress corrosion cracking. PG&E tested and overhauled or replaced other snubbers similarly situated. MFP Exh. 91 at 3-4.

MFP is correct in its claim that PG&E did not have a program in place that would have prevented this failure. However, MFP cites no regulatory requirement that would obligate PG&E to devise such a program, and we know of none.

MFP Exh. 91 discusses the regulatory scheme governing snubbers. There is a Technical Specification requirement that all snubbers be operable during specified plant operations with some exclusions for non-safety-related systems. Technical Specification 3.7.7.1 requires that when a snubber becomes inoperable it be replaced or restored to operable status within 72 hours from the time of discovery. The regulatory scheme therefore relies on corrective action and obligates PG&E to correct snubber failure within a specified time period. MFP Exh. 91 at 2.

The PG&E corrective maintenance program is recognized with approval by NRC. Staff Test., ff. Tr. 2159, at 2 (Peterson), 5-7 (Narbut, Miller). Corrective maintenance is a normal part of the surveillance and maintenance program. PG&E Test. at 38-41 (Ortore, Giffin). The program therefore cannot be found generally deficient solely because equipment failure was not prevented or because corrective action was necessary to restore failed equipment. PG&E has a program for the inspection and testing of snubbers. The program would not detect internal stresses on components or manufacturing defects before failure. There is no evidence that effective preventive maintenance could have been devised to prevent failure from manufacturing defects. Such a program would require disassembly of snubbers for the purpose of determining manufacturing tolerances of components. There is no assurance that component stress or corrosion would be present and visible when disassembly was undertaken. Tr.
1218 (Giffin). No expert has advocated that PG&E devise such a preventive
maintenance program.

MFP has not cited any deficient or inadequate corrective action taken by
PG&E in this incident and we found none in our review of the record. We find
that PG&E had no regulatory obligation to undertake a preventive maintenance
program for the purpose of preventing the snubber failure that occurred. There
is no evidence that such a program would improve safety because the failure was
a unique and isolated case. MFP Exh. 91 at 4. The Board finds that the snubber
failure has no adverse implications regarding the programmatic adequacy of the
PG&E surveillance and maintenance program.

27. Gas Decay Tank Missed Surveillance

The issue of the missed gas decay tank surveillance is based on MFP Exhs.
95 and 96 and requires the Board to decide whether this incident is part of a
pattern of missed surveillance tests that reflects a programmatic weakness in the
surveillance testing program.

MFP asserts that this incident is part of a pattern that demonstrates a weakness
in PG&E's surveillance testing program. This incident is said to be evidence
of a general program deficiency because it is part of a pattern of disabled or
threatened safety systems and part of a repetitive pattern of missed surveillances
this incident does not reflect a pervasive problem and does not represent a
programmatic breakdown. PG&E FOF ¶M-A128. The NRC Staff asserts that
this incident has nothing to do with the maintenance program at Diablo Canyon
and that it does not represent a programmatic breakdown. Staff FOF ¶I-201.

In this incident, a 24-hour gas decay tank surveillance required by Technical
Specifications (TS) was not performed within required time limits. The test was
performed about 2 hours later than required. The late test counted as a missed
surveillance and a TS violation that resulted in the preparation of an NCR and
an LER submitted to the NRC. MFP Exhs. 95, 96.

The root cause of the missed surveillance was an inadequate instruction given
to the technician. The instruction said the test should be performed daily when
it should have said the test was required by Technical Specifications to be
performed every 24 hours. Contributing to the error was the fact that the errant
chemistry technician had forgotten the requirements although he had previously
received 20 hours of instruction on them. MFP Exh. 95 at 5-6, 13. When
circumstances required that he defer the surveillance, he did so without regard to
the expiration of the TS time requirement. Corrective actions included revising
the instructions and counseling the technician.

The Board finds that root-cause determination and corrective action taken
by PG&E were adequate as stated in MFP Exhs. 95 and 96 because there is
Corrective action is an integral and necessary component of a surveillance and maintenance program. When performed adequately, corrective action provides reasonable assurance of safety in future operations with respect to the specific incident at issue. The fact that reliance is placed on corrective rather than preventive action is not *per se* an indication of programmatic deficiency. It is the failure of corrective action that leads to concerns for the adequacy of a program. Thus, there is no regulatory requirement to prevent all unwanted events even though MFP would have it so. Moreover, where corrective action has been adequate and the incident is properly brought to a close, the incident itself cannot logically be used as cumulative evidence of programmatic deficiency. For all of the foregoing reasons, the Board concludes that the incident of the missed surveillance is not evidence of a general programmatic deficiency in the PG&E surveillance and maintenance program.

28. *Seismic Clips Not Installed*

MFP Exh. 98 is an NCR that describes and analyzes events surrounding the discovery on December 3, 1992, that Unit 1 reactor trip and bypass breakers did not have seismic clips installed as required by plant procedures. The nonconforming condition existed from the time of Unit 1 restart on November 3, 1992 to December 3, 1992, when it was corrected. MFP Exh. 98 at 2-5 (NCR DC1-92-OP-N062, Rev. 0, January 27, 1993).

MFP asserts that this event contributes to a conclusion of general programmatic deficiency in the surveillance and maintenance program because: PG&E root-cause analysis identified a programmatic deficiency; prior corrective action in a similar event did not prevent this one; other contributing causes such as personnel inattention further demonstrate program weakness (outline III.A, II.B, IV.A, IV.E). MFP FOF ¶¶467-472.

PG&E claims that it corrected the problem promptly; no inoperable conditions existed without seismic clips; it is making programmatic corrections. PG&E FOF ¶¶M-A132 through M-A134. The Staff agrees with PG&E and claims that this isolated event is not indicative of pervasive programmatic failure. Staff FOF ¶¶I-202 through I-205.

There is no dispute concerning MFP’s assertions of procedural error and degraded condition of equipment associated with this incident. Each error is cited directly from MFP Exh. 98, which is PG&E’s self-critical NCR. The Board is called upon to decide whether these errors support an inference of general

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30 MFP did not cross-examine PG&E witnesses on any aspect of the missed surveillance and it did not controvert the adequacy of PG&E’s cause determination and corrective action.
programmatic deficiency in the PG&E surveillance and maintenance program. MFP Exh. 98 at 7; MFP FOF ¶¶467, 468.

The record contains no factual evidence related to this event other than that in Exh. 98 and the testimony of PG&E's experts. As has been MFP's practice, it cites PG&E's documents with precision for the purpose of demonstrating error but takes no account of the analyses and corrective actions that are also set forth in the NCR and testimony. The Board accepts MFP's assertion that error in procedure and degraded condition of equipment existed at the time of the incident. However, PG&E's unrebutted description of corrective actions carries the same weight as its description of flaws, and there is no evidence that PG&E's corrective actions were inappropriate or ineffective. The Board finds them reasonable on its own review. We therefore conclude that with respect to the seismic clips the degraded condition has been corrected and the associated root cause has been identified. No flaw in equipment or procedure is now known to exist on that subject. Therefore there is no basis for an adverse conclusion relative to PG&E's surveillance program or to question the safety of future operations.

The Board rejects MFP's claim (MFP FOF ¶¶469-470) that prior corrective action developed for a similar event did not prevent this incident. The previous case dealt with missing clips on initial installation, whereas the one before us is concerned with reinstallation of clips after routine testing. MFP Exh. 98 at 11, 14; Tr. 1241-43 (Vosburg). The two cases have different causes and the previous corrective actions would not have prevented the event cited here.

The Board concludes that the missing seismic clips incident was resolved and that the incident does not suggest a general programmatic deficiency in the PG&E maintenance and surveillance program.

29. Containment Fan Cooling Unit (CFCU) Backdraft Dampers

MFP asserts that failures associated with Licensee's corrective maintenance of Containment Fan Cooler Unit (CFCU) backdraft dampers over a period of time is evidence of general deficiency in the Licensee's surveillance and maintenance program (outline ¶¶I.B, II.A, II.B, II.C, III, IV.A, IV.C, IV.G). The last of these items (outline ¶IV.G, MFP FOF ¶¶60-61) refers to financial matters involving a ratepayer settlement between PG&E and the State of California and is outside the scope of Contention I.

PG&E and the NRC Staff acknowledge that performance failures in corrective maintenance of backdraft dampers occurred in both units at Diablo Canyon. PG&E Test. at 88-89; Tr. 1261-62 (Giffin); MFP Exh. 100; Staff Test., ff. Tr. 2159, at 8-9. The Applicant and Staff claim that the failures were limited to difficulties in correcting backdraft damper problems and were not indicative of a general breakdown in the PG&E surveillance and maintenance program.
PG&E FOF ¶M-A144; NRC Staff FOF ¶I-217. The Board must decide if the backdraft damper problems outlined herein were of limited scope and significance or if they contribute to a conclusion of general breakdown in the licensee's surveillance and maintenance program.

Each of the DCPP units has five containment Fan Cooler Units (CFCUs) within the containment to provide ventilation and cooling during normal operations and during accident conditions. Each CFCU has a backdraft damper downstream of the fan. The backdraft damper is designed to close on reverse air flow and prevent non-operating fans from rotating in a reverse direction. PG&E Test. at 88 (Giffin).

When a fan is not running, reverse rotation from airflow in the discharge duct is an indicator that the backdraft damper is not closed completely. Reverse rotation of a CFCU fan is significant because at sufficient reverse speed the fan may trip on overload upon receiving a start signal in the event of a LOCA. Containment overpressurization during a LOCA is a possible consequence in certain analytical scenarios involving three non-operational CFCUs with stuck-open backdraft dampers. MFP Exh. 102 at 8-9.

The Applicant has a history of finding reverse CFCU fan rotation in one or both units during inspections dating back to 1986. Corrective maintenance taken between 1986 and 1991 on failed backdraft dampers included replacement of parts, design changes in damper linkages, and addition of springs to assist damper closure. Nevertheless, reverse rotation was observed in a Unit 1 CFCU during an inspection in March 1991. PG&E decided that no corrective action was needed. In January 1992, two backdraft dampers were found in Unit 2 with counterweights that had fallen off. Other counterweights were found to be too loose.

Inspection of counterweights in Unit 1 determined that they were attached but some were installed too tightly. The Applicant concluded by analysis that this would not affect performance of the CFCU safety function. However, three CFCU backdraft dampers were found stuck open in a February 19, 1992 inspection of Unit 1. It was also found that some damper linkage bars had previously been installed incorrectly on two of the dampers, and that there were degraded bolting problems on some dampers. The Applicant concluded and reported to NRC that three Unit 1 backdraft dampers were inoperable, that the condition was outside the design basis of the plant, that it had entered the applicable Technical Specification, and that the condition had potentially existed since March 1991. Operability of all three CFCUs was restored by February 26, 1992. MFP Exh. 102 at 4; MFP Exh. 103 at 5. The Applicant subsequently determined in consultation with Westinghouse that the stuck-open dampers did not render the CFCUs inoperable and that the plant had continuously met its Technical Specification requirements for the number of operable CFCUs.
between March 1991 and March 1992, when the correct design configuration was restored. MFP Exh. 103 at 9.

The Applicant reported to NRC in early April 1992 that all five Unit 1 backdraft dampers and one in Unit 2 had been overhauled and inspected. All Unit 2 dampers had been inspected and found to be correctly assembled. Subsequently, in April 1992, the Applicant found reverse rotation in a Unit 2 fan, counterweights installed too tightly in Unit 2 dampers, and washers installed in Unit 2 dampers contrary to approved design. Corrective work was completed on these problems near the end of April 1992. MFP Exh. 102 at 2-7.

The Applicant reported to NRC that the root cause of its problems with the backdraft dampers was failure to perform proper maintenance. Contributing causes were found to involve management underestimation of safety significance, poor planning of damper work, inadequate work instructions, inadequate job turnover, no Quality Control involvement, inadequate Plant System and System Design engineer involvement, inadequate post-maintenance testing, and missed opportunities from prior problems. MFP Exh. 103 at 8.

NRC issued an NOV to PG&E in June 1992, listing three Severity Level IV violations related to the CFCU backdraft damper problems. The violations were: (A) Work order instructions were not implemented; (B) Inspection of Unit 2 CFCUs done without appropriate procedures; (C) Failure to correct reverse rotation in CFCU 1-5 from March 27, 1991, to February 22, 1992. NRC accepted PG&E’s analysis of operability in the matter of the three Unit 1 CFCUs with stuck-open backdraft dampers and did not cite the company for violation of the applicable Technical Specification.

Later during the period September 25, 1992, to November 13, 1992, the Applicant found cracked backdraft damper blades in both Units. It determined that this was a condition potentially outside the design basis of the plant. None of the blades failed in normal service. However, PG&E concluded that longitudinal cracks were of sufficient length to result in blade failure if challenged by the postulated design-basis LOCA pressure wave. The Applicant reported in its LER of November 17, 1992, that it had replaced the blades in Unit 1 with blades made of fatigue-resistant material and had plans for Unit 2 blade replacement at the next scheduled outage. MFP Exh. 101. All blade replacement has now been completed. PG&E Test. at 89 (Giffin).

The Board finds that the matter of cracked backdraft damper blades was resolved promptly and effectively. There is no record of improper maintenance. This matter is unrelated to the issues previously discussed in this section. The Board concludes that this episode does not contribute to a concern for possible programmatic deficiency in the Applicant’s surveillance and maintenance program. Tr. 1254-55 (Giffin).

The Board concludes that the problems cited in the Staff IR, the Staff NOV and in Staff testimony show that there were deficiencies in PG&E management
and in the performance of the Applicant’s system engineers, maintenance engineers, corporate engineers, and maintenance personnel regarding the repair and maintenance of backdraft dampers. However, there is no evidence that any of these deficiencies are related to improper financial considerations, as alleged by MFP. The Staff concluded that there was inadequate implementation of basic engineering instincts. Tr. 2210-11 (Miller); NRC Exh. 2; MFP Exhs. 102, 140. PG&E was concerned about organizational deficiencies and later undertook a general inquiry into maintenance practices on the HVAC system. MFP Exh. 100; Tr. 1255-56 (Giffin).

The Board concludes that repetition of this poor performance in other aspects of the Applicant’s maintenance program would raise serious questions about programmatic effectiveness. The Staff characterized PG&E’s performance in this instance as “the biggest black mark in the past few years.” However, this performance has not been widely repeated in other aspects of the Applicant’s maintenance program. The Staff evaluated the Applicant’s performance in the CFCU problem in context with its overall performance in maintenance and found it to be an isolated event. The Staff gave a superior SALP rating to the maintenance program in full consideration of the CFCU problems. Tr. 2214-16 (Miller, Peterson, Narbut).

The Staff’s testimony is credible and entitled to substantial weight. There is no credible contrary evidence. The Board therefore concludes that the Applicant’s poor performance in the CFCU problem was isolated and not repeated throughout the maintenance program. We find that the CFCU problem at Diablo Canyon does not support an inference of general programmatic deficiency in the maintenance program and we reject MFP’s FOF to the contrary. However, we are including the interrelationship of engineering and maintenance, as reflected in the CFCU maintenance problems, as one of the series of examples giving rise to the need for a study to improve interdepartmental communications regarding maintenance activities that we are directing PG&E to perform.

30. Control of Foreign Material/Cleanliness/Housekeeping

MFP asserts that a variety of incidents involving unattended debris and foreign materials left inside containment have occurred at both units of Diablo Canyon, allegedly starting in 1985 and extending to December of 1992. According to MFP, problems involving debris and foreign material have safety significance, have occurred repeatedly, and have not been effectively resolved by PG&E despite numerous opportunities to do so. It urges the Board to find that
PG&E's control of foreign materials is inadequate and unacceptable. MFP also urges adoption of findings of general deficiency in the PG&E surveillance and maintenance program (outline ¶¶ I.A, II.A, II.B, IV.E).

There is no dispute by PG&E or the NRC Staff that the incidents of debris and foreign material in containment occurred as claimed by MFP. PG&E responds that the incidents cited by MFP are only loosely connected to one another and they collectively do not show a pervasive problem of foreign material or debris control in containment. PG&E FOF ¶¶ M-A145, M-A146. PG&E claims further that past problems with debris control have been corrected and current housekeeping in the plant is unassailable. PG&E FOF ¶ M-A156. The NRC Staff claims that the events cited by MFP are few in number, unconnected with one another, and are not evidence of any general breakdown in the Applicant's surveillance and maintenance program. Staff FOF ¶I-228.

The Board is called upon to decide whether the incidents cited by MFP of debris or foreign material periodically left in containment collectively indicate a programmatic deficiency in the PG&E surveillance and maintenance program.

a. Foreign Material Exclusion

MFP Exhs. 107 and 108 document a series of violations involving loose tools in containment, untimely personnel actions to correct foreign material exclusion deficiencies, failure of corrective actions to prevent repetition, and loss of cleanliness controls. The violations occurred over a short period of time from March through May 1988. NRC issued NOVs citing PG&E with first a Severity Level V violation (MFP Exh. 108) and later a Severity Level IV violation (MFP Exh. 107).

PG&E's replies to the NOVs are documented in PG&E Exhs. 25 (PG&E Letter No. DCL-88-150, June 6, 1988) and 26 (PG&E Letter No. DCL-88-184, July 18, 1988). The Applicant outlined its corrective actions which included development of foreign material exclusion procedures, revision of administrative procedures to ensure compliance with cleanliness controls, revision of procedures to require Quality Control Department surveillance of housekeeping in containment when the reactor vessel is open, and additional training for personnel. PG&E acknowledged that corrective actions stated in Exh. 108 (issued May 5, 1989) did not prevent the loss of cleanliness control cited in Exh. 107 (issued June 17, 1989).

31 MFP relies on the following exhibits consisting of NRC and PG&E regulatory documents in support of its assertions: MFP Exh. 105, NRC IR 92-31 (12/11/92); MFP Exh. 106, NRC Diablo Canyon Shutdown Risk and Outage Management Inspection, NRC IR 50-275/92-201 (12/8/92); MFP Exh. 107, NRC IR 88-10 and 88-11 (6/17/88); MFP Exh. 108, NRC NOV in IR 88-07 (5/5/88); MFP Exh. 109, NCR DC2-91-TN-N102 R2 (11/18/92); MFP Exh. 110, NCR DC0-91-MM-N042 (5/19/92); MFP Exh. 111, LER 2-91-012-00 (3/5/92); MFP Exh. 113, PG&E reply to NOV in NRC EA 89-241 (3/12/90); MFP Exh. 35, PG&E Self-Evaluation of DCNPP (7/93).
MFP Exh. 110 is an NCR issued May 19, 1992, that analyzes programmatically several instances of loss of foreign material exclusion area (FMEA) controls of the type described in MFP Exhs. 107 and 108. FMEA controls are for the purpose of preventing entry of loose parts into the reactor coolant system during refueling or maintenance activities. Root cause for several instances of loss of FMEA controls was found to be due to management failure to implement the FMEA program as described in applicable administrative procedures. Contributing causes included "lack of ownership" on FMEA jobs, inconsistent interpretation of requirements, procedures not user friendly, management expectations not communicated, and insufficient FMEA boundary identification. The Technical Review Group (TRG) conducted a thorough investigation and recommended many corrective actions. There is no evidence that the corrective actions were ineffective and they appear reasonable to the Board. MFP Exh. 110 at 5-14.

MFP Exh. 113 (March 12, 1990) is PG&E's reply to an NRC NOV in which it acknowledges three violations that in the aggregate were categorized as a Severity Level III violation applicable to Units 1 and 2 containment recirculation sumps. One of the aggregated violations was for an inadequate inspection of the Unit 1 containment sump for loose debris. Debris that could cause restriction of sump suction during a LOCA was found inside the upper grating assembly of the Unit 1 sump by an NRC inspector. The inadequate PG&E inspection was due to individual failure to implement a clear procedure. PG&E Test. at 106 (Crockett). PG&E took several corrective actions including initiating video probe inspection of sump pipes and valves for debris, revision of technical and administrative procedures to ensure attention to recirculation sump cleanliness, implementation of foreign material exclusion requirements for sump activities, and establishment of foreign material exclusion requirements for sump suction piping during refueling outages. There is no evidence challenging the effectiveness of the corrective actions and the Board sees no reason to do so. This violation has not been repeated. Tr. 1508-09 (Crockett).

b. Unattended Material in Containment

MFP Exh. 111 is an LER issued in March 1992 reporting unattended tools and debris found in Unit 2 containment in October 1991 and Applicant failure to meet the containment inspection requirements of TS 4.5.2.c after containment integrity was established. MFP Exh. 109 is an NCR issued November 18, 1992, documenting the debris control problems in Unit 2 containment cited above. The root cause for this event was determined to be "lack of a comprehensive program for control of material after containment integrity has been established." A contributing cause was lack of understanding of requirements by some individuals who failed to complete a required data sheet certifying that a visual
inspection had been performed and no loose debris was present in containment. To correct the problem the Applicant established a comprehensive new program for control of material in containment, and trained personnel in the procedures. MFP Exh. 109 at 9-12, 23-25.

MFP Exh. 105 is an NRC NOV issued December 11, 1992, citing PG&E with a Severity Level IV violation for corrective actions (described above for Unit 2) that were ineffective to prevent uncontrolled materials inside Unit 1 containment when containment integrity had been established. Loose, unattended materials were found near the Unit 1 containment sump on November 5, 1992, after containment integrity had been established. The safety significance of this event was low and Applicant’s proposed corrective actions (offered immediately at the exit meeting) were accepted by the NRC Staff as adequate to correct the deficiency. MFP Exh. 105 at 6-8.

c. Other Material Control Issues

MFP Exh. 106 is an NRC IR documenting a 1992 Staff shutdown risk and outage management inspection conducted in part by headquarters Staff. A deficiency was found in which a \(\frac{3}{8}\)-inch instrument tubing disconnected for maintenance was not capped to prevent entry of foreign material. The Applicant had no procedures to control entry of foreign material into disconnected instrument tubing. This was the only FMEA deficiency cited and the team found in general that the housekeeping and material control throughout the plant were strengths. MFP Exh. 106 at 20-21, A-3. PG&E added the missing requirement to its procedures for instrumentation. Tr. 1516-17 (Crockett). This was an isolated event of low safety significance that was corrected by minor procedural changes. It has no implication for the programmatic adequacy of Applicant’s surveillance and maintenance program. Tr. 2237-38 (Miller). The Board gives it no weight in its decision.

MFP Exh. 35 is a PG&E self-evaluation of Diablo Canyon issued in July 1993. Deficiencies in the performance of some supervisors with responsibilities for housekeeping and programmatic deficiencies in implementation of housekeeping practices were found. MFP Exh. 35, MA.1-1, MA.2-1. Deficiencies related to uncontrolled debris refer specifically to material found in the Turbine and Auxiliary Buildings for which we have no evidence on safety significance. The report concludes that “minor housekeeping discrepancies remain high.” The NRC Staff, however, finds the plant clean and in a general state of good house-

\[32\] All previous evidence on the safety significance of debris relates to its significance in containment where sump screens could become clogged during an accident or foreign material could inadvertently enter the reactor coolant system. There is no similar evidence in the record for the Turbine Building or Auxiliary Building.
keeping. Tr. 2239-40 (Miller, Narbut). The Staff inspector occasionally finds material on the floor but the plant staff takes care of it quickly.

We conclude that there is likely a continuing flurry of minor housekeeping discrepancies at Diablo Canyon. This has no adverse implications for the surveillance and maintenance program because there is no evidence that the discrepancies cited in MFP Exh. 35 have safety significance. The overall housekeeping program produces generally good results. We find the self-critical analyses displayed in MFP Exh. 35 to be a programmatic strength because they focus attention of plant personnel and supervisors on the continuing need to be alert for developing problems. Minor housekeeping deficiencies at DCPP are entitled to no weight in the licensing decision before us and we reject MFP FOF to the contrary.

d. Board Analysis

The Board has considered the cluster of exhibits on material control in the light presented by MFP (i.e., that in the aggregate they would show a programmatic deficiency in material control in containment which in turn would contribute to an aggregate finding of pervasive deficiency in the plant surveillance and maintenance program). Based on Staff testimony and the exhibits themselves, we conclude that the Applicant had programmatic-level problems both in the control of debris in containment and implementation of FMEA requirements during the 1988 time frame and thereafter. In both areas, PG&E and Staff analyses found programmatic deficiencies. There was repetitive occurrence of deficiencies after corrective actions had been taken. Root causes were related to adequacy of management, adequacy of instructions to personnel, adequacy of technical procedures, and comprehensiveness of corrective actions. The difficulties were corrected, however, and recent inspections show little or no deficiency with material control in containment. Tr. 2236-40 (Miller, Narbut).

It does not aid the inquiry to further aggregate deficiencies related to FMEA issues with those related to debris in containment absent evidence, which is lacking here, that deficiencies in different categories are traceable to the same procedures, personnel, or management. We conclude that the Applicant and Staff are correct to distinguish deficiencies into separate categories because this is the way they are identified, analyzed, and corrected in practice. Tr. 2235-36 (Miller).

In presenting its case through exhibits prepared by PG&E or the Staff, MFP ignored corrective actions that appear in the same or associated exhibits that are relied upon to show deficiencies. However, we do not read these documents selectively but consider both the deficiency and the corrective actions they describe to be equally credible. Therefore, in general, a deficiency such as this one that has been resolved for the purpose of enforcement will not rise
to the importance of mandating denial of the license extension. We do not sit to sanction PG&E for past deficiencies or violations of NRC regulations.\textsuperscript{33} Our inquiry is related only to whether the plants are being sufficiently well maintained that they can be operated with reasonable assurance of safety in the requested license recapture periods. Thus, for MFP's case to be persuasive, there must be evidence that there are current serious defects in the surveillance and maintenance program which the Applicant is either unwilling or unable to correct.\textsuperscript{34} The record does not support that view.

The Applicant's and NRC Staff's testimony were persuasive that such defects or impediments to correction do not exist in matters relating to debris in containment and we find that the past safety-significant deficiencies cited by MFP have been adequately corrected. For all of the foregoing reasons we reject MFP's FOF on debris issues in their entirety and find that PG&E has carried its burden of proof on the issues of debris and foreign material exclusion in containment.

31. Steam Generator Feedwater Nozzle Cracking

A steam generator feedwater nozzle is a 20-inch-diameter piping connection through which feedwater flows into each steam generator. The nozzles and immediate upstream piping are susceptible to interior surface cracking caused by thermal stress that occurs when, on infrequent occasions, cold water flows through a hot nozzle. Ultrasonic inspections of Unit 1 feedwater nozzle welds performed earlier than scheduled during a refueling outage in September 1992 showed some surface cracking. A short piping section and the pipe-to-nozzle welds were replaced on all four Unit 1 steam generators. Later metallurgical investigations showed that the repairs were unnecessary because the cracks were actually smaller than originally thought and within the allowable range of the ASME Code. Calculations showed that the plant could have been operated at least to the end of another refueling cycle, when regular inspections were

\textsuperscript{33} Commonwealth Edison Co. (Braidwood Nuclear Power Station, Units 1 and 2), ALAB-890, 27 NRC 273, 278 (1988). The Appeal Board found on the matter of possible violation of Commission regulations: "But this is not an enforcement proceeding and the issue at hand is thus not whether a sanction should be imposed against the utility because of its asserted noncompliance with a Commission regulation. Rather, we are concerned in this licensing proceeding with whether the Licensing Board correctly authorized the issuance of operating licenses . . . ."

\textsuperscript{34} Commonwealth Edison Co. (Byron Nuclear Power Station, Units 1 and 2), ALAB-770, 19 NRC 1163, 1169 (1984). The Appeal Board observed on the matter of denial of an application "such a result would depend for its validity upon a supported finding that it is not possible for the ascertained quality assurance failings either to be cured or to be overcome to the extent necessary to reach an informed judgment that the facility has been properly constructed." Here the issue is not whether the plant has been properly constructed but whether it has been properly maintained. We conclude, however, that with respect to the maintenance and surveillance program, the application before us could not be denied unless there was a supported finding that maintenance deficiencies could not or would not be corrected. We may impose, and in fact are imposing, conditions to correct certain aspects of the maintenance and surveillance program that we deem deficient.
scheduled, without hazard from feedwater nozzle weld cracking. PG&E Test. at 91-92 (Crockett); Tr. 1536-37, 1540-41, 1551 (Crockett). PG&E has now decided to perform nondestructive testing on main feedwater piping during each refueling outage rather than on the 10-year schedule allowed by the ASME Code. Tr. 1552-53 (Giffin).

MFP Exh. 117 is a voluntary LER (Indications on the Main Feedwater Piping Near the Steam Generator Feedwater Nozzles Due to Thermal Failure, 10/30/92) submitted to the NRC for information purposes that describes the steam generator feedwater nozzle cracking problem. As part of background, it discloses that Unit 1 feedwater nozzle radiography performed in 1986 during the first refueling outage in response to NRC IE Bulletin 79-13 was incomplete. It also discloses that some radiography techniques employed at Unit 1 in 1979, 1986, and 1987 may not have been in full compliance with Bulletin 79-13 requirements. Radiographs on pipes with cracks from the 1992 repairs suggest that the cracks would not have been detected by radiography. PG&E concluded that the errors had no safety significance.

MFP's complaint in this matter arises from its interpretation of the early radiography errors disclosed by PG&E in the LER (MFP Exh. 117). In MFP’s view, the errors that occurred in 1986 and 1987 had safety significance because they were blatant, they remained uncorrected for a long time, and they could have led to serious safety risk had the rate of cracking been more rapid. This exemplifies a maintenance and surveillance program not functioning as it should, according to MFP. MFP FOF ¶552.

According to MFP, most maintenance problems disable or threaten essential safety systems (outline ¶I.A); there is untimely detection and correction of aging effects (outline ¶II.C); and there is inadequate routine surveillance, tests, and inspections (outline ¶IV.C). The foregoing failures are claimed in turn to be contributing evidence of a generally inadequate surveillance and maintenance program at Diablo Canyon.

PG&E concludes that the discovery and resolution of the nozzle cracking problem is an example of the proper functioning of the DCPP maintenance and surveillance program. Tr. 1538 (Crockett); PG&E Test. at 92-93 (Crockett). According to PG&E, the NRC Staff thought that the PG&E analysis of the nozzle cracking problem was reasonable. Tr. 1556 (Crockett); see Staff FOF ¶1-231.

There is no disputed material fact related to the discovery and correction of feedwater nozzle weld cracking in 1992. However, MFP calls upon the Board to agree with its adverse opinion of the 1986 and 1987 errors in radiography. We decline to do so because the issue was not ventilated at hearing; NRC Bulletin 79-13 is not in the record; there is no record of regulatory obligations created for the Applicant by Bulletin 79-13; the safety significance of the errors is not self-evident, coming as they did early in the operating life of the plant; and
PG&E's conclusion of no safety significance is uncontradicted. We find this issue, developed for the first time in MFP's proposed findings of fact, to be speculative.

It is undisputed, however, that in 1992 PG&E found and corrected small surface cracks in the Unit 1 steam generator feedwater nozzle connection welds well before crack growth could have exceeded code-allowable dimensions. Tr. 1553-54 (Giffin). This was effective preventive maintenance. Contrary to MFP proposed general findings of fact for this incident, no essential safety system was disabled or threatened; the detection and correction of the cracks was timely because it occurred before any code allowable was exceeded; the inspection leading to the discovery of cracks was not routine but proactive and it resulted in early detection.

The Board concludes that nothing in this incident undermines confidence in the surveillance and maintenance program at Diablo Canyon. The Board rejects MFP's contrary claims and finds that PG&E has proved its case on the steam generator feedwater nozzle weld cracking issue.

32. Procedural Controls During Shot Peening Operations

Three incidents of unanticipated spread of radioactive contamination and/or airborne radioactivity occurred during inspection and maintenance operations on steam generator hot and cold legs, one on September 25, 1992, one on September 26, 1992, and one on October 2, 1992. Circumstances in all three incidents were similar. In each case a cold-leg manway door was opened while shot peening was being carried out on the hot leg of the steam generator and eddy current testing was being carried out on the cold-leg side. The hot leg was pressurized with dry air and the air from the shot peening operation, while the cold leg was supposed to be under negative pressure from an exhaust system using a high-efficiency particulate air filter, but the open manway door provided a direct outlet for the contaminated air, bypassing the filter. The contamination incidents resulted in an NOV of Severity Level IV. MFP Exh. 118 at 1, 8.

Between the first and second incidents, between the second and third, and after the third, the Applicant took corrective actions in an attempt to forestall recurrence. These included additional instructions for those performing the maintenance and inspection work, and the addition of a checklist to the procedure for the eddy current testing and further instructions for the shot peening procedure. Finally, the air flow direction was reversed after the last incident, moving the dry air input to the cold leg and the filtered exhaust to the hot leg. PG&E Exh. 22 at 9-10.

MFP would have us conclude from this series of incidents that "these factors, taken together with the other deficiencies described [herein], indicate an inadequate maintenance and surveillance program at DCNPP." MFP FOF ¶566

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at 202. MFP categorizes these incidents as ones that disabled or threatened safety systems (outline ¶I.A), as a previous corrective action that failed to prevent recurrence (outline ¶II.B), as representing insufficient communication (outline ¶IV.A), and as an example of inadequate work instructions (outline ¶IV.E).

Both the Staff and PG&E would have us find that "MFP Exhibit 118 can be accorded no weight." PG&E FOF ¶M-A166 at A-70, Reply FOF ¶R-A102 at A-50; Staff FOF ¶I-237 at 95. Both state that the document is "only peripherally" related to maintenance. PG&E FOF ¶M-A166 at A-70, Reply FOF ¶R-A104 at A-50; Staff FOF ¶I-237 at 96. The Staff and PG&E interpret the meaning of the terms "maintenance" and "surveillance" far too narrowly. These incidents were all the results of improper actions on the part of persons performing maintenance and surveillance activities. PG&E sought to correct all of them by improving the training of maintenance and surveillance personnel and by altering or adding to maintenance and surveillance procedures. To say that such incidents do not bear upon the maintenance and surveillance program is to stand logic on its head. Although it is true that the primary purposes of the procedures, eddy current testing and shot peening, may have been accomplished, in our view doing the job includes the notion of doing it safely, without putting plant personnel or public at risk.

We do not, however, find that the incidents noted weigh strongly enough to condemn the entire program or even to call it to question. These were three incidents within the space of about a week in which a one-time operation was attempted for the first and only time. We do not find it surprising that errors of this degree were made, nor are we shocked to note that it took three tries to correct them. The evolution of these incidents reflects somewhat poorly upon the maintenance and surveillance program, but not so poorly as to condemn that program, and the careful analysis and prompt actions taken to correct the flaws weigh heavily in the entire program's favor.

33. Unplanned Activation of Engineered Safety Features (ESF)

MFP submitted as exhibits a series of documents (MFP Exhs. 119, 120, 121, 122, 122A, 123, 124, 126, and 127) describing five incidents in which unplanned ESF actuations occurred. PG&E's analyses of these events and its reports of them to NRC found that personnel error lay at the root of each, as all three parties agree. PG&E FOF ¶¶MA-169 through MA-173 at A70-A72; Staff FOF ¶¶I-240 through I-244 at 96-97; MFP FOF ¶¶573-77 at 205-07.

MFP would have us find that "[i]nadvertent ESF actuations are significant occurrences" and that "the number of personnel errors involving unplanned ESF actuations reflects poorly upon the adequacy of the maintenance and surveillance program at DCNPP" (MFP FOF ¶580 at 207, ¶587 at 209). We cannot agree.
The number of surveillance and testing operations performed annually runs into the thousands. Tr. 834-35 (Crockett). The five instances noted in MFP's exhibits were indeed "benign": careful analysis in each case concluded that no threat existed to the public safety. Although it is true that inadvertent actuations are to be avoided (Tr. 1576 (Vosburg)), they are scarcely the "absolutely horrible" (Tr. 1578 (ZamEk)) matters that MFP, in cross-examination, tried to make them out to be. Indeed, we agree with PG&E and the Staff that, generally speaking, ESF actuations move the plant to a more conservative condition. Tr. 1576 (Vosburg); Staff FOF ¶1-239 at 96; PG&E FOF ¶168 at A-70. For obvious reasons, tripping the plant is to be avoided, and any inadvertent ESF actuation causes undesirable reporting and paperwork. Tr. 1577-78 (Vosburg). But these are not inherently unsafe incidents and they do not appreciably contribute to the wear-out or breakdown of safety-related equipment. Tr. 1580 (Vosburg).

Having read MFP's exhibits in some detail, we are favorably impressed first with the apparent paucity of the mistakes compared to the total number of actions taken per year and second with the diligent and analytical dissection of each error that PG&E carries out, even when the subject error is of little safety significance. We find the overall impression borne by this particular set of exhibits to be very favorable to the maintenance and surveillance program at DCPP.

34. Limitorque Valve Failure

MFP offered two documents concerning a single failure of a Limitorque valve operator. These are, respectively, an NCR and an LER reporting on and analyzing the failure of a Limitorque valve operator during a test of that operator. MFP Exhs. 128, 129; Tr. 1589-90 (Ortore).

Analysis indicated that the operator failed because a locknut and the setscrew intended to secure the locknut had not been tightened properly. The immediate situation was corrected, an investigation was performed to determine the reasons why the locknut was not properly secured, the INPO network was informed of the occurrence, crews were tailboarded on the importance of the proper attention to details on such valves, other similar valves were inspected for loose nuts and set screws, the hardness of the worm gear shafts in other valves was measured and it was found that this factor varied, suggesting that part of the cause was an inability of the set screw to properly hold the locknut, (indeed, contact with the manufacturer disclosed that the material of the worm shaft had been changed), and the procedure for assembly of the locknut was revised to specifically include instructions for tightening the set screw. It was revealed in the course of the investigation that loose nuts were to be found only on valves worked on by one specific technician. MFP Exh. 128 passim.
MFP would have us find that the DCPP maintenance and surveillance program is deficient because it did not catch this problem before it occurred by supplying instructions on the tightening of set screws, measuring the hardness of the worm shafts, and developing a "proper method for securing the lock nut to the worm shaft." MFP FOF ¶94 at 211. We note that even in the state revealed by the test, any suspect valve operators would have been capable of carrying out their safety functions. MFP Exh. 129 at 7. We also note the diligence and completeness with which the investigation was pursued and the sensible steps taken to prevent recurrence. In our view, far from showing any fundamental flaw in the maintenance and surveillance program, this incident and its followup demonstrate the program's strength. This problem, however, represents another example that leads to our conclusion that PG&E should perform a study seeking improvement of interdepartmental communications for maintenance-related activities.

35. Motor Pinion Keys in Limitorque Motor Operators

MFP submitted an exhibit (MFP Exh. 132) concerning failed motor pinion keys in motor-operated valves, and both direct and cross-examination were carried out on witnesses familiar with the exhibit (Tr. 1615-25 (Ortore, Vosburg)). MFP Exh. 132 is a voluntary LER submitted by PG&E concerning an incident in which a motor pinion key failed. The analysis did not show any safety problem, and the LER was submitted on a voluntary basis in order to keep NRC and the industry informed of potential mechanical failures. Indeed, other similar valves were found to be operable even with their motor pinion keys sheared, inasmuch as the friction between motor pinion and shaft is sufficient to operate the valve without the key. MFP Exh. 132, at 3, 6, 7; Tr. 1616, 1618 (Ortore), 1621 (Vosburg).

The key sheared off during the incident because, through a miscommunication between the maintenance personnel and operating personnel, it was subjected to "short stroking" while in a manual mode of operation, an overstressing condition that it would generally not encounter in service. The vendor, in fact, believed that the key was of sufficient strength, but has now changed the design to specify a stronger material. MFP Exh. 132 at 3, 1.

MFP would have us find that the miscommunication that revealed the low strength of these keys "reflects a pattern of miscommunications between maintenance and operations, which has caused other problems in these plants" and that the low strength of the keys and the failed keys in certain valves reflect a "significant number of safety defects in safety components that are found only through luck," and that "PG&E's inability to detect and correct these hidden defects in a timely way could have a significant adverse effect on safety. . . ." MFP FOF ¶¶604 and 605 at 214.
In our view, the fact that the valves were still operable with the internal defect suggests that the hidden defects were not serious safety matters, and the thorough review and analysis of the situation, once discovered, reflects very positively upon PG&E's willingness to analyze and improve its procedures when chance reveals hidden flaws, however inconsequential.

Communications can, of course, always be improved between organizations sharing responsibility for plant maintenance and operation, and in this case we believe they have been. Surely the entire episode does not reflect any fundamental problems in maintenance and surveillance.

36. Control of Lifting and Rigging Devices

MFP presented two instances that it alleged showed failure on the part of DCPP maintenance and surveillance personnel to properly control and implement lifting and rigging procedures. The first occurred on March 7, 1991. It was an incident in which a crane was being used to lift a relief valve into position on a main streamline outside containment. MFP Exhs. 135, 136. The boom of the crane came too close to a 500 kV power line and the line arced to ground, causing a loss of offsite power. The 230 kV startup system had been cleared for maintenance and was not available. The emergency diesels started and loaded the vital busses, constituting an ESF actuation, and there was a momentary loss of residual heat removal.

Refueling was in progress at the time and one assembly was in the manipulator crane and positioned over the core. Several systems were affected by the loss of power, and not all equipment functioned as intended. For example, the auxiliary building ventilation fans could not be restarted until certain components were replaced; emergency diesel EDG 1-1 started, but only after 19 seconds rather than the 10 seconds that is the Tech Spec limit; and the Unit 1 control room emergency lighting failed to function. MFP Exh. 135 at 5-8; MFP Exh. 136 at 5-9.

Safety analyses concluded that the health and safety of the public were not endangered by this occurrence. MFP Exh. 135 at 11; MFP Exh. 136 at 12. However, personnel safety was endangered by the arc to ground of a 500 kV line. Tr. 1635 (Giffin).

The root cause of the event was human error compounded by ineffective use of existing management systems. Apparently the crane crew did not even know that the 500 kV line was energized; they assumed that since the plant was shut down the line was dead; and they did not know it could be used to backfeed power into the plant. The foreman was apparently distracted by the many other activities he was coordinating at the same time. MFP Exh. 136, Attach. 2 passim.
Although this incident seems to the Board to indicate a number of flaws in the maintenance and surveillance program, it does not seem focussed upon the sort of knowledge and experience expected of the rigging and lifting crafts. It scarcely takes an expert rigger to know that one should stay away from high-voltage lines with crane booms. The problems seem again to center around communication (a knowledge of the state of the system one is working on), training, and attention.

The second incident involved a radwaste container being prepared for shipping. On May 28, 1992, the primary and secondary cask lids were being installed on this container and a mechanical maintenance foreman was supervising the operation. He left the area. The lids had initially been lifted with three slings and placed on the cask. The clearance between the lid and the cask was very close and the lid required some alignment. To facilitate this alignment, the crew decided to use two chainfalls and a sling in the operation. They mistakenly chose two 1-ton chainfalls to lift a weight that was close to 2400 pounds for each chainfall, because they misjudged the weight. MFP Exh. 137, Attach. at 4; PG&E Exh. 27, Encl. 1 at 1-2. The error became a subject of an NRC inspection report and resulted in a Severity Level IV Violation. MFP Exh. 137, Cover Letter at 2.

The work of loading the cask was being carried out under Maintenance Procedure M-50.23, and was being supervised (at least at the start) by a mechanical maintenance foreman. When he left the scene, the rigging crew, in violation of rules and of the scope of the tailboard that had introduced the work, improvised in an area where their knowledge was insufficient. PG&E Exh. 27, Encl. at 2.

There appears to be a difference of opinion as to the significance of this incident with respect to personnel safety: the NRC inspector noted "that this was a personnel safety issue and that the individual standing on the cask lid could have been seriously hurt if the chain had parted" (MFP Exh. 137 at 4), whereas PG&E management opined that the incident "did not present a threat to personnel safety" since "the lid would have dropped a maximum of two inches and could not have slipped off the lip of the container. . . ." PG&E Exh. 27, Encl. 2 at 1. It seems to the Board that, whichever opinion one adopts, it is clear that an incident like this one could have personnel safety significance, and it is important that measures be in place to prevent such happenings.

MFP would have us find that "these two incidents share some pertinent characteristics, and thus they demonstrate a deficiency in PG&E's ability to control lifting and rigging devices for heavy loads." MFP FOF ¶633 at 227.

PG&E believes that the two incidents are unrelated, or at least that they do not "have any commonality." PG&E Exh. 27, Encl. 2 at 1; PG&E FOF ¶M-A190 at A-77. Staff witness Miller said that the question whether there might be a common causal factor between the two incidents had not yet been decided
(Tr. 2248). Both Staff and PG&E would have us find that the later of the two incidents, the chainfall error, was not related to maintenance (PG&E Reply FOF ¶R-A111 at A-52; Staff FOF ¶1-258 at 103-04). Both cite our previous ruling on contentions (LBP-93-1, 37 NRC at 23) wherein we found that these and other incidents did not have a common focus with respect to a failure of the personnel and training programs. PG&E FOF ¶MA-191 at A-78; Tr. 1637-38.

Although the two incidents may not reflect in a common manner on the personnel and training programs, we do see certain parallels. Further, since the second incident was being carried out under a procedure that PG&E itself styles a “Maintenance Procedure” under the direction of an employee titled “Mechanical Maintenance Foreman,” we believe that both bear upon the adequacy of the maintenance program, and that both reflect poorly upon that program’s ability to communicate both vertically (from supervisor to supervised) and horizontally (from itself to other organizational components).

Nevertheless, we do not see in these incidents any basic flaw of sufficient proportions to warrant denying the license amendment. These incidents, however, are being included as part of the basis for our requirement that PG&E conduct a study seeking improvement in interdepartmental communications regarding maintenance-related activities.

37. Main Feedwater Pump Overspeed Trip Due to Failure of Power Supply to Speed Sensing Probes

MFP points out several failures of the feedwater pump speed controllers. MFP FOF ¶¶634-657 at 227-35; MFP Exhs. 138, 139, 140, 140A, 142. On March 6, 1992, a reactor trip occurred because of a low-low water level in the 1-3 steam generator. The low-low level was the result of a trip of the 1-1 feedwater pump. The inverter feeding the speed controller on that pump had failed, an automatic transfer to a second inverter also failed, and the loss of the speed control channel caused the pump to go to a maximum speed condition, which resulted in a pump trip. MFP Exh. 138 at 1-4.

PG&E’s analysis of the event concluded that the root cause of the failure was that the original (pre-1989) design of the speed probe system was a single-channel design and hence incompatible with the later-installed Lovejoy system that failed. The problem had been earlier identified in a letter from a technician, a letter that never received a response. Id. at 10. The failure of the probes to transfer to the alternate power supply was caused by a small piece of insulating debris, which had fallen between the points of a relay contact. MFP Exh. 140A at 4. In the course of investigating this event, PG&E discovered that the type of inverter whose failure had set off the sequence had failed nine times between 1990 and 1992, each of those failures having resulted in repair or redesign in consultation with the manufacturer. MFP Exh. 138 at 2-4.

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On April 23, 1991, a failure of main feedwater pump speed control had also occurred and had led to a turbine trip and a reactor trip. The root cause of that event was found to be failure of an amplifier in the Lovejoy control system. MFP Exh. 142 at 2-5.

The inverter difficulties all arose from a set of new inverters installed in November of 1989 in an effort to give the pump speed control a more reliable power supply. Tr. 1651 (Giffin); MFP Exh. 138 at 2. Obviously the effort was less than fully successful.

MFP would have us find that inverter failure was a “long standing problem” at DCPP, and that PG&E’s actions were ineffective in preventing the problem’s repeated recurrence. MFP FOF ¶643 at 232. Even PG&E concedes that “[w]e waited too long and continued to try to fix [the problem] instead of just putting in a new design” and “we should have written off the power supply.” Tr. 1652 (Giffin); MFP Exh. 138 at 18.

The Staff and PG&E do not see the problem as a maintenance and surveillance problem. The Staff says, “MFP offers no connection between these findings and PG&E’s maintenance and surveillance program . . . . The issue of concern to PG&E and NRC related to the timeliness of PG&E’s design engineering program efforts, not to the maintenance program.” Staff FOF ¶I-261 at 104-05; Tr. 2246-47 (Miller). PG&E says the sequence of events “did not reflect directly on either maintenance or surveillance.” PG&E FOF ¶M-A195 at A-79; Tr. 1653 (Giffin).

Once again we believe that the Staff and PG&E read the scope of the contention too narrowly. If maintenance efforts fail or are untimely because of a failure to properly coordinate with the engineering department or because of a failure of engineering to properly support maintenance, that is in itself a failure of the maintenance program viewed in a holistic sense.

MFP would also have us find that “[f]inancial consideration influenced PG&E’s corrective action.” MFP FOF ¶648 at 233; MFP Exh. 138 at 18. That may well be so. There does not, however, seem to be any tendency to compromise safety for financial reasons. Indeed, both PG&E’s technical witnesses and the technical witnesses for the NRC Staff characterize the pump speed controller failures as matters of little or no safety significance. Tr. 1653 (Giffin); Tr. 2216 (Miller). We agree. It appears that the greatest significance for the main feedwater pump failure is the effect it has on operability and availability of the plant rather than on safety. Although PG&E’s response to the failures may have been as “untimely and inefficient” as MFP would characterize it (MFP FOF ¶650 at 233), there seems to have been no substantial effect on safety.

MFP is correct that any problem with a feedwater pump can introduce the possibility of a transient, and that transients are not desirable from either a safety or availability standpoint. But we accept the professional opinions of
the technical witnesses presented by the Staff and PG&E to the effect that the pumps are not safety-related equipment. Tr. 1653 (Giffin); 2219 (Peterson).

We are again confronted with a situation in which the response of the maintenance and surveillance program as a whole has been less than perfect. The delay in fixing the inverters in particular demonstrated poor engineering support for the maintenance effort. But the matter is not one of substantial safety significance, and we cannot see it as reason to deny the license extension. We are, however, including this matter as one of the bases for our requirement that PG&E perform a study seeking to improve coordination of the maintenance department with other departments (such as engineering) engaged in performing maintenance-type activities.

38. Inadvertent Containment Ventilation Isolation

MFP introduced a series of NCRs and LERs purporting to show instances of containment ventilation isolation (CVI) resulting from personnel error. MFP Exhs. 144, 145, 146, 146A, 147, 148, 149, 149A, 150, 150A, 151, 151A. In the views of the Staff and the Applicant (which coincide), these events are unrelated to one another except that they all led to CVI. Staff FOF ¶I-269 at 107; PG&E FOF ¶M-A202 at A-82. Both Staff and Applicant point out that CVI is inherently a “benign” event, that is, simply a change to a safer (more conservative) condition, and that the wear and tear on safety devices resulting from CVI is minimal. Staff FOF ¶I-267 at 107; PG&E FOF ¶M-A199 at A-80; both citing Tr. 1670-71 (Vosburg).

MFP would have us find that these incidents show several major flaws in the DCPP maintenance program: ineffectiveness of attempted corrective actions, lack of communication and coordination between maintenance and other departments, financial considerations influencing safety decisions, failure to adhere to procedure and policy guidelines, and untimely response to deficiencies in the radiation monitoring system. MFP FOF ¶¶663, 665, 670, 674, 680, 684. The Staff and Applicant would have us find that, there being no real nexus between these events, the charge of ineffective corrective actions is not warranted. PG&E FOF ¶¶M-A202, M-A203 at A-82; Staff FOF ¶¶I-270 and I-271 at 108. Both of these parties point out that recent regulatory changes have been made in reporting requirements to downplay the importance to safety of CVI events. PG&E FOF ¶¶M-A199 at A-81; Staff FOF ¶I-267 at 107; both citing Tr. 1668-69 (Vosburg). Both the Staff and Applicant also point out that the radiation monitoring system is in the process of being upgraded to a digital system that should be less sensitive to electrical noise in the plant. PG&E FOF ¶M-A200 at A-81; Staff FOF ¶I-269 at 108, both citing Tr. 1673-74 (Giffin).

Neither the Staff nor PG&E addresses the matter of financial considerations, but we find that the portion of the record cited by MFP (MFP Exh. 148 at 7,
15) — when taken in context — does not suggest that financial considerations played any strong role in the decisions made on methods to address the CVI problem at hand.

We do, however, find two matters troubling. The first is the fact that “[t]here is no plant or GC procedure specifically regarding work on energized equipment” (MFP Exh. 150A at 12). This lack of procedures is particularly serious inasmuch as four of the CVI events resulted from errors on the part of personnel who were working on energized equipment. These numerous errors warrant a specific list of precautions for affected personnel. We do not accept PG&E’s argument that these precautions are “common knowledge to journeymen electricians” (id.) since, if this were the case, there would not have been the four CVI events.

The second matter is the timeliness of PG&E’s response to the oversensitivity of the radiation monitoring system to electrical noise. The system has exhibited this characteristic “since the Units have been operating” (MFP Exh. 149A at 5), yet PG&E is only “in the process of installing” a new system, and while the specific monitors involved in the incidents listed by MFP no longer give trouble, other instruments in the system still do. Tr. 1673-74 (Giffin). Despite the avowed benignity of a CVI incident, as we noted in Section 33, supra, unneeded actuation of ESF should be avoided. It stresses the crew and diverts resources. Tr. 1577-78 (Vosburg). The Board feels that it is high time the steps (apparently well known) that are needed to further suppress this undesirable ESF actuation should be taken.

Accordingly, we direct that the conversion of the radiation monitoring system be completed and that a set of rules for working on energized equipment be promulgated.

39. Reactor Trip on Steam Generator Low Level

Two exhibits offered by MFP (MFP Exhs. 155, 156) were the NCR and LER concerning a reactor trip occasioned by low steam generator level that occurred on February 1, 1991. A carpenter was carrying planks intending to erect a scaffold for inspection and repair of a feedwater valve. The planks struck an instrument air valve, closing it and shutting off the operating air supply to two feedwater valves and their bypasses. The feedwater valves failed closed, the feedwater supply to two steam generators ceased, the steam generator level dropped, the reactor tripped on low steam generator level and steam flow/feedwater flow mismatch and the turbine tripped. MFP Exhs. 155 at 2-3, 156 at 1; Tr. 1692-93 (Giffin).

When the reactor trip and turbine trip occurred and the plant transferred from its own generated power to outside power, four pieces of equipment failed to operate: a circulating water pump failed to restart, a 25 kV motor-operated disconnect failed to open, a control rod drive mechanism cooling fan failed to
start, and a main turbine stop valve failed to close fully. MFP Exhs. 155 at 3-4, 156 at 3-5; Tr. 1694-95 (Giffin). PG&E's safety analysis of the event indicated that such a string of failures was, in fact, bounded by previous analyses and that the health and safety of the public was not adversely affected. MFP Exhs. 155 at 8, 156 at 9-10. The cause of each of the four subsidiary failures was identified: the circulating water pump failed because of a malfunctioning relay (Tr. 1699 (Vosburg)), the 25 kV disconnect failed because outage workers had wrapped plastic sheeting around one of its operating shafts, the control rod drive cooling fan failed because of temperature and age-induced changes in its magnetic starter, and the main turbine stop valve failed to close because of underlubrication of a bushing on its actuator spring. MFP Exhs. 155 at 3-4, 156 at 4-5. Corrective actions were taken to prevent recurrence of the initiating event, including a revision of the procedure governing erection of scaffolding. Corrective actions were also taken to forestall recurrence of the subsidiary events. MFP Exh. 156 at 11-12; Tr. 1693, 1702 (Giffin); Tr. 1699, 1701 (Vosburg).

MFP would have us find that this incident represents another case in which multiple maintenance deficiencies occurred and previous corrective actions were ineffective (MFP FOF '11 at 248, 702 at 251). It would also have us find that the incident presents "substantial and multiple inadequacies in PG&E's maintenance and surveillance program" (MFP FOF ¶ 704 at 252). PG&E would have us find that this was an isolated event, that it has been adequately addressed to minimize future occurrences, and that it is an example of how a "living" maintenance program incorporates operating experience in order to improve. PG&E FOF ¶¶ M-A209 through M-A211 at A-84 through A-85, citing Tr. 1694-96 (Giffin), 1700 (Vosburg). PG&E sees no programmatic concerns stemming from this incident. PG&E Reply FOF ¶R-A120 at A-55 through A-56. The Staff, too, sees this as an isolated incident that has been properly resolved and that has actually resulted in enhancing the maintenance program. Staff FOF ¶I-275 at 110.

In this instance we agree with PG&E and the Staff. We see this as an incident in which a virtually unforeseeable random event with no serious safety implications has resulted in a thorough and intensive analysis, ultimately improving the maintenance and surveillance program.

40. Auxiliary Saltwater Pump Crosstie Valve

MFP presented an exhibit (MFP Exh. 168) in which was described an incident where an auxiliary saltwater pump crosstie valve was found with its manual handwheel inoperable because of extensive rust buildup. MFP points out an ostensibly inconsistent in the testimony of PG&E witnesses concerning the safety status of this valve and its capacity for manual operation (MFP FOF ¶ 705 at 253). It contrasts the statements of witnesses Giffin and Ortore (Tr.
1725) to the effect that the function of closing the valve is not safety significant with that of witness Vosburg (Tr. 1718) that the closing of the crosstie valve is a safety function.

We see no real inconsistency. Witness Vosburg merely testified that the design of the system takes account of the manual operation capability of the valve in order to make it unnecessary to design the remote operator to Class I (safety grade). Witnesses Ortore and Giffin noted that the entire capacity of the valve to be operated — both electrical and manual — is itself Class II because operation of the valve is not required for mitigation of an accident. (The body of the valve is Class I since it is part of the primary pressure boundary.)

MFP's own exhibit shows that the operating capability is only needed if, at a time some 13 hours after an accident, it becomes necessary to separate two redundant trains of auxiliary saltwater cooling in the event that a leak develops in a passive component of one of the two trains (MFP Exh. 168 at 7-8), and the manual operator would be needed only if the electrical operator simultaneously failed. A second valve in series with the valve whose manual operator failed was available in any event, and although that valve's manual operator was clogged with paint it was quickly and readily freed for service. *Id.* at 3-4, 15-16. The maintenance program has been changed to require inspection of these manual handwheel operators. *Id.* at 18-19; Tr. 1730 (Giffin).

MFP would have us find that the failure to include regular inspection of the handwheels in the original maintenance and surveillance program "reflects a basic inadequacy in the program" (MFP FOF ¶ 706 at 254). Because MFP's own exhibit concludes that, even with the valves in the condition found, "the ASW system would have functioned as designed to support post-accident operation" (MFP Exh. 168 at 8), we cannot agree with MFP on this point. Clearly the analysis and review of the incident has improved the program, but clearly also it was adequate before the incident occurred.

MFP makes a second point: that the response to the original discovery of the stuck handwheel was intolerably tardy (MFP FOF ¶¶ 715 at 257, 722 at 259). This is because, while the flaw was discovered in June of 1990 and an attempt was made to correct it in September of 1990, actual repair was not accomplished until the NRC resident inspector called the outdated repair tag to the plant manager's attention in January of 1991. It appears that the first attempt to correct the situation was abandoned because plant management knew that spare parts were not available and was reluctant to disassemble the valve without such parts. MFP Exh. 168 at 2-3. We have no record evidence of the time needed to get spare parts for such valves, so we cannot judge whether the period was too long or not. Certainly the fact that the valve was ultimately repaired without spare parts suggests that a sufficient effort could have fixed it more quickly. Nevertheless, we see no serious programmatic fault in PG&E's behavior in this instance. The matter was a flaw in a system that was not directly
safety-related, there existed adequate redundancy during the period before repair, and PG&E has taken adequate steps to prevent recurrence.

41. Testcock Valve on Diesel Generator

MFP introduced an exhibit (MFP Exh. 172) that concerned the failure of a testcock valve on a diesel generator. This exhibit describes the following occurrence: Maintenance was being performed on a diesel generator, and a testcock, a device to permit checking cylinder pressures, had been replaced. Mechanical Maintenance performed an initial leak check on the testcock, and the engine was run to bring it to operating temperature, when another leak check was to be performed. When Mechanical Maintenance tried to perform this second check, the mechanic inadvertently checked and tried to tighten a testcock other than the one that had been replaced, and that testcock broke off. Analysis and investigation revealed that the broken testcock had failed because of high cycle vibration fatigue caused by loosening in service. Id. at 2-3, 5; Tr. 1746-47 (Giffin).

MFP would have us find that the degradation of the broken testcock was identified because of an error in post-maintenance testing (MFP FOF ¶726 at 260), and that seems true enough. But MFP would also have us find that, when taken in conjunction with the incident of the failed motor operator keys described above, this, being a second instance wherein a flaw was discovered when a maintenance worker made an error, indicates some basic infirmity in the maintenance program. MFP FOF ¶727. That we cannot find. Both the Staff and PG&E would have us find that this is a very minor incident with no real bearing on the fundamental soundness of the PG&E maintenance and surveillance program. Staff FOF ¶1-286 at 113; PG&E FOF ¶M-A219 at A-87. We note that, even had the damaged testcock gone undetected and broken off while the diesel was running, it would not have caused the diesel to fail its intended function. Tr. 1749-50 (Giffin).

This, even taken with the matter of the failed motor operator keys, is surely no indicator of any significant flaw.

42. Main Feedwater Check Valve

Four of MFP’s exhibits (MFP Exhs. 190, 191, 192, 193) allegedly relate to the malfunction of a main feedwater check valve at Unit 1. Although it appears to the Board that three of the four documents (MFP Exhs. 191, 192, 193) involve that valve only peripherally, we are considering them together in order to correspond to the treatments given in the proposed findings of the parties.
The first document reports the finding of a condition of leakage in a main feedwater check valve and the considered decision, based upon evaluation of the safety significance of this leakage and upon the fact that operators could readily take account of the condition of the valve, that there was no need to repair the leakage immediately. The fundamental cause of this leakage was a failure on the part of the valve’s vendor to make clear the proper procedure for reassembling the valve after servicing. That problem has been corrected. MFP Exh. 190 at 2, 5-9.

The subject matter of the other three exhibits (MFP Exhs. 191, 192, 193) was PG&E’s treatment of, and response to, an actuation of the P-14 ESF at Unit 1. That actuation occurred at a time when the feedwater check valve was still leaking, and it was at first thought that that condition might have contributed to the event, but later analysis showed that the check valve leakage did not really contribute. MFP Exh. 190 at 3; Tr. 1781 (Vosburg). The ESF actuation was primarily brought about by leakage through the main feedwater control valve and its bypass valve, both of which malfunctioned because of a drift in the valve position controller. MFP Exh. 191 at 5. That condition has been corrected by increasing the frequency of surveillance of the position controller’s condition. Tr. 1783-84 (Giffin); 1786 (Vosburg).

The P-14 interlock trips the main feedwater pump and the turbine and closes the main feedwater isolation and regulating valves in order to protect the turbine from damage by water intrusion. MFP Exh. 192 at 4-5; Tr. 1773 (Vosburg).

MFP would have us find that inadequate maintenance was performed on the main feedwater check valve during Unit 1’s third refueling outage (MFP FOF ¶735 at 263). That is apparently correct. As we have noted above, the material supplied by the vendor of the valve apparently did not contain adequate instructions for its proper assembly after servicing. That matter was corrected, and it apparently did not lead to any serious consequences. Further, careful safety analyses showed the leakage would not lead to any serious safety problems. MFP Exh. 190 at 6-8. As to MFP’s proposed finding that PG&E’s response to the leakage was untimely (MFP FOF ¶738 at 264), we see no reason to fault the management decision to leave the leakage uncorrected.

MFP would also have us find that poor communication played an important part in the series of events herein described, inasmuch as MFP believes that no proper notification was given to the reactor operating staff that leaky valves might occasion trouble during a startup. MFP FOF ¶743 at 265, citing MFP Exh. 193 at 1. The NRC comment that MFP cites in support of this postulate is, in fact, apparently in part a simple misunderstanding of the role the check valve played in the P-14 actuation incident. Although we do not have the original report of that incident sent to NRC, the revision introduced shows, as we noted above, that the leaking check valve played little part in the ESF actuation. The valves primarily to blame for the ESF actuation were not known to be faulty at
the time. No serious lack of communication between maintenance and operations is apparent to the Board here.

MFP repeats that untimely action after the discovery of the leaking check valve was to blame for "numerous reactor trips, an ESF, and a degraded feedwater system." MFP FOF ¶¶ 746-50 at 266-67. We see no instances here recorded where leaking valves of any sort led to a reactor trip — the ESF occurred during recovery from a trip due to other causes (Tr. 1781 (Vosburg)) — nor do we see a substantially degraded feedwater system. We see no evidence here of a significant deficiency in the maintenance and surveillance program.

43. ASW Pump Vault Drain Check Valves

MFP introduced an exhibit (MFP Exh. 196) that describes an incident in which the check valves in both Auxiliary Saltwater (ASW) pump vault drains were simultaneously removed for servicing. Because both chains of a redundant system were being worked on at the same time, PG&E witness Giffin, out of an abundance of caution, initiated the NCR process, but engineering analysis showed that the removal of the valves did not affect the operability of the ASW pumps and that the incident did not, in fact, present a nonconformance. Tr. 1795-96 (Giffin). Thus the document is not really an NCR, and, indeed, it contains within it the information that the incident was neither nonconforming nor reportable (MFP Exh. 196 at 6-7, 12).

Nonetheless, MFP would have us consider certain findings in the report as matters that reflect adversely upon the maintenance and surveillance program of the DCPP. MFP FOF ¶ 754 at 268, citing MFP Exh. 196 at 5-6; MFP FOF ¶ 755 at 269, citing MFP Exh. 196 at 11. Both the Staff and PG&E would have us find that, inasmuch as the report does not suggest any hazard to the public health and safety (indeed, it specifically discounts any such hazard (MFP Exh. 196 at 6)), and because it is not actually an NCR, it cannot lend any support to MFP's contention that the maintenance and surveillance program is flawed. PG&E FOF ¶M-A233 at A-92 through A-93; Staff FOF ¶I-296 through I-297 at 116-17. Although we cannot endorse the reasoning of PG&E and the Staff in this — clearly, a recounting of an egregious failure of the maintenance and surveillance program, whether in an NCR or elsewhere, whether it directly hazarded the public health and welfare or not, could cast doubt on that program — we find, after carefully considering the matters MFP has pointed out, that none of them rises to the level of a significant challenge to the program.
44. Motor-Operated Valve Failed to Cycle on Actuation Signal

MFP introduced an exhibit (MFP Exh. 210) concerning a motor-operated safety injection valve that failed to cycle closed and open when tested. The valve opened properly on a signal to do so, then closed on a signal to close, but failed to open a second time on a second attempt to open. Investigation revealed that the operator's declutch fork had been installed upside-down during maintenance 8 years previously, prior to the start of plant operation, and that the excessive stresses induced by this improper installation ultimately caused the failure. *Id.* at 2-3. MFP would have us find, by a tortuous chain of reasoning interpreting 10 C.F.R. Part 50, App. A, that this chain of events violated the so-called “single failure criterion” (MFP FOF ¶¶ 762 and 763 at 271-72), and it would have us find this despite the fact that the valve in its as-found condition would have operated in an emergency. MFP Exh. 210 at 5; Tr. 1809-10 (Ortore).

We note that, at the time the erroneous installation of the clutch fork occurred, the maintenance instructions and training were not equivalent to present standards. MFP Exh. 210 at 6; Tr. 1810 (Ortore).

MFP would further have us find that this is a case wherein a “deficient installation went undetected until the component failed . . . .” MFP FOF ¶ 764 at 272. We note that in fact the failure was detected by a routine surveillance intended to detect just such failures, and that during the eight-year period the valve was regularly tested and performed as it should have. Tr. 1810 (Ortore).

We see this occurrence as an isolated instance that has been dealt with properly, an instance that does not suggest a significant flaw in the maintenance and surveillance program.

45. Fire in Electrical Panel

MFP introduced an exhibit describing the occurrence of a fire in an electrical panel. The fire was discovered both through the activation of a smoke detector annunciator and by a mechanic's helper who saw smoke and spread the alarm. The fire brigade responded and soon extinguished the fire. The damage was such that the exact cause of the fire could not be determined, but analysis by knowledgeable people led to the conclusion that the fire resulted from overheating of a loose terminal on a 480-volt breaker. It was further believed that the terminal was loose because the termination was of the compression type, a type that is dependent upon the skill of the installer for acceptable results. MFP Exh. 216 at 1, 2, 4, 6.

The exhibit notes that such terminations were replaced in the 1970s on Class I high-voltage equipment, but that a “conscious, economic decision” was made not to replace them on Class II equipment, a condition that accords with accepted IEEE practice. MFP Exh. 216 at 5.
MFP would have us find that PG&E's behavior in this instance is a case of putting financial considerations above safety and hence shows that financial considerations have undermined the maintenance and surveillance program at DCPP. MFP FOF ¶¶ 767-768 at 273-74. It does not seem so to us. The financial consideration led only to economizing on nonsafety matters. Indeed, the panel that failed "has no effect on the safe shutdown capability of either unit." MFP Exh. 216 at 6. Improved terminations have been installed and a system of infrared thermography inspections has been instituted to reduce the probability of recurrence. Id. at 7; Tr. 1823-24 (Crockett). We see no basic flaw here.

46. Chemical and Volume Control System Diaphragm Leakage

MFP cross-examined PG&E's witnesses on certain instances of leakage from valves in the Chemical and Volume Control System (CVCS) of the plants. Tr. 1826-39; PG&E Test. at 100-02. To clarify matters addressed in that testimony and cross-examination, PG&E introduced two exhibits (PG&E Exhs. 28, 29). Although the technical specification for leakage from the CVCS was exceeded in each case, careful analysis concluded that there was no effect on the public health and safety, inasmuch as the leakage limits are set by consideration of the doses in the control room and at the site boundary over the entire 30-day course of a very severe accident. PG&E Exhs. 28 at 5-6, 29 at 4-5.

These two instances of leakage occurred in 1991 and 1992, but they stemmed from different root causes and the precautions taken to prevent repetition of the first occurrence would not have prevented the second. Tr. 1832-33 (Giffin).

MFP would have us find that multiple deficiencies led to these incidents and that "this broad array of deficiencies implicates the overall adequacy of PG&E's maintenance and surveillance program." MFP FOF ¶784. We do not agree. The incidents of leakage stemmed from different causes, those causes were in each instance carefully analyzed, and proper steps were taken to improve the program. PG&E Exhs. 28 at 6, 29 at 5; Tr. 1831-33 (Giffin). We see no indication in these events that the maintenance and surveillance program is seriously flawed.

47. Conclusion on Maintenance and Surveillance Program

We began our discussion of the Maintenance and Surveillance Program with the general conclusion of the Staff witnesses that the program was adequate and, indeed superior. We then tested this overall general conclusion against the incidents cited by MFP.

There is additional testimony and other evidence dealing with a general evaluation of the Maintenance and Surveillance program and how it compares to other such programs throughout the industry. PG&E performs approximately
14,000 preventive maintenance tasks and 7,000 corrective maintenance tasks annually at DCP. PG&E Test. at 38, 40 (Ortore). The incidents referenced by MFP, some of which (as detailed above) are quite serious, represent but a small percentage of those tasks. PG&E claims, and we have no reason to doubt, that the nonconformances, although typical of the range of matters that confront the maintenance and surveillance system, are "not the normal. They're the exception of how we do business." Tr. 2072 (Giffin).

Collectively the incidents demonstrate that PG&E has not reached perfection — but no one (including MFP) expects that it would or could do so. As a PG&E witness observed, "we are not perfect. We would like to be, but we're not." Tr. 2071 (Giffin).

Clearly perfection — in context, "error free maintenance" — is not required to provide the "reasonable assurance" necessary for us to approve the license extensions here sought. Tr. 2275 (Peterson). Compared with nuclear power plant industry norms, however, PG&E ranks quite favorably. The NRC has frequently commended PG&E for achieving a high level of safety performance at the DCP. PG&E Exh. 19 (NRC commendation letters dated June 22, 1993, February 5, 1993, June 30, 1992, and February 3, 1993).

Moreover, the Commission periodically conducts a Systematic Assessment of Licensee Performance (SALP) which, in effect, evaluates the performance of operating reactors in specified disciplines, one of which is maintenance and surveillance. PG&E Test. at 182-83 (Giffin). Ratings are currently categorized into three levels — 1 ("superior level of safety performance"), 2 ("good level of safety performance"), and 3 ("acceptable level of safety performance").

For the most-recent SALP review period as of the time of the hearing (from July 1, 1991, through December 31, 1992), PG&E received six "1" ratings and one "2 and improving" rating. Maintenance and surveillance received a "1" rating. PG&E Test. at 183 (Giffin); PG&E Exh. 20. A plant need not receive a "1" rating to qualify for a license extension of the type sought here — indeed, a "3" rating would be sufficient. Tr. 2275-76 (Peterson).

In addition, PG&E presented the opinion of Tedd A. Dillard, a maintenance expert employed as Supervisor of Component Programs for the Nuclear Division of Florida Power & Light Company (FP&L) and, previously, from May 1983 to November 1988, the Manager of Maintenance for FP&L's St. Lucie Nuclear Power Plant. PG&E Test. at 116. Mr. Dillard testified (as had other PG&E witnesses) that excellence in operating records of a plant directly stems from an adequate maintenance and surveillance program and that PG&E's record in
this respect is among the leaders in the nuclear industry. The Staff expressed a similar view.

Notwithstanding such accolades, MFP has brought to our attention several aspects or areas of the maintenance and surveillance program that warrant some corrective action. We commend MFP for its efforts in this regard. Although not sufficient to warrant denial of the license application, they are sufficient to warrant orders for correction. Specifically, we direct the following corrections:

1. The telatemp sticker program must be improved, as described under item IV.C.1, above. These improvements need be made only to the extent PG&E determines to use such a program in fulfilling its EQ requirements.

2. Conversion of the radiation monitoring system must be completed and a set of rules for working on energized equipment be promulgated (item IV.C.38, above).

3. PG&E must undertake a study, to be submitted to the Staff for review, concerning methods for improving communications between maintenance and other departments, to the extent maintenance elects to use those departments in implementing its maintenance and surveillance program (see items IV.C.9, 10, 15, 29, 34, 36, 37).

We delegate scheduling and confirmation of satisfactory completion of these matters to the NRC Staff. Such delegation of post-hearing matters is appropriate where, as here, they involve deficiencies that should be corrected but which do not pertain to the basic findings necessary to the issuance of a license. Public Service Co. of New Hampshire (Seabrook Station, Units 1 and 2), CLl-90-3, 31 NRC 219, 230-31 (1990); Consolidated Edison Co. of New York, Inc. (Indian Point, Unit 2), CLI-74-23, 7 AEC 947 (1974).

V. RENEWED MOTION TO REOPEN THE RECORD

MFP's August 8, 1994 Renewed Motion to Reopen the Record seeks to include in the record on Contention I an NOV issued by the NRC Staff on July 14, 1994, together with various materials included in two inspection reports dealing with the subject of that violation as well as with certain other matters covered in those reports. The motion is opposed by both PG&E and the NRC Staff.

Such motions are governed by 10 C.F.R. § 2.734, which requires that a motion to reopen a closed record be timely (except in circumstances not here pertinent), that it address a significant safety or environmental issue, and that it demonstrate that a materially different result would be or would have been likely had the newly proffered evidence been considered initially. Further, the motion must be accompanied by one or more affidavits.

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On July 22, 1994, the Staff advised the Board and parties of the issuance of the NOV. Letter from NRC Staff counsel to Licensing Board, dated July 22, 1994, transmitting copy of NOV dated July 14, 1994. The NOV cover letter to PG&E, dated July 14, 1994, characterizes the NOV (based on IR 94-08) as "a significant violation involving the failure of your engineering staff to fully recognize or correct operational deficiencies in the Auxiliary Saltwater (ASW) System, despite several opportunities to recognize the existence of these deficiencies."36

The letter went on to note that NRC had also considered separate citations for failure to implement adequate design control measures to assure that ASW specifications and procedures were adequate to properly limit maximum Component Cooling Water (CCW) temperature during a design basis accident, and for failure to provide complete and accurate information to the NRC regarding the results of ASW system testing.

The NRC explained that those failures were a "direct consequence of the poor engineering work" and, as a result, "separate citations are not warranted." NRC Letter to PG&E, dated July 14, 1994.

In its Renewed Motion, MFP notes that it previously had sought to reopen the record to introduce IR 93-36 (January 12, 1994), to demonstrate that the surveillance program for the ASW system was inadequate and PG&E failed to perform needed maintenance, and that in LBP-94-9 we dismissed the motion without prejudice because the issues raised were as yet "unresolved." In that Order, we also established a threshold showing for any renewed motion, that the information be demonstrated as "significant and possessing substantive implications with respect to implementation of the maintenance/surveillance program" at DCPP. LBP-94-9, 39 NRC at 125 (footnote omitted).

MFP characterizes the NOV as confirming the existence of problems initially raised in IR 93-36. MFP goes on to claim that the motion is timely filed, that it raises significant safety and environmental issues, and that it is likely to affect the outcome of the case relative to Contention I "because it contradicts testimony at the hearing by PG&E and the NRC staff and because it corroborates many aspects of [MFP's] position that PG&E's maintenance and surveillance program is inadequate." MFP adds that "the fact that PG&E appears to have misrepresented the operability of the ASW system and the status of its maintenance and surveillance program implicates the integrity of PG&E's entire maintenance and surveillance program and the reliability of PG&E's testimony in this case." Renewed Motion at 3.

36 The Staff transmitted copies of IR 94-08 to the Board and parties by Memorandum dated March 17, 1994 (Board Notification 94-06).
PG&E and the Staff do not contest the timeliness of the Renewed Motion, at least insofar as it seeks to add the NOV to the record. (They question the timeliness of other matters arising from IR 94-08.) Nor at this time do they contest the safety significance of the contention to which the new inspection findings may be relevant. Rather, they question the significance and indeed relevance of the “engineering” matter to the maintenance and surveillance contention. They mention PG&E’s August 11, 1994 response to the NOV, including corrective actions to prevent recurrence (copies of which were included in PG&E’s response to the motion) and NRC’s acceptance of that response (also included in PG&E’s response to the motion). They also each stress that the matter addressed in the NOV was an engineering performance issue, not a maintenance, surveillance, or equipment operability issue and thus has little bearing on Contention I.

Finally, they argue that the other issues that MFP attempts to raise were derived from IR 93-36 but were closed out by the Staff in IR 94-08, without giving rise to any enforcement action. They thus assert that MFP’s motion does not meet the threshold established in LBP-94-9 for reopening the record.

In support of its response, PG&E presented the affidavit of Michael J. Angus, PG&E’s Manager of Nuclear Engineering Services, who is responsible for overall management of PG&E’s engineering support and design engineering activities at DCPP. He affirms that, with the exception of the one NOV, all inspection issues cited in the Renewed Motion have been closed out. He also describes the limited scope of the NOV and the method of resolving or closing out the other issues derived from IR 93-36 that were raised by MFP.

For its part, the Staff’s response included affidavits of three of the witnesses who appeared before us during the evidentiary hearing — Paul P. Narbut, Sheri R. Peterson, and Mary H. Miller. Most important, Mr. Narbut, the Staff Senior Inspector who was the author of both IR 93-36 and IR 94-08, confirms that PG&E has a sound maintenance and surveillance program and that he does not have any “current concerns” for the operability of the ASW system. He expresses his belief that PG&E has shown that the ASW system was “at all times operable” and that it “has done a credible job of addressing my technical and management inspection issues.” He also describes a number of technical inadequacies and factual errors in the Renewed Motion.

For their part, Ms. Peterson and Ms. Miller reaffirm their earlier testimony that PG&E’s maintenance and surveillance program is clearly supportive of safe facility operation. They too differentiate an engineering deficiency from a deficiency in the maintenance and surveillance program. They note that the single violation does not equate to overall inadequate performance and that it would be taken into account in future SALP evaluations. Ms. Miller explicitly states that “[t]he fact that specific problems and findings were identified is not unusual or unexpected and is not inconsistent with NRC’s SALP evaluation.”
Affidavit of Mary H. Miller in support of NRC Staff Response to MFP's Renewed Motion to Reopen the Record, dated August 25, 1994, at ¶5.

In reviewing the motion, we must recognize the rigorous standards that the Commission has imposed to warrant reopening of a closed record. And we find that those standards have not here been satisfied.

First, we agree with MFP that the NOV concerning engineering activities is sufficiently related to maintenance and surveillance of the ASW system to be within the scope of Contention I. We are unwilling to thrust the violation into a separate organizational box in order to dispose of it artificially on that basis. Instead, we view it as another aspect of the relationship between maintenance and engineering that is included in the INPO definition of maintenance that we adopted as a guideline earlier in this Decision. Further, a Severity Level III violation is also significant enough to constitute information pertinent to the contention and to satisfy that aspect of the reopening criteria. Finally, the Renewed Motion was clearly timely filed, at least insofar as it was based on the NOV.

We are denying the Renewed Motion for one basic reason: the proffered information could not result in a different decision from the one we otherwise are reaching. The NOV undoubtedly constitutes a "black mark" on PG&E's record, comparable in some respects to the CFCU matter. Cf. Tr. 2214 (Miller). That incident was taken into account in NRC's SALP evaluation, but it did not preclude PG&E from receiving a superior rating. In the SALP report, it was deemed to be "an isolated example [that] didn't really warrant a programmatic problem." Tr. 2215 (Peterson). In the words of Ms. Miller, "[i]t's possible to have superior performance and not be perfect." Tr. 2166 (Miller). On the basis of the Staff affidavits submitted in response to this motion, we view this NOV similarly — a deficiency that, particularly with respect to maintenance and surveillance, does not reflect a programmatic inadequacy.

By the same token, based on the Staff affidavits, none of the other matters arising out of IRs 93-36 or 94-08 warrants reopening of the record, either separately or as a group (even considered in conjunction with the NOV). None has thus far resulted in escalated enforcement action by the Staff, although several "apparent violations" were still under review as of the time IR 94-08 was issued.

In the context of licensing rather than enforcement significance, and of Contention I in this proceeding, the most serious apparent violation is the failure to provide complete information to the Staff. As set forth in IR 94-08,

the inspector concluded that the licensee failed to provide complete and accurate information to the NRC in regards to the CCW 1-2 heat exchanger's ability to meet the design basis heat load. This failure is considered an apparent violation (Apparent Violation 50-275/94-08-02).
Inspection Report 50-275/94-08; 50-323/94-08, Details at 5. According to Mr. Narbut, this "apparent violation" concerns "failure to report material details, i.e., incompleteness" of a report, not "misrepresentation" as characterized by MFP. Narbut Affidavit ¶2. Significantly, the Staff has not issued an NOV on this matter and thus does not seem to deem it significant enough to warrant further enforcement action. As set forth by Ms. Miller, PG&E's "integrity in responding to maintenance problems . . . is not raised in the NOV, nor is . . . integrity considered a concern." Miller Affidavit ¶9.

We conclude that the incident cited by MFP (either alone or in conjunction with the other matters raised by the motion) could not alter the result we are reaching and the motion is therefore being denied.

VI. CONTENTION V (Thermo-Lag Interim Compensatory Measures)

Contention V, as initially submitted, read as follows:

It is the contention of the San Luis Obispo Mothers for Peace that the Thermo-Lag material fails as a fire barrier and, in fact, poses a hazard in the event of a fire or an earthquake. Until this situation is adequately resolved, the license for Diablo Canyon Nuclear Plant certainly should not be extended.

LBP-93-1, 37 NRC at 26.

Thermo-Lag is a fire barrier material that has been used at DCPP. Recent testing of Thermo-Lag material has raised questions as to its ability to perform satisfactorily as a fire barrier for the rated durations specified for certain applications. The problem with Thermo-Lag fire barriers is generic in the nuclear power plant industry because a majority of nuclear power plants have used the material to satisfy NRC fire protection requirements. The asserted deficiencies with Thermo-Lag are that (1) Thermo-Lag fire barriers may not provide the fire resistance necessary to satisfy NRC fire protection requirements; (2) Thermo-Lag may burn more readily than originally believed; and (3) the ampacity derating factors used by licensees to derate power cables may not be great enough to account for the insulating effects of the Thermo-Lag material.

PG&E Test., ff. Tr. 1277, at 3, 4; NRC Staff Test., ff. Tr. 1417, at 2 (Madden).

The NRC has issued a series of Information Notices regarding deficiencies found in Thermo-Lag 330 fire barrier material. Additionally, it has required that nuclear power plants implement interim compensatory measures, pending determination by the Staff of possible additional corrective steps that may be required. See NRC Bulletin 92-01 (6/24/92) and Supplement 1 to NRC Bulletin 92-01 (8/28/92).

PG&E's response to this NRC request is documented in a September 28, 1992 Response to NRC Bulletin 92-01, Supplement 1. PG&E Exh. 3. In this
response, PG&E identified eleven specific Thermo-Lag fire areas at DCPP that are subject to these interim compensatory measures. PG&E's compensatory measures include: (1) a roving fire watch where fire detection devices are employed; or (2) a continuous fire watch where fire detection devices are not available. Tr. 1287, 1288 (Cosgrove, Powers). PG&E's interim compensatory measures have been accepted by the NRC Staff and documented in a letter dated October 27, 1992. PG&E Test., ff. Tr. 1277, at 13; PG&E Exhs. 3, F-1.

In admitting this contention, we limited it to the portion dealing with the adequacy of PG&E's resolution of the Thermo-Lag issue. Specifically, we accepted the allegation that PG&E has failed to implement adequately and abide by the Commission's interim compensatory measures required for the use of Thermo-Lag fire barriers. LBP-93-1, 37 NRC at 27-28, as clarified by "Memorandum and Order (Discovery and Hearing Schedules)," dated February 9, 1993, at 2 (unpublished). The scope of this contention does not include whether fire watches, as a compensatory measure, are an adequate substitute for Thermo-Lag fire barriers declared inoperable. To reiterate, the sole issue is whether PG&E has adequately implemented and will continue to implement adequately the Staff-approved compensatory measures at DCPP. Tr. 1297, 1299, 1430; LBP-93-1, 37 NRC at 27-28, as clarified by "Memorandum and Order (Discovery and Hearing Schedules)," dated February 9, 1993, at 2.

As litigated, Contention V also does not concern inside-containment applications (radiant energy shields) of Thermo-Lag material. In rejecting a late-filed contention in this proceeding, we specifically ruled that, as a result of PG&E's decision to replace Thermo-Lag material in this application with shields of a different manufacturer, the issue of radiant energy shields and the allegation that the Thermo-Lag material is itself a fire hazard in these applications no longer raised an issue creating a genuine dispute. LBP-93-9, 37 NRC at 444-45.

With respect to this contention, PG&E offered testimony from David K. Cosgrove, Supervisor of the Safety and Fire Protection Group at DCPP, and Robert P. Powers, Manager of the Nuclear Quality Services Department of PG&E's Nuclear Power Generation Business Unit. The NRC Staff presented testimony from Patrick M. Madden, Senior Fire Protection Engineer, Office of Nuclear Reactor Regulation, and Mary H. Miller, Senior Resident Inspector at DCPP. All of these witnesses were well qualified for their testimony.

MFP asserts that the interim compensatory measures have been inadequately implemented and hence are ineffective. It advances essentially three reasons: (1) that PG&E has not demonstrated reasonable assurance that its interim compensatory measures can and will be reliably implemented until such time as the generic Thermo-Lag issue is resolved; (2) that inoperable fire detection/suppression equipment, coupled with the failure by personnel to implement or perform compensatory fire watches, compromises the critical detection/suppression component of PG&E's defense-in-depth fire protection program.
and jeopardizes the safe operation of the plant; and (3) that human error and inadequate understanding jeopardize the adequacy of PG&E's implementation of compensatory fire protection measures at DCPP. MFP FOF ¶¶791, 793, 797.

Only a moderate amount of Thermo-Lag is installed at DCPP. "Moderate" describes an installation incorporating between 100 and 1000 square feet or between 100 and 1000 linear feet of fire barrier material. PG&E has already replaced the Thermo-Lag in the Unit 2 containment and has advised that it would replace all the Thermo-Lag in the Unit 1 containment during the refueling outage that was then scheduled for February 1994. NRC Staff Test., ff. Tr. 1417, at 2-3 (Madden).

PG&E has utilized a roving fire-watch program throughout DCPP "essentially since Units 1 and 2 have been in operation." PG&E Test., ff. Tr. 1277, at 6, 7. Therefore, implementation of the fire-watch portion of the interim compensatory measures required only that "the tour route [be] slightly modified to encompass the additional fire areas." Id. at 14. In response to a PG&E objection that attempted to limit inquiry into fire watches solely to those established for Thermo-Lag purposes, we ruled that "since the fire watch program is merely an extension of an existing program . . . inquiry into potential deficiencies in the existing program, the fire watch program, [is] permissible." Tr. 1297.

We also ruled that inquiry into other aspects of the implementation of interim compensatory measures (beyond fire watches) was permissible. That does not mean, however, that inquiry into all aspects of the fire protection program in all fire areas at DCPP is permissible, as claimed by MFP (MFP FOF ¶789). There must be a demonstrated relationship to implementation of the interim compensatory measures.

MFP has specified a number of particular incidents or conditions that are said to demonstrate that PG&E is not properly implementing the interim compensatory measures (MFP Exhs. F-1A, F-2, F-3, F-5, F-6). Most involve missed hourly or continuous fire watches, relating to fire watches initially established prior to the Thermo-Lag watches. We find these are relevant because of the administrative similarity between those watches and the Thermo-Lag watches. We will deal with each specifically.

First, MFP cites an LER that reflects a 1991 Technical-Specification violation for failure to perform an hourly fire-watch patrol for areas that had inoperable fire barriers (not related to Thermo-Lag deficiencies). The fire watch was not performed because the hourly roving fire watch was unable to exit from the radiologically controlled area of the plant and exchange duties with another fire watch in the turbine building. The root cause was determined to be a lack of adequate instructions to fire-watch personnel. MFP Exh. F-1.

The next document is a 1992 LER representing a continuous fire watch missed through personnel error. Corrective action included clarification of procedures and additional personnel training. MFP Exh. F-2.
The third document is also a 1992 LER reporting another continuous fire watch missed through personnel error. The sprinkler fire water to certain areas was isolated in accordance with an equipment tagout request without the Shift Foreman noting that a continuous fire watch was needed. An hourly watch ended up patrolling in the affected area. The root cause was determined to be personnel error on the part of the Shift Foreman, and corrective action included counseling the Shift Foreman and operators involved and issuing an Operations Coordination Instruction concerning equipment tagout requests affecting the fire protection system. MFP Exh. F-3. The incident did not involve a Thermo-Lag fire area. Tr. 1330 (Cosgrove).

The next document was also a 1992 LER, involving two separate events. In the first, fire detectors in a particular area were inoperable for more than an hour, with no compensatory measures in place. In the second, fire detectors in another area were inoperable for more than an hour without a continuous fire watch in place. Both events were attributed to personnel error. Corrective actions included revision of procedures, preparation of an incident summary outlining the events, and clearly stating the expectations for dealing with spurious alarms and enhancing on-shift training of plant operators. MFP Exh. F-5.

The final document cited by MFP also concerned two events, occurring in late 1992. In the first, the fire detection computer was inoperable for more than an hour, without initiation of required compensatory measures. In the second, the fire detection computer also malfunctioned, but the malfunction was not detected until the following day. Consequently, the required roving hourly fire watch was not instituted in a timely manner. (During investigation, PG&E discovered another computer malfunction.) The December 28, 1992 LER reported that the investigation was still in progress. MFP Exh. F-6. None of these events involved Thermo-Lag barriers. Tr. 1325 (Cosgrove).

PG&E maintains that, since the initiation of the interim compensatory measures for Thermo-Lag fire areas, it has successfully completed 100% of the hourly fire watches. PG&E FOF ¶T23, citing PG&E Test., ff. Tr. 1277, at 14-15 (Cosgrove, Powers), and Tr. 1320 (Powers). It defines a successful tour of Thermo-Lag areas to be one entry into the defined area within the appointed hour and concludes that the interim compensatory measures have been successfully implemented. PG&E FOF ¶T23, citing Tr. 1307-08 (Powers). The Staff agrees. Staff FOF ¶¶V-30, V-54. MFP does not dispute the record concerning Thermo-Lag watches but continues to assert that the other record is more representative.

Although we agree with MFP that the various missed fire watches are relevant for evaluating the likelihood of missed Thermo-Lag watches, we do not regard PG&E's overall record as flawed or as posing a threat to the adequacy of its compliance with fire-protection requirements. Reasons for various missed
watches have been identified, and PG&E has taken adequate steps to prevent their recurrence.

During the hearing, the Board also explored claims to the effect that PG&E had improperly altered the records of fire watches (Tr. 1282-87, 1322-24, 1389-1409 (Cosgrove, Powers)). No party has pursued that matter in its FOF, and we thus regard it as abandoned.

In short, nothing in the record would suggest that PG&E's implementation of the Thermo-Lag interim compensatory measures was so flawed that license denial (or even license conditions) are warranted.37

VII. CONCLUSIONS OF LAW

The Licensing Board has considered all of the evidence submitted by the parties as well as the entire hearing record. That record consists of the Commission's Notice of Hearing, the pleadings filed herein, memoranda and orders issued in this proceeding, the transcript of the hearing, and the exhibits received or deemed to be received into evidence. Based on the findings of fact set forth in Parts IV and VI, above, which are supported by reliable, probative and substantial evidence as required by the Administrative Procedure Act and the Commission's Rules of Practice, we conclude that:

1. PG&E has met its burden of proof with respect to both Contention I (subject to certain limited conditions) and Contention V.

2. With respect to the matters placed in controversy by these two contentions, and subject to the limited conditions set forth with respect to Contention I, there is reasonable assurance that: (a) the Diablo Canyon Nuclear Power Plant can and will be operated without endangering the public health and safety for the requested 40-year operating life; (b) such activities will be conducted in compliance with the Commission's regulations; and (c) such activities will not be inimical to the common defense and security.

3. All issues, arguments, or proposed findings presented by the parties but not addressed herein have been found to be without merit or unnecessary for this decision.

37 By letter dated March 9, 1994, the Applicant advised us that, as it notified the Staff on February 14, 1994, "PG&E will complete replacement of the Thermo-Lag . . . as appropriate with other fire systems by December 31, 1994. Compensatory measures will be maintained as appropriate for each Thermo-Lag installation until its replacement is complete." PG&E Letter No. DCL-94-034 at 4. Although our resolution of Contention V is not based on this communication (which is not in the record and has not been subject to cross-examination), we note that, when accomplished, it would render Contention V moot.
VIII. ORDER

WHEREFORE, on the basis of the foregoing, in accordance with 10 C.F.R. § 2.760, it is this 4th day of November 1994, ORDERED:

1. The Director, Office of Nuclear Reactor Regulation, is authorized, upon making requisite findings with respect to matters not at issue in this Initial Decision, and subject to the conditions specified on pages 180-81 with respect to Contention I, to issue the amendment proposed by PG&E in its application of July 9, 1992.

2. This Initial Decision shall become effective and constitute the final action of the Commission forty (40) days after the date of its issuance, subject to any review pursuant to the Commission's regulations.

3. MFP's Renewed Motion to Reopen the Record, dated August 8, 1994, is hereby denied.

4. In accordance with 10 C.F.R. § 2.786, any petition for review of this Initial Decision must be filed within fifteen (15) days after service of the decision. Any other party may file, within ten (10) days after service of a petition for review, an answer in support of, or in opposition to, the petition for review. The petition for review may be granted or denied in the discretion of the Commission, giving weight to the considerations of 10 C.F.R. § 2.786(b)(4).38

THE ATOMIC SAFETY AND LICENSING BOARD

Charles Bechhoefer, Chairman
ADMINISTRATIVE JUDGE

Dr. Jerry R. Kline
ADMINISTRATIVE JUDGE

Frederick J. Shon
ADMINISTRATIVE JUDGE

Rockville, Maryland
November 4, 1994

38 In the near future, we shall issue transcript corrections for the evidentiary hearing.
By immediately effective order dated November 16, 1993, the NRC Staff suspended the byproduct materials license of the Indiana Regional Cancer Center (IRCC) that authorized IRCC to use strontium-90 for the treatment of superficial eye conditions. See 58 Fed. Reg. 61,932 (1993). The order also modified the license to preclude Dr. James E. Bauer, the Radiation Safety Officer and the sole authorized user listed in the license, from engaging in any activities under the license. This proceeding was convened at the request of IRCC and Dr. Bauer to enable them to contest the validity of the Staff's order. See 58 Fed. Reg. 67,427 (1993). Now, by joint motion dated October 28, 1994, the parties request that we approve an October 28, 1994 settlement agreement they have
provided and dismiss this proceeding without any findings on facts in dispute among the parties or resolution of any disputes, other than those rulings already issued is this proceeding.¹

Pursuant to section 81 and subsections (b) and (o) of section 161 of the Atomic Energy Act of 1954, 42 U.S.C. §§ 2111, 2201(b), 2201(o), and 10 C.F.R. § 2.203, we have reviewed the parties’ settlement accord to determine whether approval of the agreement and termination of this proceeding is in the public interest. On the basis of that review, and according due weight to the position of the Staff, we have concluded that both actions are consonant with the public interest. Accordingly, we grant the parties’ joint motion to approve the settlement agreement and dismiss this proceeding.

For the foregoing reasons, it is, this fourth day of November 1994, ORDERED that

1. The October 28, 1994 joint motion of the parties is granted and we approve their October 28, 1994 “Settlement Agreement,” which is attached to and incorporated by reference in this Memorandum and Order.

2. This proceeding is dismissed.

3. If this determination becomes final agency action because the Commission declines review, see 10 C.F.R. § 2.786(a), within seven days of the date of the memorandum from the Secretary of the Commission indicating that the Commission declines review, Staff counsel should advise the Board and the Office of the Secretary, in writing, whether the Staff prefers that the in camera Board and Commission record copies of the May 18, 1994 “NRC Staff’s

¹See, e.g., LBP-94-21, 40 NRC 22 (1994).
Response to Board Order dated May 6, 1994" be returned to the Staff or destroyed.2

THE ATOMIC SAFETY AND LICENSING BOARD

G. Paul Bollwerk, III, Chairman
ADMINISTRATIVE JUDGE

Charles N. Kelber
ADMINISTRATIVE JUDGE

Peter S. Lam
ADMINISTRATIVE JUDGE

Rockville, Maryland
November 4, 1994

2 Copies of this Memorandum and Order are being sent this date to counsel for IRCC and Dr. Bauer by facsimile transmission and to Staff counsel (without the accompanying attachment) by E-mail transmission through the agency's wide area network system.
ATTACHMENT 1

October 28, 1994

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE ATOMIC SAFETY AND LICENSING BOARD

In the Matter of

Docket No. 030-30485-EA
(EA No. 93-284)
(Byproduct Material License No. 37-28179-01)

INDIANA REGIONAL CANCER CENTER
INDIANA, PENNSYLVANIA

SETTLEMENT AGREEMENT

On November 16, 1993, the Staff of the Nuclear Regulatory Commission (Staff) issued "Order Modifying and Suspending License (Effective Immediately)" to the Indiana Regional Cancer Center (Licensee). 58 Fed. Reg. 61932 (November 23, 1993) (Order). On December 2, 1993, the Licensee and James E. Bauer, M.D., the Radiation Safety Officer and Authorized User listed on Byproduct Material License No. 37-28179-01 (strontium-90 license), requested a hearing on the Order. In response to the Licensee's and Dr. Bauer's request, an Atomic Safety and Licensing Board was established on December 14, 1993. 58 Fed. Reg. 67427 (December 21, 1993). The Licensee and Dr. Bauer deny that the strontium-90 license was violated.

The parties to the above-captioned proceeding, the Staff, the Licensee, and Dr. Bauer, agree that it is in the public interest to terminate the above-captioned proceeding without further litigation and agree to the following terms and conditions:

1. The Licensee agrees to voluntarily withdraw its request to renew Byproduct Material License No. 37-28179-01 (strontium-90 license) and request the termination of the strontium-90 license in accordance with 10 C.F.R. § 30.36 no later than January 16, 1995.
2. The Staff does not intend to, and, consequently, agrees not to take any further civil or administrative enforcement action against either the Indiana Regional Cancer Center, under the strontium-90 license, or Dr. Bauer, other than the Order Prohibiting Involvement in NRC-Licensed Activities issued on May 10, 1994 (59 Fed. Reg. 25673 (May 17, 1994)), based on (a) the same facts outlined in the Order Modifying and Suspending License (Effective Immediately), dated November 16, 1993 (Order) (58 Fed. Reg. 61932 (November 23, 1994)); and (b) any other facts or assertions revealed as a result of the NRC’s Office of Investigation’s investigation (No. 1-93-065R) of the Licensee’s activities under the strontium-90 license. This settlement is limited to the above-captioned civil proceeding and does not preclude the government from taking any other non-civil action if deemed appropriate as a result of OI investigation No. 1-93-065R.

3. The Staff, the Licensee, and Dr. Bauer agree that upon termination of the strontium-90 license in accordance with 10 C.F.R. § 30.36, the provisions of section IV of the Order and the above-captioned proceeding would become moot.

4. The Staff, the Licensee, and Dr. Bauer agree that this Settlement Agreement does not constitute and should not be construed to constitute any admission or admissions in any regard by either the Licensee or Dr. Bauer regarding any matters set forth by the NRC in the Order.

5. The Staff, the Licensee, and Dr. Bauer also agree that the matters upon which the Order is based have not been resolved as a result of this Settlement Agreement. This Settlement Agreement shall not be relied upon by any person or other entity as proof or evidence of any of the matters set forth in the Order.

6. The Staff, the Licensee, and Dr. Bauer shall jointly move the Atomic Safety and Licensing Board designated in the above-captioned proceeding for an order approving this Settlement Agreement and terminating the above-captioned proceeding.

Respectfully submitted,

Marcy L. Colkitt
Counsel for the Indiana Regional Cancer Center and James E. Bauer, M.D.

Marian L. Zobler
Counsel for NRC Staff

Dated at Rockville, Maryland
this 28th day of October, 1994
Applicant’s motion for summary disposition is granted in part. After viewing all evidence favorably toward Intervenor, the Board assumed that Applicant had indirectly transferred control of its operating license without appropriate written permission from the NRC. However, the Board held that even if Licensee had made such a transfer, that without more would not demonstrate that the requested license amendment (to transfer operating authority to a new licensee) should be conditioned.

For transfer of the license to be restricted, Intervenor would need to show that the recipient of the license is lacking in character or integrity. This could be demonstrated in this case only by showing material misrepresentations to the Nuclear Regulatory Commission. Consequently, the hearing in this case will be restricted to questions related to alleged misrepresentations.

This Memorandum and Order grants in part “Georgia Power Company’s Motion for Summary Disposition of Intervenor’s Illegal Transfer of License Allegations” (Motion). The consequence is that there will be a hearing limited to
the issue of whether Georgia Power Company, et al. (Georgia Power) has misled the Nuclear Regulatory Commission with respect to the control of licensed operations of the Vogtle Electric Generating Plant (Vogtle).

**INDIRECT TRANSFER OF CONTROL: PROHIBITED WITHOUT WRITTEN CONSENT**

A company must retain actual control of licensed activities. Even indirect transfers of a license are prohibited. If all that was prohibited was a transfer of the right to control licensed activities, then there would be no need to specify that "indirect" transfers also were prohibited. What is important is that the licensed entity, which has been approved by the Nuclear Regulatory Commission, should not enter into a new relationship that permits individuals who are not included in the license to control licensed activities, directly or indirectly.

**RULES OF PRACTICE: SUMMARY DISPOSITION; GENUINE ISSUE OF FACT**

Once Applicant has submitted a motion that makes a proper showing for summary disposition, the litmus test of whether or not to grant the summary disposition motion is whether Intervenor has presented a genuine issue of fact that is relevant to its allegation and that could lead to some form of relief.

**CHARACTER AND INTEGRITY: TRANSFER OF A LICENSE; EFFECT ON TRANSFER**

In the case of a license amendment application that would result in the transfer of an operating license, the transfer may be restricted if the proposed recipient of the license is lacking in character and integrity. Not every previous defect on the part of the recipient would require that the license transfer be conditioned or denied. For example, merely showing that the license had previously been illegally transferred to the recipient would not bar the granting of the amendment unless the illegal transfer was accompanied by material omissions or misstatements to the Nuclear Regulatory Commission.

**INDIRECT TRANSFER OF A LICENSE: NOT PERMITTED; REALITY TEST**

A licensee may not transfer an operating license for a nuclear power plant either directly or indirectly. Even if formal authority is maintained in an acceptable form, if people not included in the license have substantial influence
over the operation of the nuclear power plant, the omission of their names from the license may be improper. Only appropriate consent in writing by the Nuclear Regulatory Commission may validate an unauthorized transfer of influence to operate the plant.

RULES OF PRACTICE: PROOF OF MISREPRESENTATIONS

For each allegation of a misrepresentation, the Board will need to know as precisely as we can: (1) what was said, (2) in what context the statement existed, (3) the proof that the statement was inaccurate or incomplete, (4) when (if applicable) the statement was corrected, and (5) why we should be concerned about the length of delay between the statement and when it was corrected. This will require proof of a time line of actual events, demonstrating not only that they occurred but also when they occurred.

The Board also will require that the proof offered will make some allowance for inaccuracies in expression, understanding, and memory. So the Board will need to know also how much time passed before the alleged misstatement was made.

RULES OF PRACTICE: BRIEFS; CHARTS FOR CLARITY

It would be helpful to us if time lines and charts were used to communicate Intervenor's points clearly. Such simple and easy-to-grasp devices would be appreciated in the filings of all the parties.

MEMORANDUM AND ORDER
(Summary Disposition: Illegal Transfer Allegation)

This Memorandum and Order grants in part “Georgia Power Company's Motion for Summary Disposition of Intervenor's Illegal Transfer of License Allegations” (Motion). The consequence of our decision is that we shall hold a

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1 The Motion was filed August 24, 1994. On October 4, 1994, Mr. Allen L. Mosbaugh (Intervenor) filed his "Response to Georgia Power Company's Motion for Summary Disposition of Intervenor's Illegal Transfer of License Allegation" (Response). On October 3, the Staff of the Nuclear Regulatory Commission (Staff) filed its "Response in Support of Georgia Power Company's Motion for Summary Disposition of the Illegal License Transfer Issue."

On October 14, Georgia Power filed two motions, a "Motion to Strike Intervenor's Response to Georgia Power's Motion for Summary Disposition" (Motion to Strike) and a "Motion for Leave to File a Reply to Intervenor's Response to Georgia Power's Motion for Summary Disposition (Illegal License Transfer)" (Motion to Respond). The Motion to Respond was accompanied by a reply. On October 26, 1994, Intervenor filed a "Response to Georgia Power's Motion to Strike Intervenor's Response to Summary Disposition."
hearing limited to the issue of whether Georgia Power Company, et al. (Georgia Power) has misled the Nuclear Regulatory Commission with respect to the control of licensed operations of the Vogtle Electric Generating Plant (Vogtle).

We find that Georgia Power's motion, viewed without consideration of the Response, makes a proper showing for summary disposition that an illegal transfer did not occur. It sets forth statements of allegedly undisputed facts from which this Board may infer that Georgia Power retained full control of its operating license. We note that Georgia Power did not ask us to determine that illegal transfer would have no licensing consequences. We reach that conclusion on our own motion.

In this situation, the litmus test of whether or not to grant the summary disposition motion is whether Intervenor has presented a genuine issue of fact that is relevant to its illegal transfer allegation and that could lead to some form of relief. En route to our decision on Georgia Power's Motion, we concluded that our conclusion — with hindsight — that Georgia Power had illegally transferred its operating license would not by itself require any relief in this license amendment proceeding. We would consider granting relief only if Intervenor shows that Georgia Power misrepresented material facts to the Nuclear Regulatory Commission with respect to the control of Georgia Power's nuclear operations. In particular, Intervenor must show material misrepresentations concerning the relationship between Georgia Power, on the one hand, and SONOPCO or Southern Nuclear, on the other hand.

In determining the summary disposition motion, we have not used the preponderance-of-evidence test to weigh the evidence. For the purposes of this decision, we assume the truth of all reasonable inferences about illegal transfer that may be drawn from the record before us, including evidence referred to in Intervenor's proposed genuine issues of fact and from the stipulation of the parties. This standard of interpretation caused us to assume that both the SONOPCO project and Southern Nuclear were so influential in managing the nuclear business of the Vogtle plant that there was an indirect transfer of control without any appropriate consent in writing by the Nuclear Regulatory Commission. Hence, for purposes of this motion only, we shall treat the transfer as illegal.

In reaching our determination, we have relied in part on a final set of stipulations relating to the transfer of control issue. These stipulations, together with attached exhibits, were filed August 1, 1994, by counsel for Georgia Power: "Stipulations Relating to Allegations of Illegal License Transfer" (Stipulations). It contains some material with asterisks that were not agreed to by all parties. We have not relied on "stipulations" with asterisks.

Also pending, but not yet ripe because a response has not been filed, is Intervenor's October 24, 1994 "Motion to Reopen Discovery."

The parties also sometimes refer to Southern Nuclear as SONOPCO.

However, we did not consider this the end of our inquiry concerning the
granting of summary disposition. We asked whether an "illegal transfer," with­
out more, would cause us to restrict the granting of the requested license amend­
ment. We concluded that more would have to be shown. It is our conclusion
that there must be some additional showing before we would condition or deny
the transfer of the license.

The contention admitted in this proceeding is:

The license to operate the Vogtle Electric Generating Plant, Units 1 and 2, should not be
transferred to Southern Nuclear Operating Company, Inc., because it lacks the requisite
character, competence and integrity, as well as the necessary candor, truthfulness, and
willingness to abide by regulatory requirements.

The petition in this case argued that illegal transfer of the license to operate Vogtle had caused a change in safety consciousness at the plant. However, Intervenor has abandoned that portion of its contention by not pursuing that part of its allegation in its response. Had the evidence permitted us to assume that an illegal license transfer has contributed to a change in safety consciousness, we would question the appropriateness of the requested amendment.

Intervenor also has alleged that Georgia Power misled the Nuclear Regulatory Commission about who controlled licensed activities at Vogtle, through the omission of facts and through misstatements. We have determined that there is a material issue of fact concerning whether or not omissions or misstatements did occur. Since proof of misstatements may lead us to grant relief, this is the sole issue of fact that we shall admit for a hearing. Hence, the only evidence we will admit at the hearing will be evidence: (1) showing what statements or omissions were made by Georgia Power officials to the NRC concerning the control of Vogtle, (2) providing the context to reach a conclusion concerning the falseness and the materiality of the statements or omissions, and (3) permitting us to assess the degree of culpability involved in the statements or omissions.

I. BACKGROUND OF THE CASE

Background helpful in understanding the pending Motion may be found in the following passages from our prior decision, LBP-93-5, 37 NRC at 98, 99-100 (footnotes are renumbered from the original):

Georgia Power proposes to amend its license to operate Vogtle. The proposed amendments would have no effect on the ownership of Vogtle, but they would allow Southern Nuclear

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5Id. at 100 ("organization of SONOPCO marked a change from a "conservative" to a more "risk taking" attitude).
Operating Company, Inc., ("Southern Nuclear") to become the operator — thus, operation would pass from one wholly owned subsidiary of Southern Company (Georgia Power) to another (Southern Nuclear).

* * *

Mr. Mosbaugh’s principal allegation is that Southern Nuclear lacks the character and competence to operate a nuclear power plant. Briefly, Mr. Mosbaugh alleges that in 1988 Southern Company began making changes at Vogtle that eventually would lead to the filing of the pending application. The first operative step was the organization of a Southern Nuclear Operating Company (SONOPCO) project. At the time, Mr. Mosbaugh served as Superintendent of Engineering Service, at the Vogtle Plant, with 400 employees reporting to him. Mr. Mosbaugh concluded that the organization of SONOPCO marked a change from a “conservative” to a more “risk-taking” attitude in the operation of Vogtle. He was particularly concerned that SONOPCO seemed less concerned about NRC reporting requirements. Mr. Mosbaugh alleges that, subsequent to the time that SONOPCO began to have influence, Georgia Power filed false and misleading reports with the NRC and its officials filed material false statements in response to NRC questions.

We note that Intervenor has abandoned his allegation concerning a change from a “conservative” to a more “risk-taking” attitude. There are no facts contained in Intervenor’s Response or in the Stipulation of Facts that would permit us to find a genuine issue of fact with respect to this branch of the original contention.

II. LAW CONCERNING SUMMARY DISPOSITION

As a scholarly Licensing Board remarked in Sacramento Municipal Utility District (Rancho Seco Nuclear Generating Station), LBP-93-23, 38 NRC 200, 239-40 (1993):

The Commission has recently reiterated the legal standards to be applied with respect to motions for summary disposition pursuant to 10 C.F.R. §2.749. After describing analogies of the rule to motions for summary judgment under Rule 56 of the Federal Rules of Civil Procedure, the Commission observed:

[10 C.F.R. § 2.749] specifies that summary disposition may be granted only if the filings in the proceeding, including statements of the parties and affidavits, demonstrate both that there is no genuine issue as to any material fact and that the moving party is entitled to a decision as a matter of law.

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7 Mosbaugh Labor Case at 6. We consider that this information, submitted by Georgia Power, places the allegations in context.

8 Id.

9 “Amendments to Petition to Intervene and Request for Hearing” (Mosbaugh), December 9, 1992 (Amendments to Petition) at 15-19.

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The party seeking summary judgment bears the burden of showing the absence of a genuine issue as to any material fact. In addition, the Board must view the record in the light most favorable to the party opposing such a motion. Thus, if the proponent of the motion fails to make the requisite showing, the Board must deny the motion — even if the opposing party chooses not to respond or its response is inadequate. However, if the movant makes a proper showing for summary disposition, and if the party opposing the motion does not show that a genuine issue of material fact exists, the Board may summarily dispose of all arguments on the basis of pleadings.

To preclude summary disposition, when the proponent has met its burden, the party opposing the motion may not rest upon "mere allegations or denials," but must set forth specific facts showing that there is a genuine issue. Bare assertions or general denials are not sufficient. Although the opposing party does not have to show that it would prevail on the issues, it must at least demonstrate that there is a genuine factual issue to be tried. The opposing party must controvert any material fact properly set out in the statement of material facts that accompanies a summary disposition motion or that fact will be deemed admitted.

Moreover, when the movant has satisfied its initial burden and has supported its motion by affidavit, the opposing party must either proffer rebutting evidence or submit an affidavit why it is impractical to do so. If the presiding officer determines from affidavits filed by the opposing party that the opposing party cannot present by affidavit the facts essential to justify its opposition, the presiding officer may order a continuance to permit such affidavits to be obtained, or take any other appropriate action.


We also have accepted the following principle found in the comments to Rule 56 of the Federal Rules of Civil Procedure: 10

Where an issue as to a material fact cannot be resolved without observation of the demeanor of witnesses in order to evaluate their credibility, summary judgment is not appropriate.

We are aware, however, that there has been extensive deposition testimony in this case and that, while we have not seen the demeanor of a deponent, a deposition provides us an opportunity to review the cross-examination of a witness. 11

III. THE LAW

A. Illegal Transfer

Section 184 of the Atomic Energy Act, titled "Inalienability of Licenses," provides:

No license granted hereunder . . . shall be transferred, assigned or in any matter disposed of, either voluntarily or involuntarily, directly or indirectly, through transfer of control of any license to any person, unless the Commission shall, after securing full information, find that the transfer is in accordance with the provisions of this [Act], and shall give its consent in writing.

Section 184 of the Atomic Energy Act, cited in Safety Light Corp., ALAB-931, 31 NRC at 362 [emphasis added by us].

We interpret this statute to require that a company retain actual control of licensed activities. If all that was prohibited was a transfer of the right to control licensed activities, then there would be no need to specify that "indirect" transfers also were prohibited. What is important is that the licensed entity, which has been approved by the Nuclear Regulatory Commission, should not enter into a new relationship that permits individuals who are not included in the license to control licensed activities, directly or indirectly.

This case is, however, somewhat complicated because the license was issued to Georgia Power, which is a wholly owned subsidiary of Southern Company. As a result of this preexisting relationship, Southern Company necessarily exercised some influence over licensed activities. However, we have not been shown the extent to which Southern Company was expected to exercise influence. Nor has a party developed an argument about the extent to which the formation of the SONOPCO project might have been merely a permissible way for Southern Company to continue to exert its influence.

B. Character and Competence

As we stated above, at p. 293:

Mr. Mosbaugh's principal allegation is that Southern Nuclear lacks the character and competence to operate a nuclear power plant.

However, Intervenor has not challenged any aspect of Southern Nuclear's competence apart from its integrity or character. There is extensive precedent before the Nuclear Regulatory Commission concerning the need for an operator of a nuclear power plant to have adequate integrity and character. A leading precedent on this question is Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit 1), CLI-85-9, 21 NRC 1118, 1136 (1985), which provides the following overview of this topic:

The concept of "integrity," or "character," is a . . . difficult one to define. See generally, e.g., ALAB-772, supra, 19 NRC at 1206-08; Houston Lighting and Power Co. (South Texas Project, Units 1 and 2), LBP-84-13, 19 NRC 659 (1984). A generally applicable standard for integrity is whether there is reasonable assurance that the Licensee has sufficient character
to operate the plant in a manner consistent with the public health and safety and applicable NRC requirements. The Commission in making this determination may consider evidence regarding licensee behavior having a rational connection to the safe operation of a nuclear power plant. This does not mean, however, that every act of licensee is relevant. Actions must have some reasonable relationship to licensee's character, i.e., its candor, truthfulness, willingness to abide by regulatory requirements, and acceptance of responsibility to protect public health and safety. In addition, acts bearing on character generally should not be considered in isolation. The pattern of licensee's relevant behavior, including corrective actions, should be considered.

In determining character, false statements may be telling indications of lack of character and might be sufficient to preclude an award of an operating license, at least as long as implicated individuals retained any responsibilities for the project. Consumers Power Co. (Midland Plant, Units 1 and 2), LBP-84-20, 19 NRC 1285, 1297 (1984), citing Houston Lighting and Power Co. (South Texas Project, Units 1 and 2), LBP-84-13, 19 NRC 659, 674-75 (1984), and Consumers Power Co. (Midland Plant, Units 1 and 2), CLI-83-2, 17 NRC 69, 70 (1983). In addition, it is clear that a "material false statement" under section 186a of the Atomic Energy Act encompasses omissions as well as affirmative statements. Consumers Power Co. (Midland Plant, Units 1 and 2), ALAB-691, 16 NRC 897, 911 (1982), citing Virginia Electric and Power Co. (North Anna Power Station, Units 1 and 2), CLI-76-22, 4 NRC 480, 489 (1976), aff'd sub nom., Virginia Electric and Power Co. v. Nuclear Regulatory Commission, 571 F.2d 1289 (4th Cir. 1978); Metropolitan Edison Co. (Three Mile Island Nuclear Station, Unit 1), ALAB-774, 19 NRC 1350 (1984).12

IV. THRESHOLD MATTERS

Before we come to the substance of the Motion, the Staff Response and the Response, we must first discuss and dispose of some pending threshold motions.

A. Motion to Strike

Georgia Power has filed a Motion to Strike. Intervenor opposes the Motion as prohibited by our rules. He correctly points out that once a party has filed a motion for summary disposition pursuant to 10 C.F.R. § 2.749, the Licensing Board is expressly prohibited by the rule from entertaining any further supporting statements. He argues that the Motion to Strike should not be entertained by

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the Board because it is a prohibited supporting statement. Response to Motion to Strike at 1.

We have decided to grant this motion in part. Intervenor is correct in arguing that Georgia Power may not properly move to strike Intervenor's legal argument. We do not think Intervenor made an egregious error in legal argument that justifies a motion to strike. On the other hand, we find that other parts of the Motion to Strike are proper. We are persuaded by some of Georgia Power's arguments concerning the failure to place evidence in its full context. Because of this failure to interpret evidence in full context, we agree with Georgia Power that we should not rely on facts that the intervenor asserts based solely on the undocumented recollections of Intervenor's counsel about events occurring during a deposition.13

We note Intervenor's apparent agreement that a Motion to Strike may be properly filed if it has substantial merit. On October 13, 1994, Intervenor filed a "Request to Strike NRC Staff's Response to Summary Disposition of the Illegal License Transfer Issue" (Motion to Strike Staff Response). Intervenor should not have submitted that filing unless it thought the filing might be proper. We therefore accept the shared view of the parties that a Motion to Strike may be proper if it is based on reasonable grounds. To avoid the filing of a proper Motion to Strike, a party should be very careful in its citations to the record. We do not find that Intervenor conformed to our high standards for such citations.

On the other hand, we also are not persuaded by the Motion to Strike. We have referred to that motion to guide our review of the Response, which we found at times to be insensitive to the full context in which evidence occurred. We think our willingness to accept this guidance from Georgia Power is sufficient penalty for Intervenor for what we find to be carelessness. Striking the response would, in our judgment, be disproportionate to the offense. In making this judgment, we rely in part on our conclusion that Intervenor presented many arguments that are properly supported in the record, so that his filing was helpful to the Board.

We consider Intervenor's Motion to Strike the Staff's Response to be moot. In disposing of the Motion, we found our key concern to be the detailed factual assertions in the Response. Since the Staff had not seen these assertions when it filed its own response, it did not directly address those assertions and therefore did not present arguments that were helpful to us in deciding what assumptions to draw from the evidence presented.

13 As examples, we consider meritorious the following allegations in the Motion to Strike: (1) p. 9, ¶b; (2) p. 10, ¶c; (3) p. 11, ¶c; (4) p. 14, ¶b; (5) p. 17, ¶b; (6) p. 23, ¶c; (7) pp. 25-30, ¶b j, k, l, m; (8) p. 31, ¶d. We note that intervenor was forced to rely on the recollection of counsel concerning the content of depositions because it decided, for financial reasons, not to purchase transcripts of its depositions.
B. Motion for Leave to Reply

Georgia Power's Motion for Leave to File a Reply is denied. It had ample opportunity to present to this Board its legal arguments concerning the proper legal standards to apply to the Motion for Summary Disposition. A reply is expressly prohibited by 10 C.F.R. § 2.749.

C. Public Utilities Holding Company Issues

Intervenor's arguments concerning whether or not Georgia Power complied with the Public Utilities Holding Company Act are not within the scope of the admitted contention and shall not be considered.

V. FINDINGS

A. Control of the Vogtle Plant

The principal allegation presented by the Response is that Southern Nuclear controlled nuclear operations at the Vogtle Plant before it obtained a license amendment that would permit it to do so. An important related issue is the whether this "control" indicates a lack in the character and integrity of the participating individuals or of Southern Nuclear, which is the proposed transferee of Georgia Power's operating license.

We have determined that we may start the review of the facts before us with the Intervenor's Response. The Motion addresses some aspects of the formal structure of authority between Georgia Power and the entities to which it delegated tasks related to its nuclear operations. On the other hand, Mr. Mosbaugh addressed in his findings of fact the pragmatic question of who actually exercised authority for the operation of the Vogtle Nuclear Power Plant. The specific facts alleged in Intervenor's Response were not addressed in the Motion. Hence, to the extent that we verify that the alleged facts are supported by the record, it is appropriate for us to assume, for purposes of deciding the summary judgment motion, that they are true.

Intervenor has portrayed for us the way that it believes that SONOPCO and Southern Nuclear have actually operated. From Georgia Power's perspective, the same facts would be interpreted very differently. However, we have determined that the overall pattern, favorably interpreted from Intervenor's perspective, permits us to assume that the practical ability to make major decisions about Vogtle had shifted from Georgia Power to SONOPCO.
A difficulty we face in deciding how to interpret the facts is that key SONOPCO employees were double- or triple-hatted. That is, they served more than one master. This makes it difficult to determine how power actually was exercised. In this regard, we note that the party seeking the amendment has the burden of proof and it is Georgia Power's responsibility, at this stage of the proceeding, to demonstrate that there are no reasonable inferences from which to assume that control of Vogtle had shifted to SONOPCO.

What, then, is SONOPCO? For most of the time with which we are concerned, it was a project without corporate existence. However, what happens in the real world does not always comport with legal niceties. From the evidence produced by Intervenor it is permissible to assume that SONOPCO was a powerful entity within Southern Company. One sign of its power is that it was a consultant to Georgia Power pursuant to an unusual agreement previously negotiated with Southern Company Services. Under that agreement, Georgia Power could not terminate the consulting arrangement without "mutual agreement" — meaning that Southern Company Services' contract as a consultant was perpetually assured unless it also agreed to terminate that arrangement.

We assume from the evidence that the most significant individual for determining whether there was an indirect shift of authority is Mr. Robert P. McDonald. He was the principal nuclear officer for Georgia Power and for Alabama Power. As an officer of Georgia Power, he was designated as Executive Vice President (Nuclear Operations) and reported to Mr. Sherer (or his successor, Mr. Dahlberg). We assume that, for some purposes, he reported directly to Mr. Joseph M. Farley, the Chief Executive Officer and President of Southern Nuclear.

We assume for the purpose of this proceeding that Mr. Farley, who had been President of Alabama Power Company, was a reluctant candidate to be SONOPCO chief executive because he already had "a high profile job" at Alabama Power and Light. We assume he was a persuasive manager with a broad interest in administration, as indicated by this NRC testimony by Mr. McDonald:

14 Stipulations at I-2, ¶4b (Phase II).
15 Intervenor's Exh. 7, Scherer 12/21/88 DOL Dep. at 19.
16 Scherer 12/21/88 DOL Dep. at 15-16. Also, see the ensuing discussion in the text.
17 Georgia Power Company's Response to the Board's Questions Concerning the Illegal License Transfer Issue, August 24, 1994 at 2-3; Hairston Affidavit ¶16 (attached to the Response); Exh. B (also attached), letter of R.P. McDonald, April 24, 1989; "Amended and Restated Agreement," attached to letter of John Lamberski of October 24, 1994, at 10 ("shall remain in effect until terminated by mutual agreement of said parties" — with a limited exception stated in the following paragraph).
18 Stipulations, Exh. 3, Hairston Aff., at 6, ¶19.
19 Hairston Aff. at 9, ¶19. See also Scherer 12/21/88 DOL Dep. at 15-16; Stipulations, Exh. 11, Report Details at 3; Intervenor's Exh. 4, Long Dep. at 48, 55; Intervenor's Exh. 13, Smith notation.
20 Addison Dep., June 9, 1994 (GPC filing) at 37-38.
He represents you might say the flow of individualized type leadership. Are those people who are manning those jobs, are they trained well enough? What are we looking for, for building people in the future. He gets on administrative things. When we get to budget and compare all these budgets what we do is, we get the Alabama budget and Georgia budget and we get all these people who are on the board together and have one big meeting and present the budget all at one time.

Each of them can see what is happening. We had one of those meetings here about two months ago, and he gave us some pointed comments, and the Southern Company President gave us some pointed comments. They can each see what is happening in the others and they can visually compare them. We think and they think that it's promoting management all the way around.21

We assume from the evidence that Mr. Farley held Staff conferences for SONOPCO at which the status of the nuclear plants was discussed.22 He appears to have made regular reports to the Southern Company Board of Directors.23 Mr. Farley stated that he “managed” the nuclear budget for each of the companies, which includes Georgia Power.24 Our record tends to show that at one time there was some concern by Oglethorpe Power Corporation, one of the owners of Vogtle, concerning the supervision of Mr. McDonald and how actively Mr. Farley was involved.25 While that concern may have been subsequently resolved, its mere existence requires us to make assumptions adverse to the interests of Georgia Power.

There also is some question concerning the way in which Mr. Dahlberg viewed his responsibility for managing nuclear operations. For example, there is evidence that upon becoming Chief Executive Officer of Georgia Power, Mr. Dahlberg reviewed the qualifications of the management of Georgia Power but excluded all nuclear operating people, even though 70% of Georgia Power’s assets were nuclear.26 Therefore, we assume someone else could have held that authority. Additionally, the record indicates that Georgia Power Company’s Executive Vice-President for Nuclear Operations was “inadvertently” omitted from its 10-K Report to the Securities and Exchange Commission.27 Our record does not contain any evidence concerning the significance of this omission.

21 Stipulations, Exh. 19, McDonald Dep. at 27-28.
22 Intervenor’s Exh. 4, Long Dep. at 48, 55.
23 We note that Mr. Farley may have briefed the Southern Company Board of Directors on important nuclear matters, including those related to Georgia Power. However, we do not rely on this allegation in reaching our opinion. Intervenor cited specific Board Meeting dates but did not document them in our record. Response at 34-35.
24 Although Mr. Farley also said that he does not make the decision because the decision has to be Mr. Dahlberg’s, the assumption the Board has adopted is based on practical control not on authority, so this statement is not directly relevant. Farley DOL Dep. at 94-95.
25 Intervenor’s Exh. 24, Oglethorpe SEC Intervention Reply at 4; Intervenor’s Exh. 13, Dahlberg Dep. at 96.
27 Motion to Strike at 16-17.
With respect to whether Mr. Dahlberg had effective control over SONOPCO, we assume from the evidence that Mr. Dahlberg began to form a Georgia Power group that would help him review the operations of SONOPCO. That group withered and was disbanded under circumstances that lead us to assume that Mr. Farley had a powerful influence on this decision.\textsuperscript{28} The apparent importance of this group to Mr. Dahlberg, at one time, is indicated in his Memorandum of December 27, 1988, to: ”Executive Officers, Division Vice Presidents, General Office Department Heads and Division Managers.” This memorandum, Intervenor’s Exhibit 26 says:

> It is important for us to realize that while our nuclear operations may be managed in Birmingham and ultimately will be managed by a separate Southern subsidiary, Georgia Power will be held accountable by our regulatory groups, our stockholders, and the public for the operation and performance of our nuclear units. It is essential that Georgia Power Company be involved in the operations of our units, monitor their performance and integrate nuclear operations goals, accountabilities, and financial planning into Georgia Power Corporate Plan.

> Effective immediately, a Nuclear Operations Contract Administration Group is formed to interface with our nuclear operations group in Birmingham. This group will report to Mr. G.F. Head, Senior Vice President, who will be responsible for all nuclear operations interactions.

Mr. McDonald appears to have been a triple-hatted SONOPCO employee, located in Birmingham\textsuperscript{29} where Mr. Farley’s office also was located. We assume that Mr. McDonald had more frequent in-person contacts with Mr. Farley than with Mr. Dahlberg. Furthermore, Georgia Power planned to apply for a license amendment that would make Southern Nuclear the operator of Vogtle and would have Mr. McDonald report solely to the chief executive for Southern Nuclear.\textsuperscript{30} So we may assume for the purpose of this proceeding that Mr. McDonald was more dependent for his career on Southern Nuclear than on Georgia Power. (We make this assumption in considering a summary disposition motion even though subsequent events call it into question. Both Mr. McDonald and Mr. Farley have retired and Mr. Dahlberg has become CEO of the Southern Company.)

We also assume for the purpose of this proceeding that SONOPCO executives and prospective Board members sometimes operated collegially. Some meetings appear to have been called “Board Meetings” in a participant’s appointment

\textsuperscript{28} Intervenor’s Exh. 31, Testimony of Mr. Head (according to representation of Mr. Kohn) at 652; Intervenor’s Exh. 31, Farley Dep. at 570; Intervenor’s Exh. 31, Farley Dep. at 587-88. Intervenor’s Exh. 31, Hobby Tr. at 1160 (possibly substantiated in Hobby Log, Intervenor’s Exh. 18).

\textsuperscript{29} Stipulation at 4-5, ¶¶s 12, 14, 19.

\textsuperscript{30} Stipulations at 2. We note that Intervenor did not concur with this stipulation, but this use of the stipulation is adverse to the interest of Georgia Power, which offered it into our record.

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book, and these meetings also were referred to as "informal board meetings."31 Since there was no corporation, there was no Board, in a formal sense. However, the existence of these meetings suggests a participative style of management. We assume, for purposes of the pending motion that undoing collegial decisions may be harder than undoing individual decisions, particularly because Mr. Farley lent special credibility to the group.

On the other hand, evidence indicates that Mr. McDonald was in regular contact with Mr. Dahlberg by telephone and, at times, face to face. Mr. Dahlberg apparently received written reports about nuclear operations.32 In addition, Mr. Dahlberg appears to have been actively involved in some matters, such as whether or not Georgia Power would agree to performance standards set by the Public Utilities Commission.33 However, we are not aware of evidence concerning how much detail Mr. Dahlberg received in his reports, the nature of his review or the scope of his responsive actions. We also do not know if there was a different scope for routine or special matters, such as the nuclear budget of Georgia Power or policies concerning scheduled outages.

A portion of the case on illegal transfer is admissible direct testimony or inferences drawn from the report of an NRC Staff inspection. For example, Mr. Robert W. Scherer, former Chief Executive Officer of GPC, testified, in December 1988, that:

Right now the relationship is that SONOPCO will operate the generating plants, the nuclear generating plants, for the individual operating companies, Alabama and Georgia, that own nuclear power facilities.

* * *

[T]he formation of [SONOPCO] . . . , the actual configuration of it, exists in reality in Birmingham because we have brought together the corporate general office staff of Alabama and Georgia, and also of Southern Company Services, into one central location, with the responsibility of operating nuclear plants of the various operating companies. [Emphasis added.]

Scherer 12/21/88 DOL Dep. at 19 (Intervenor's Exhibit 7).34

31 Intervenor's Exhs. 11 and 12. Farley DOL Dep. at 84-85.

Mr. McDonald's testimony is slightly different from Mr. Farley's. He states that there was no informal Board but "a meeting of the parties." He states that there have been one or two of those meetings of people who were envisioned to be on the Board. This included Mr. Harris, Mr. Dahlberg, Mr. Franklin, Mr. Addison, Mr. Farley, and Mr. McDonald. The meeting covered "the major problems that the plants have." McDonald DOL Dep. at 69-70.

Mr. Dahlberg remembered only one meeting of the proposed Board of Directors of SONOPCO. He said there may have been a discussion of litigation with Oglethorpe and of major budget issues, including the cost of condenser tubes at the Hatch Plant. They also discussed "the number of outages that would be planned." Dahlberg DOL Dep., May 1990 at 68-70.

33 Dahlberg DOL Dep. at 92-95; DOL Tr. at 336-42; Hobby Dep. at 62-63.
34 See also Stipulations, Exh. 5, authorizing the transfer of nuclear management to a nuclear operating management subsidiary of Southern Company. This formal resolution does not seem to retain temporary operating authority in Georgia Power.
We consider Intervenor's Exhibit 15 as evidence that supports the presupposition that there are questions about who was in charge. That exhibit is a telephone list titled, "Telephone List — On-Call Project Manager." On the list, as number one under the heading, "Georgia Power Company Corporate Management," is Mr. Joseph M. Farley. Mr. Dahlberg is in the same category as fourth on the list. Mr. Mosbaugh, in his affidavit, states that he was a "Vogtle Duty Manager" and that his instructions were that in the event of "significant operational and emergency events" he was expected to call the people listed as, "Georgia Power Company Corporate Management." Intervenor's Exh. 22, Mosbaugh Affidavit, ¶¶5, 8, and passim.

Another piece of evidence is a summary of a December 19-21, 1988 Inspection of GPC plants by the Staff of the Nuclear Regulatory Commission. At that time, the Staff stated:

Additionally, it was determined that although the new operating philosophy of the corporate staff in a support role as opposed to an overview role was sound, the Vogtle Final Safety Analysis Report needed to be revised to reflect this philosophy change.

Stipulations, Exh. 11, Summary at 2. We note that within the nuclear administration area of inspection the Staff found that "the FSAR requirements were not reflective of the new corporate support role concept" and that "new policy and instructions are being drafted." Stipulations, Exh. 11, Report Details at 6.

For all the foregoing reasons and upon consideration of the entire record in this matter, we assume for purposes of deciding this motion that Georgia Power did indirectly transfer the control of Vogtle nuclear operations to SONOPCO and to Southern Nuclear.

B. Effect of Illegal Transfer on Safety

Intervenor has made no showing that the transfer of authority to SONOPCO and to Southern Nuclear had any effect on the safety of Vogtle. We therefore dismiss that portion of its allegation of illegal transfer.

C. Alleged Omissions or Misrepresentations

The testimony of Mr. Scherer, plus inferences from other evidence presented above beginning at page 19, requires us to assume, for the purpose of the pending Motion, that Georgia Power made omissions or misrepresentations in its presentations to the Nuclear Regulatory Commission. However, we wish to caution Intervenor to be meticulous in presenting evidence about alleged omissions and misrepresentations, which are hard to prove even when they have occurred. For each allegation, we will need to know as precisely as we can: (1)
what was said, (2) in what context the statement existed, (3) the proof that the statement was inaccurate or incomplete, (4) when (if applicable) the statement was corrected, and (5) why we should be concerned about the length of delay between the statement and when it was corrected. This will require proof of a time line of actual events, demonstrating not only that they occurred but also when they occurred.

We also will require that the proof offered will make some allowance for inaccuracies in expression, understanding and memory. So we will need to know also how much time passed before the alleged misstatement was made.

It would be helpful to us if time lines and charts were used to communicate Intervenor's points clearly. Such simple and easy-to-grasp devices would be appreciated in the filings of all the parties.

D. Misrepresentation Before the SEC

On June 22, 1988, the Southern Company filed an application with the SEC to form SONOPCO as a subsidiary. Stipulations, Exh. 6. Intervenor alleges that this filing made no mention of the interim formation of a SONOPCO project.

The Board finds that this allegation is not supported in the record and does not constitute a genuine issue of fact that should be scheduled for a hearing. The SEC filing contains the following:

Southern anticipates implementing the SONOPCO operating structure in a transitional process involving three phases, with each phase being designed to improve the safety and efficiency of the nuclear operations over that obtained in the previous phase. Southern anticipates that each phase of this project will have benefits for system operations independent of the benefits derived from subsequent phases and will evaluate each phase prior to implementation.

The initial phase will be to form a matrix organization in which key management personnel will be shared between APC [Alabama Power Company] and GPC [Georgia Power Company] pursuant to shared employment agreements in substantially the form attached as Exhibit B-1 hereto. No changes in corporate structures will be needed to accomplish this pooling of management resources. Exhibit B-2 hereto presents the matrix organizational structure during phase one. (Board Comment: Exhibit B-2 is a block organizational chart entitled, Phase One Matrix Organization)

The second phase, to commence upon approval by the Commission of this application/declaration, will entail creation of the nuclear operating company as a service company providing nuclear services to APC and GPC.

In addition, the SEC gave the public notice of the proposed change on August 12, 1988. (SEC Release No. 35 — 24694, Stipulations, Exh. 8) The SEC Notice also describes the proposed phased change in organization:

SONOPCO's operating structure will be implemented in three phases. Initially, key nuclear operations management personnel will be shared between APC and GPC.
the second phase, which would begin upon approval by the Commission of the present application-declaration, SONOPCO will be organized as a service company that will provide APC and GPC with nuclear services, including plant operating services, fuel procurement services, administrative services and technical services, but will not own, finance or operate any nuclear or other utility assets. In the third phase, SONOPCO will become responsible, on behalf of the owners and through contract with them, for the operation and maintenance of all nuclear generating facilities owned by Southern electric system companies.

SONOPCO may apply to the Nuclear Regulatory Commission ("NRC") or its successor for facility licenses or permits for the Farley Nuclear Plant ("Farley"), owned and operated by APC, and for the Hatch Nuclear Plant ("Hatch") and Vogtle Nuclear Plant ("Vogtle"), each of which is jointly owned by GPC, the Municipal Electric Authority of Georgia, Oglethorpe Power Corporation, and the City of Dalton, Georgia, and for which GPC is the present licensee and operator under an existing operating agreement. . . . (Stip. Ex. 8 at 2)

Our reading of the SEC filing is that the SEC was fully informed of the phased approach to establishing Southern Nuclear. Hence, Intervenor has not demonstrated the existence of a genuine issue of fact.

E. Communications Between Georgia Power and the NRC

We are aware from our study of the record that there were extensive communications between Georgia Power and the NRC. The NRC also amassed substantial knowledge of Georgia Power through its resident inspector program and its inspection program. For Intervenor to demonstrate material misrepresentations or omissions, it must place communications by Georgia Power in the full context of its relationship with the NRC. In this section of our Memorandum and Order, the Board sets forth some of the facts that show to our satisfaction that communications were complete and above board. The purpose of this presentation of facts is to inform the Intervenor of part of the context within which it must prove its case:

On July 25, 1988, the NRC was informed by GPC that a project organization had been established for each plant. Stip. Ex. 9, enclosure 1. The NRC also was furnished with separate organization charts for "Nuclear Operations — Transition Organization" and for Vogtle Project Transition Organization. Stipulations, Ex. 9, enclosure 3. We find that NRC was duly informed of GPC's plans for reorganization at this meeting. "It is our opinion that this meeting was beneficial and has kept us apprised of your nuclear operations organization." (Aug. 11, 1988 Letter from Region II Administrator to GPC; Stip. 9.)

The following material fact presented by GPC has not been opposed by Intervenor and is therefore admitted:

6. GPC and SONOPCO Project personnel met repeatedly with representatives of the NRC to keep them abreast of all events pertaining to the phased formation of SONOPCO. NRC representatives also conducted site inspections of the offices in Birmingham to ensure compliance with NRC regulatory requirements. Stip. ¶¶ 5, 6, 10, 14, 15, 16, 21, 25 and 29; Hairston Aff. ¶7).
F. Transfer of Nuclear Operations to Birmingham

Finally, we note that Intervenor has claimed that NRC Region II was told that GPC's nuclear operations would remain in Atlanta until SEC approval for SONOPCO is obtained and the location of SONOPCO would not be decided until after SEC approval. Intervenor cites the July 25, 1988 meeting summary as support for this allegation. (Stip. Exh. 9, Encl. 1.) Intervenor claims this information is inaccurate in three respects: (1) NRC was not advised that a "SONOPCO project" would be formed; (2) NRC stated that GPC's nuclear operations would not be moved until SEC approval was obtained, whereas, in fact, GPC's nuclear operations were moved prior to SEC approval; and (3) the location of SONOPCO had not been selected, whereas, in fact, Birmingham site had already been selected. Intervenor's Response at 18-19.

The evidence supports Intervenor's allegation that on August 11, 1988, the NRC appears to have understood that a move of the corporate office location would be decided only after SEC approval of the formation of SONOPCO had been obtained. However, Mr. Addison announced only 41 days later that he had decided to move the offsite nuclear management and support functions of both Alabama Power and Georgia Power to a location near Birmingham. Furthermore, the NRC knew no later than December 19, 1988, that the move took place on November 1, 1988. Since Intervenor has not alleged any motivation for this delay and has not shown that Georgia Power gained anything through this delay, we are unimpressed by the amount of the delay that may have occurred before disclosure. Consequently, we do not find this to be a material misrepresentation and we do not admit it as a genuine issue of fact.

VI. CONCLUSION

Pursuant to 10 C.F.R. § 2.749, we assume for purposes of deciding this motion that Georgia Power did indirectly transfer the control of Vogtle nuclear operations to SONOPCO and to Southern Nuclear. However, we conclude that even if this transfer did occur, it would not provide an adequate reason to grant relief in this license amendment proceeding.

The Board acknowledges that Georgia Power did not request this ground for decision. However, our consideration of this case led us to that conclusion because we decided that merely showing an illegal transfer would be irrelevant. We recognize that Georgia Power may want to demonstrate at the hearing that it

35 Stipulations, Exh. 9, Encl. 1.
36 Stipulations, Exh. 10.
37 Stipulations, Exh. 11, Inspection Report at 1 ("Results"). We note, as well, that the NRC has a resident inspector at Vogtle. He was likely to know of a change of this importance as soon as it occurred.
did not illegally transfer control of its license. It may choose to introduce such proof in order to demonstrate that its representations to the Nuclear Regulatory Commission were not misleading. However, since we consider illegal transfer irrelevant to the outcome of the proceeding, we will permit such proof only to the extent relevant to allegations of misrepresentation.

On the other hand, we also conclude that there are genuine issues of fact concerning whether Georgia Power may have misrepresented its relationship to SUNOPCO and Southern Nuclear. These allegations require a hearing at which we can determine whether or not they are true. We stress that no allegations of misrepresentation have been proven. This decision determines only that a hearing on this issue shall be held.

We also have determined, however, that there is no genuine issue of fact concerning the following issues: (1) whether or not Georgia Power improperly withheld information from the Securities and Exchange Commission, (2) whether or not Georgia Power improperly delayed informing the NRC that its corporate offices were being moved to Birmingham, and (3) whether or not Georgia Power has violated the Public Utilities Holding Company Act. This third issue is excluded from the hearing because it is beyond the scope of the admitted contention.

VII. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is, this 8th day of November 1994, ORDERED that:


2. A hearing concerning alleged misrepresentations to the Nuclear Regulatory Commission shall be convened on December 19, 1994, at a location to be decided.

3. Summary disposition is granted for the following issues, which are no longer part of this case:

   (1) whether or not Georgia Power improperly withheld information from the Securities and Exchange Commission,

   (2) whether or not Georgia Power improperly delayed informing the NRC that its corporate offices were being moved to Birmingham, and
(3) whether or not Georgia Power has violated the Public Utilities Holding Company Act.

THE ATOMIC SAFETY AND LICENSING BOARD

James H. Carpenter (by PBB)
ADMINISTRATIVE JUDGE

Thomas D. Murphy
ADMINISTRATIVE JUDGE

Peter B. Bloch, Chair
ADMINISTRATIVE JUDGE

Rockville, Maryland
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

Thomas S. Moore, Chairman
Richard F. Cole
Frederick J. Shon

In the Matter of

Docket No. 70-3070-ML
(ASLBP No. 91-641-02-ML)
(Special Nuclear Material License)

LOUISIANA ENERGY SERVICES, L.P.
(Claiborne Enrichment Center)

November 18, 1994

RULES OF PRACTICE: DISCOVERY

Section 2.740(f) like its counterpart in the last sentence of Rule 37(d) of the Federal Rules of Civil Procedure from which the Commission’s provision was copied, applies exclusively to situations where a person or party totally fails to respond to a set of interrogatories or document requests. See 8 Charles A. Wright et al., Federal Practice and Procedure § 2291 at 809-10 (1970). See, e.g., Laclede Gas Co. v. Warnecke Corp., 604 F.2d 561, 565 (8th Cir. 1979).

RULES OF PRACTICE: DISCOVERY

Where a party has filed objections to one or more interrogatories or document requests or set forth partial, albeit incomplete, answers in a discovery response, the last sentence of section 2.740(f) has no applicability. The proper procedure in such a situation is for the party opposing the discovery to await the filing of a motion to compel and then respond to that motion.
MEMORANDUM AND ORDER

On November 9, 1994, we issued a memorandum and order granting the October 5, 1994 motion of the Intervenor, Citizens Against Nuclear Trash, to compel the Applicant, Louisiana Energy Services, L.P. (LES), to respond to a number of discovery requests. That ruling resolved the discovery disputes between the Intervenor and the Applicant over the Intervenor's interrogatories 40, 44-52, and 58 and document requests 10-14. Remaining for our resolution, however, are the disputes between the Applicant and the Intervenor over the Intervenor's interrogatories 59 and 60 and document request 19. These discovery disputes come before us on the Applicant's September 16 and 20, 1994 motions for protective orders.

In its responses to interrogatory 59 and document request 19, the Applicant stated its objections to the discovery requests. Similarly, the Applicant set forth its objection and, in addition, provided a partial answer in its discovery response to interrogatory 60. Then, rather than wait and oppose any forthcoming motion to compel from the Intervenor as it did with its other discovery responses, the Applicant filed two motions for a protective order with respect to interrogatories 59 and 60 and document request 19.

Although its motions do not reveal why the Applicant sought protective orders in these circumstances, we note that there appears to be a misapprehension among members of the NRC bar that the last sentence of the Commission's discovery rule on motions to compel, 10 C.F.R. § 2.740(f), requires the filing of a motion for a protective order when only an objection or an incomplete answer is provided in response to a discovery request. That provision states that "[f]ailure to answer or respond shall not be excused on the ground that the discovery sought is objectionable unless the person or party failing to answer or respond has applied for a protective order pursuant to paragraph (c) of this section." This provision, like its counterpart in the last sentence of Rule 37(d) of the Federal Rules of Civil Procedure from which the Commission's provision was copied, applies exclusively to situations where a person or party totally fails to respond to a set of interrogatories or document requests.\(^1\) Where a party has filed objections to one or more interrogatories or document requests or set forth partial, albeit incomplete, answers in a discovery response, the last sentence of section 2.740(f) has no applicability. The proper procedure in such a situation is for the party opposing the discovery to await the filing of a motion to compel and then respond to that motion. The reason for this should be obvious: upon receiving the objection or partial answer to its discovery request, the party

seeking the discovery may not wish to pursue the discovery further and the matter then is at an end, without the Licensing Board becoming involved and the expenditure of any resources by the parties or the Board.

Moreover, the filing of a motion for a protective order where the proponent of the order already has filed objections or partial responses to the discovery requests shifts the burden of going forward from the party seeking discovery to the party opposing it. But most significantly, in such circumstances the party seeking a protective order arguably must meet a higher standard to thwart the discovery than when merely opposing a motion to compel. Under the Commission's rule for protective orders, 10 C.F.R. § 2.740(c), like the corresponding provision of Rule 26(c) of the Federal Rules of Civil Procedure, the movant must demonstrate "good cause" that a protective order is necessary "to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense." No such requirement exists for opposing a motion to compel under section 2.704(f) of the Commission's discovery rules.

Regardless of the Applicant's reasons for filing the motions for protective orders, they are before us for resolution and we must judge them by the good cause standard of section 2.740(c). We turn first to the Applicant's September 16 motion seeking an order that it need not respond to interrogatories 59 and 60.

Interrogatory 59, like the other interrogatories we dealt with in our November 9 ruling, seeks information about the Applicant's actions in selecting the site near Homer, Louisiana, for the Claiborne Enrichment Center. Specifically, the interrogatory seeks the identity of any Louisiana churches and community groups and any Louisiana charitable, civic, or political organizations to whom the Applicant made donations before and during the site selection process. In its response to this interrogatory and in its motion for a protective order, the Applicant objects to the discovery on the ground that it is not relevant to any of the contentions in the proceeding.

Even assuming that a general relevancy objection can meet the good cause test of section 2.740(c) in order to protect the movant from "annoyance," such an objection is without merit here. The Applicant's relevancy objection to interrogatory 59 raises the same issue in the same context as the Applicant's previous objections to Intervenor's interrogatories 40, 44-52, and 58. In our November 9 ruling, as well as our earlier June 18, 1992 ruling, we rejected the Applicant's arguments, and those rulings are controlling here. As the Intervenor points out in its response to the Applicant's motion, LES claims to have based its siting decision in part on the views of community and opinion leaders. This being so, interrogatory 59 seeks information on certain of the Applicant's actions that may have influenced these leaders. Thus, because interrogatory 59 seeks information about the site selection process and, as our previous rulings explain,
the selection process is relevant to contention J, the Applicant’s objection is without merit.

Equally, without merit is the Applicant’s bald assertion that it will be subjected to annoyance, oppression, undue burden, and expense if it must respond to interrogatory 59. More than a mere conclusory statement is needed to establish good cause for a protective order. The Applicant must provide a particular and specific demonstration of fact to meet the requirements of section 2.740(c) and it has made no such showing. Accordingly, the Applicant’s motion for a protective order with respect to interrogatory 59 is denied.

Interrogatory 60 seeks a full description of the discussions, communications, and interactions between the Applicant and Senator J. Bennett Johnston of Louisiana with respect to the Applicant’s proposal to build a uranium enrichment facility in the United States. In responding to this discovery request, the Applicant did not raise a relevancy objection. Rather, the Applicant gave a partial answer stating that LES personnel had met on a number of occasions with Senator Johnston and that he had sponsored an amendment to the Solar, Wind, Waste and Geothermal Power Production Act of 1990, which provided that uranium enrichment facilities must be licensed under 10 C.F.R. Parts 40 and 70 rather than 10 C.F.R. Part 50. The Applicant’s response then stated that any further answer would subject it to undue burden and expense. In its motion for a protective order, the Applicant reiterates this objection and states that “[a] complete response to this request would involve review by numerous individuals employed by LES and its partners of four years of records such as calendar entries, trip reports, and meeting notes.”

The Applicant’s motion for a protective order also requests that it not be required to answer portions of Intervenor’s interrogatories 38, 41, 45, 50, and 52. These interrogatories ask, *inter alia*, that the Applicant provide the race of the individuals involved in various aspects of the site selection process if such information is known. In its discovery responses, the Applicant objected to the race question in each interrogatory and also responded that it does not know the race of the individuals involved adequately answers the discovery requests. Indeed, in its October 5, 1994, motion to compel, the Intervenor states, with respect to interrogatory 45, that it accepts the

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2 Applicant’s Motion for a Protective Order (September 16, 1994) at 2-3.
3 The Applicant’s motion for a protective order also requests that it not be required to answer portions of Intervenor’s interrogatories 38, 41, 45, 50, and 52. These interrogatories ask, *inter alia*, that the Applicant provide the race of the individuals involved in various aspects of the site selection process if such information is known. In its discovery responses, the Applicant objected to the race question in each interrogatory and also responded that it did not know the race of the individuals involved. The Applicant’s response to each of these interrogatories that it does not know the race of the individuals involved adequately answers the discovery requests. Indeed, in its October 5, 1994, motion to compel, the Intervenor states, with respect to interrogatory 45, that it accepts the (Continued)
Document request 19 corresponds to interrogatory 60. It seeks any documents referring or relating to the contacts between the Applicant and Senator Johnston. In its discovery response, the Applicant objected that answering the document request would subject it to annoyance, oppression, undue burden, and expense. The Applicant's motion for a protective order reiterates that a response would require a review by numerous individuals of 4 years of records. As in the case of interrogatory 60, corresponding document request 19 is not unreasonable. Moreover, in responding to interrogatory 60 much of the work will be done for responding to this document request. Additionally, in its response to the Applicant's motions for protective orders, the Intervenor has narrowed its document request to parallel its narrowing of interrogatory 60. Thus, the impact of this discovery request is further reduced. In these circumstances, the Applicant's motion does not establish good cause for issuing a protective order. Accordingly, the Applicant's motion for a protective order with respect to document request 19 is denied.

For the foregoing reasons, the Applicant's September 16 and 20, 1994 motions for protective orders that it need not respond to Intervenor's interrogatories 59 and 60 and document request 19 are denied.

It is so ORDERED.

THE ATOMIC SAFETY AND LICENSING BOARD

Thomas S. Moore
ADMINISTRATIVE JUDGE

Richard F. Cole
ADMINISTRATIVE JUDGE

Frederick J. Shon
ADMINISTRATIVE JUDGE

Rockville, Maryland
November 18, 1994

Applicant's representation about not knowing the race of the individuals involved. Because the Applicant already has answered these interrogatories, there is no dispute between the parties and no basis for issuing a protective order under section 2.740(c).
REGULATIONS: INTERPRETATION (10 C.F.R. § 2.1205(d))
RULES OF PRACTICE: INTERVENTION PETITIONS (PLEADING REQUIREMENTS FOR STATEMENTS OF CONCERN IN SUBPART L PROCEEDING)

While the threshold showing at the intervention stage of a Subpart L proceeding is exceedingly low, a statement of concern must be plead with enough specificity to allow a presiding officer the ability to ascertain whether or not what the intervenor seeks to litigate is truly relevant to the subject matter of the proceeding.

REGULATIONS: INTERPRETATION (10 C.F.R. § 2.1237(a); 10 C.F.R. § 2.730(c))
RULES OF PRACTICE: MOTIONS (REPLIES TO ANSWERS)

A proponent of a motion does not have the right to reply to an answer to the motion; parties who do not seek leave to file a reply are expressly denied the opportunity to do so.
MEMORANDUM AND ORDER
(Ruling on Motion for Reconsideration)

In a motion dated October 26, 1994, intervenor Native Americans for a Clean Environment (NACE) seeks partial reconsideration of the Presiding Officer's Memorandum and Order of October 14, 1994. In that Order, NACE was admitted as an intervenor in this proceeding and four of the six concerns raised by NACE were admitted for litigation. NACE now requests the Presiding Officer to reconsider the decision to exclude the remaining two concerns. Those two concerns had been excluded from litigation because the Presiding Officer found them not to be germane to the proceeding.

The first statement of concern excluded reads:

SFC has drastically reduced its managerial staff without demonstrating that the extensive and highly technical tasks associated with decommissioning can be accomplished safely and effectively under the new organization.

NACE argues that the Presiding Officer, in rejecting this concern, "apparently adopted SFC's incorrect reasoning that its current activities do not constitute 'decommissioning.'" The Presiding Officer agrees with NACE's position that the activities currently being conducted at the facility are in the nature of decommissioning activities. If the proposed management changes bring about regulatory deficiencies tied to such decommissioning activities, they are fair game for litigation, being germane to the subject matter of the proceeding. However, the Presiding Officer's decision to exclude this area of concern from the proceeding has little to do with decommissioning activities.

As stated in the Memorandum and Order of October 14, although NRC's Rules of Practice do not provide explicit guidance on criteria necessary for a petitioner's areas of concern to be accepted for litigation, the Commission's statement of consideration in the adoption of Subpart L does reflect the requirement that the "issues the requester wants to raise regarding the licensing action

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1 Throughout its motion, NACE outlines its differences with respect to the "Licensing Board." The provisions of 10 C.F.R. Part 2, Subpart L, under which this proceeding is being conducted, provide for a single Presiding Officer instead of a Licensing Board to oversee the proceeding.
2 Commission practice allows a petitioner, in a motion for reconsideration, to elaborate on or refine arguments previously advanced. See Central Electric Power Cooperative, Inc. (Virgil C. Summer Nuclear Station, Unit 1), CLI-81-26, 14 NRC 787, 790 (1981).
3 See 10 C.F.R. § 2.1205(g).
5 Reconsideration Motion at 1-2.
fall generally within the range of matters . . . properly subject to challenge in [the] proceeding."\(^6\)

In Subpart L proceedings, a statement of concern must provide enough specificity to afford the Presiding Officer the ability to link the concern with the subject matter of the proceeding in order to make a decision to admit the statement for litigation. Section 2.1205 states explicitly that the request for hearing filed by a person other than an applicant must describe in detail the requester's areas of concern about the licensing activity that is the subject matter of the proceeding.\(^7\) As the Commission has stated:

> It would not be equitable to require an intervenor to file its written presentation setting forth all its concerns without access to the hearing file. Of course the intervenor is required to identify the areas of concern it wishes to raise in the proceeding, which will provide the presiding officer with the minimal information needed to ensure the intervenor desires to litigate issues germane to the licensing proceeding . . . . [Emphasis supplied]\(^8\)

As a petition for intervention setting forth a petitioner's statement of concerns, NACE's petition is partially deficient. Four of the concerns are expressed with enough clarity for the Presiding Officer to find them relevant to the license amendment, two of them are not. The lack of specificity in those two concerns leaves open the question whether they are relevant to the proceeding. First, it is unclear whether NACE is addressing staffing concerns or concerns over the technical nature of decommissioning activities and its influence on SFC management. Second, merely stating that the quality assurance program is inadequate gives no indication to the Presiding Officer that the QA program may be affected by the license amendment. Again, without more, no determination can be made regarding whether that issue is germane to the proceeding.

Throughout the NACE Motion for Reconsideration, the Presiding Officer is taken to task for not paying heed to the embellished arguments found in the NACE Reply. NACE is correct in its speculation that the Presiding Officer did not rely on the Reply arguments. Under the provisions of section 2.730(c), the moving party has no right to reply to an answer without first moving the Presiding Officer for permission to make the Reply.\(^9\) No motion was made


\(^7\)10 C.F.R. § 2.1205(d) and (d)(3).


\(^9\)Texas Utilities Electric Co. (Comanche Peak Steam Electric Station, Units 1 and 2), CLI-89-6, 29 NRC 348, 353 at n.2 (1989) (ruling on intervention petition); Detroit Edison Co. (Enrico Fermi Atomic Power Plant, Unit 2), ALAB-469, 7 NRC 470, 471 (1978); but cf. Long Island Lighting Co. (Shoreham Nuclear Power Station, Unit 1), LBP-81-18, 14 NRC 71, 72 (1981) citing Houston Lighting and Power Co. (Allens Creek Nuclear Generating Station, Unit 1), ALAB-565, 10 NRC 521 (1979) (ruling on a contention the Appeal Board noted that in motions practice a contention is akin to a complaint in federal court and an answer is akin to a motion to dismiss thereby favoring admission of a reply). In this case, however, the reasoning of Allens Creek is not applicable because the decision to exclude the statements of concern did not turn on the arguments found in SFC's answer.
on behalf of NACE and therefore the Reply was not taken into consideration in the decision to exclude the two statements of concern. Which brings us to the Motion for Reconsideration.

Much, if not all of NACE's Motion regarding the first excluded concern reargues the perceived differences between NACE's and SFC's interpretations of "decommissioning" and when decommissioning commences. There is little in the way of clarification of the first excluded statement. The uncertainties remain as before. Not enough information has been provided. While the threshold showing at the intervention stage of a Subpart L proceeding is exceedingly low, it cannot be so low as to frustrate a Presiding Officer's ability to ascertain whether or not what the intervenor seeks to litigate is truly relevant to the license amendment being challenged. In this case, the uncertainty remains and the statement is excluded from litigation in this proceeding.

NACE's statement of concern regarding the SFC quality assurance program reads: SFC's new quality assurance program is inadequate. NACE's hearing petition provided nothing to aid the Presiding Officer in his duty to determine the relevance of this subject area. The Motion for Reconsideration provided arguments that embellished on this concern for the first time. NACE alleges that changes in reporting requirements and the consolidation of two laboratories in some manner affect the reliability of audits under the quality assurance program.11

We are constrained by the Commission's Rules of Practice from allowing the NACE arguments to influence our decision. It has been longstanding precedent that motions to reconsider an order should be associated with requests for reevaluation of the order in light of an elaboration upon, or refinement of, arguments previously advanced; they are not an occasion for advancing an entirely new thesis.12 NACE's petition was void of arguments that could have clarified the deficient statement of concern. The Motion for Reconsideration cannot save that deficiency now.13

Therefore, upon reconsideration of the record before the Presiding Officer:

10 The Presiding Officer did take note of a procedural clarification included in the NACE Reply concerning the nature of the standing being requested in the proceeding by NACE and the Cherokee Nation. This information would not have needed a motion to be forwarded and acted upon by the Presiding Officer.
11 Reconsideration Motion at 6-7.
12 Central Electric Power Cooperative, Inc. (Virgil C. Summer Nuclear Station, Unit 1), CLI-81-26, 14 NRC 787, 790 (1981), citing Tennessee Valley Authority (Hartsfield Nuclear Plant, Units 1A, 2A, 1B, and 2B), ALAB-418, 6 NRC 1, 2 (1977).
13 It should be noted that SFC did not serve the Presiding Officer with a copy of its Answer to the NACE Motion for Reconsideration, although the Secretary of the Commission and the other parties were served. NRC Regulations require such motions to be filed with the Presiding Officer; therefore the Secretary had no indication that a copy needed to be forwarded. 10 C.F.R. § 2.730. SFC moved the Presiding Officer to consider the Answer even though it was received over 2 weeks late. However, since the decision to exclude the statements of concern is grounded on pleading deficiencies, the Answer was not taken into consideration in this decision.
1. The NACE area of concern regarding managerial staffing adequacy and the extensive and highly technical decommissioning tasks remains excluded from litigation;

2. The NACE area of concern regarding the adequacy of the quality assurance program remains excluded from litigation.

   Be It So ORDERED.

James P. Gleason, Presiding Officer
ADMINISTRATIVE JUDGE

November 22, 1994
Rockville, Maryland
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

COMMISSIONERS:

Ivan Selin, Chairman
Kenneth C. Rogers
E. Gall de Planque

In the Matter of Docket Nos. 50-424-OLA-3
50-425-OLA-3

GEORGIA POWER COMPANY, et al.
(Vogtle Electric Generating Plant,
Units 1 and 2) December 21, 1994

The Commission denies a petition for interlocutory review filed by the Intervenor. The petition requested interlocutory review of an Atomic Safety and Licensing Board order, LBP-94-37, 40 NRC 288 (1994), which granted in part the Georgia Power Company’s motion for summary disposition of one of the Intervenor’s allegations. The Commission finds that the Intervenor did not demonstrate a need for interlocutory review.

RULES OF PRACTICE: INTERLOCUTORY REVIEW

The Commission has long disfavored interlocutory review.

RULES OF PRACTICE: INTERLOCUTORY REVIEW

A Licensing Board decision rejecting or admitting particular issues for consideration does not in and of itself indicate that a proceeding will be affected in a pervasive or unusual manner. The basic structure of an ongoing adjudication is not changed merely because an interlocutory Licensing Board ruling is incorrect, even if it conflicts with case law or Commission regulations.
RULES OF PRACTICE: INTERLOCUTORY REVIEW

The Commission will step into interlocutory situations only when a licensing board ruling creates immediate irreparable injury or fundamentally impacts the course of a proceeding.

MEMORANDUM AND ORDER

The Commission has before it a petition for interlocutory review filed by the Intervenor, Allen L. Mosbaugh. The Intervenor seeks review of LBP-94-37, 40 NRC 288 (1994), an Atomic Safety and Licensing Board Memorandum and Order that granted in part the Georgia Power Company's motion for summary disposition of the Intervenor's transfer-of-license allegations. Both the NRC Staff and the Licensee oppose the Intervenor's petition. For the reasons stated in this Order, we deny the Intervenor's petition.

This proceeding involves the Georgia Power Company's (GPC) request to transfer its operating authority over the Vogtle Electric Generating Plant, Units 1 and 2, to the Southern Nuclear Operating Company, Inc. (Southern Nuclear). The Licensing Board admitted one consolidated contention, which alleges that Southern Nuclear lacks the "requisite character, competence, and integrity, as well as the necessary candor, truthfulness and willingness to abide by regulatory requirements." The contention relied upon two bases. The first alleged that, in violation of section 184 of the Atomic Energy Act, GPC transferred its control over the Vogtle facility to Southern Nuclear, without first obtaining the written consent of the NRC. The second alleged that certain GPC officials, who now may be in key management positions at Southern Nuclear, submitted false information to the NRC about Vogtle's diesel generators. The Licensing Board structured the proceeding to address these two general allegations in separate phases, in effect in separate hearings. The Intervenor's petition for review involves only the Licensing Board's treatment of the first basis, the illegal-transfer-of-control allegation, which will be the focus of a hearing currently scheduled to begin in early January. The Licensing Board will receive arguments on the diesel generator claim only in a separate and later hearing.

Following discovery, GPC submitted a motion for summary disposition of the illegal transfer issue. In LBP-94-37, the Licensing Board granted the Licensee's summary disposition motion in part, albeit on a ground not urged by GPC itself. The Board concluded that the legality of GPC's transfer of operations was irrelevant to the outcome of the proceeding, because no remedy for an illegal transfer was available and because the Intervenor allegedly had dropped his claim of a safety nexus. The Board allowed the Intervenor to proceed only on the theory that actual misrepresentations were made to the NRC about who
was in control of the Vogtle facility’s nuclear operations. The Board, in short, ordered that the hearing on the illegal transfer claim be limited to a single issue — whether individuals through false statements or omissions misled the NRC about who was running the facility.

The Intervenor filed his petition pursuant to 10 C.F.R. § 2.786(g), which allows interlocutory review only under limited circumstances. Under the regulation, a decision may warrant interlocutory review if it (1) threatens the party adversely affected with “immediate and serious irreparable” impact, or (2) affects the basic structure of the proceeding in a “pervasive or unusual manner.”

The Commission has long disfavored interlocutory appellate review. See Sequoyah Fuels Corp. (Gore, Oklahoma Site), CL-94-11, 40 NRC 55, 59 (1994); Sacramento Municipal Utility District (Rancho Seco Nuclear Generating Station), CL-94-2, 39 NRC 91, 93 (1994) (Rancho Seco). We find no reason here to depart from that policy. Although aspects of the Licensing Board’s decision relating to available remedies and burdens of proof appear highly questionable, the Intervenor has not demonstrated why we should take the extraordinary step of taking appellate review at this time.

We note, in response to the first prong of the test, that the Board’s decision poses no irreparable harm. Indeed, the Intervenor does not argue otherwise. He may still go forward in presenting a case about the Applicant’s character qualifications. If the Intervenor prevails before the Licensing Board, his concerns will have become moot. If he loses before the Board, he may then again petition the Commission for review and raise anew the question whether the Board improperly restricted his illegal transfer claim.

The Intervenor bases his petition for review on the second prong of the test, arguing that the decision will affect the structure of the proceeding in a pervasive or unusual manner. But a licensing board decision rejecting or admitting particular issues for consideration does not in and of itself indicate that a proceeding will be affected in a pervasive or unusual manner. See Rancho Seco, CL-94-2, 39 NRC at 94. The basic structure of an ongoing adjudication is not changed merely because an interlocutory licensing board ruling is incorrect, even when it conflicts with case law or Commission regulations. See id.

In addition, the potential prejudicial impact of the decision is unclear at this point, and is not well outlined in the Intervenor’s petition. Even under the decision, the Intervenor appears free to submit any evidence he has of misrepresentations — through acts or omissions — made to the NRC about the actual control of the Vogtle facility. It may turn out that there is a near total overlap between the evidence that the Intervenor would have submitted in the absence of the Board decision and the evidence now permitted under
that decision. But, whether or not that proves true, we do not sit simply to correct erroneous interlocutory licensing board rulings. We will step into interlocutory situations only when a Board ruling creates immediate irreparable injury or fundamentally impacts the course of a proceeding. See Safety Light Corp. (Bloomsburg Site Decontamination and License Renewal Denials), CLI-92-13, 36 NRC 79, 85-86 (1992) (conversion of a Subpart L proceeding into a Subpart G proceeding affected proceeding in pervasive and unusual manner). Accordingly, we find it appropriate here to reserve review, if necessary, to a more fully developed record and a merits-based decision.

By declining review, we intimate no judgment on the soundness of the Licensing Board's decision. Our decision today stems solely from a reluctance to take interlocutory review except in extraordinary situations.

**CONCLUSION**

For the reasons stated herein, the Intervenor's petition for review is denied. It is so ORDERED.

For the Commission

JOHN C. HOYLE
Acting Secretary of the Commission

Dated at Rockville, Maryland, this 21st day of December 1994.

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1 If the Board, based upon LBP-94-37, excludes any evidence that the Intervenor seeks to introduce, we can review that action upon appeal of the entire decision. The Intervenor may also raise at that time the same issues he has raised in his petition for review here.
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

G. Paul Bollwerk, Ill, Chairman
Dr. Charles N. Kelber
Dr. Peter S. Lam

In the Matter of

Docket No. IA-94-011
(ASLBP No. 94-696-05-EA)

DR. JAMES E. BAUER
(Order Prohibiting Involvement In
NRC-Licensed Activities)

December 9, 1994

In this proceeding concerning an NRC Staff enforcement order prohibiting the involvement of Dr. James E. Bauer in NRC-licensed activities, the Licensing Board rules on prediscovery dispositive motions regarding a number of the issues specified by the parties for litigation.

ENFORCEMENT ACTIONS: STAY OF PROCEEDINGS

Claiming a constitutional deprivation arising from a delayed adjudication generally requires some showing of prejudice. See Oncology Services Corp., CLI-93-17, 38 NRC 44, 50-51 (1993).

ENFORCEMENT ACTIONS: STAY OF PROCEEDINGS

The pendency of a related criminal investigation can provide an appropriate basis for postponing litigation on a Staff enforcement order. See id. at 53-56.
ENFORCEMENT ACTIONS: SUFFICIENCY OF CHARGES

The Staff will not be precluded, as a matter of law, from relying on allegations as the basis for an enforcement order if there is a "sufficient nexus" between the allegations and the regulated activities that formed the focus of the Staff's order. Indiana Regional Cancer Center, LBP-94-21, 40 NRC 22, 31 (1994).

LICENSING BOARDS: AUTHORITY TO DISMISS ISSUES IN ENFORCEMENT PROCEEDING
RULES OF PRACTICE: DISMISSAL OF ISSUES IN ENFORCEMENT PROCEEDING

If it can be shown there is no set of facts that would entitle a party to relief relative to proposed issue in an enforcement proceeding, then dismissal of that issue is appropriate. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 33 & n.4; Oncology Services Corp., LBP-94-2, 39 NRC 11, 23 & n.8 (1994).

LICENSING BOARDS: AUTHORITY TO DISMISS ISSUES IN ENFORCEMENT PROCEEDING
RULES OF PRACTICE: DISMISSAL OF ISSUES IN ENFORCEMENT PROCEEDING

Consistent with the analogous agency rules regarding contentions filed by intervenors, see 10 C.F.R. § 2.714(d)(2)(ii), issues that would constitute "defenses" to an enforcement order are subject to dismissal under the appropriate circumstances. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 33 n.4.

ENFORCEMENT ACTIONS: SCOPE OF PROCEEDINGS

In assessing whether the bases assigned support an order in terms of both the type and duration of the enforcement action, a relevant factor may be the public health and safety significance, including the medical appropriateness, of the specified bases. See id. at 33-34.

ENFORCEMENT ACTIONS: SCOPE OF PROCEEDINGS

In proceedings involving challenges to Staff enforcement orders, the overarching matter for consideration is whether the order should be sustained and the presiding officer's authority regarding this question "is to consider 'whether the facts in the order are true and whether the remedy selected is supported by those
facts.'" Oncology Services Corp., LBP-94-2, 39 NRC at 25 (quoting Boston Edison Co. (Pilgrim Nuclear Power Station), CLI-82-16, 16 NRC 44, 45 (1982), aff'd, Bellotti v. NRC, 725 F.2d 1380 (D.C. Cir. 1983)). The bases asserted in an enforcement order thus do provide the principal framework for the proceeding. As a consequence, any legal or factual issue a party wants to propose in challenging (or supporting) an enforcement order must bear some relationship to those bases by tending to establish, either alone or with other issues, that some explicit or implicit legal or factual predicate to the order should not (or should) be sustained. Further, a party called upon to demonstrate this relationship must be able to do so by more than a bald pronouncement that the issue is "relevant." Cf. Advanced Medical Systems, Inc. (One Factory Row, Geneva, Ohio 44041), CLI-94-6, 39 NRC 285, 308 (1994) (mere assertions of dispute over material facts do not invalidate grant of summary disposition).

MEMORANDUM AND ORDER
(Ruling on Prediscovery Dispositive Motions)

The parties to this proceeding, petitioner James E. Bauer, M.D., and the NRC Staff, have filed motions seeking dispositive resolution of certain issues concerning the May 10, 1994 Staff enforcement order that is the locus of this litigation. In that order, the Staff alleges that certain of Dr. Bauer's actions regarding regulated nuclear materials demonstrate he cannot conduct NRC-licensed activities in conformity with agency requirements. As a consequence, the immediately effective order imposes several restrictions on Dr. Bauer, including barring him from conducting any NRC-licensed activities for a period of five years.

In their dispositive motions, both parties seek a ruling on the jointly identified litigation issue of whether the order can be based on Staff allegations regarding (1) Dr. Bauer's actions while serving as radiation safety officer (RSO) and sole authorized user on a byproduct materials license permitting the Indiana Regional Cancer Center (IRCC) to use a strontium-90 source to treat specified medical conditions, and (2) his involvement in a November 1992 misadministration incident at IRCC under a different NRC license authorizing the use of iridium-192 to provide high dose rate (HDR) brachytherapy treatments. In addition, the Staff asserts that it is entitled to summary disposition on the jointly identified issue of whether the treatment of superficial skin lesions with strontium-90 violates the terms of IRCC's license. Finally, the Staff asks for dismissal of eight other issues identified by Dr. Bauer as appropriate litigation questions.

For the reasons given below, we find that the Staff is not precluded as a matter of law from relying on Dr. Bauer's purported involvement in the November
1992 incident or his alleged activities under the IRCC strontium-90 license as a basis for its May 1994 order. Further, on the joint issue of whether the treatment of superficial skin lesions with strontium-90 violates the terms of IRCC's license, we request that the parties address several questions regarding that matter. Finally, for the eight Dr. Bauer litigation issues that the Staff seeks to expel, we conclude that three should be consolidated with other issues and three should be dismissed in toto.

I. BACKGROUND

The May 1994 order at issue here is the third recent Staff enforcement directive involving Dr. Bauer. The first was a January 1993 order that suspended the license of Oncology Services Corporation (OSC) authorizing it to provide iridium-192 HDR brachytherapy treatments at six OSC Pennsylvania facilities, including IRCC. See 58 Fed. Reg. 6825 (1993). One of the cited grounds for this suspension was a November 1992 incident at IRCC in which IRCC personnel allegedly failed to detect an iridium-192 source that remained in a patient's body after she received an HDR brachytherapy treatment with an Omnitron 2000 remote afterloader machine. The Staff contended that as the authorized user under the license who was supervising the patient's treatment, Dr. Bauer did not conduct an adequate survey of the patient before permitting her to return to her nursing home, which resulted in significant radiation exposures to the patient and members of the general public. See id. at 6825-26.

In November 1993, the Staff issued a second enforcement order that suspended IRCC's license to use a strontium-90 source to treat specified medical conditions and modified that license to preclude Dr. Bauer, the RSO and the only authorized user named in the license, from undertaking any activities under the strontium-90 license. See 58 Fed. Reg. 61,932 (1993). The Staff asserted that this suspension and modification was necessary because of the use of strontium-90 to treat skin lesions, an activity it contends was not authorized under the license, and the failure of Dr. Bauer during a November 1993 inspection to provide agency inspectors with accurate and complete information regarding skin lesion treatments. The Staff also based this order on Dr. Bauer's purported involvement in the November 1992 brachytherapy treatment incident outlined in the January 1993 enforcement order. See id. at 61,932-33.

The third enforcement order, which is now before us, is directed solely to Dr. Bauer. See 59 Fed. Reg. 25,673 (1994). Relying essentially on the allegations regarding the brachytherapy treatment and strontium-90 use incidents specified in the two previous orders, the Staff has directed that for five years Dr. Bauer cannot be named in any NRC license to act in any capacity or otherwise conduct any NRC-licensed activities. In addition, to permit the agency to monitor his
compliance with regulatory requirements, for two years thereafter Dr. Bauer must inform the NRC within twenty days of accepting employment concerning, or otherwise becoming involved in, NRC-licensed activities. See id. at 25,673-74.

The licensees and/or Dr. Bauer sought a hearing to contest each of these three orders. The OSC and IRCC proceedings recently were dismissed prior to any dispositive adjudication on the merits based on licensee requests for termination of the licenses involved. See Oncology Services Corp., LBP-94-29, 40 NRC 123 (1994); Indiana Regional Cancer Center, LBP-94-36, 40 NRC 283 (1994). Dr. Bauer, however, continues to contest the validity of the May 1994 order in this proceeding.1

In that regard, acting pursuant to a Board directive, see Memorandum and Order (Initial Prehearing Order) (June 8, 1994) at 4-6 (unpublished), on June 24, 1994, Dr. Bauer and the Staff filed a joint prehearing report in which they specified the central issues for litigation in this proceeding. See Joint Prehearing Report (June 24, 1994) at 1-6 [hereinafter Joint Prehearing Report]. Subsequently, in accord with a Board prehearing order, see Order (Establishing Schedule for Prediscovery Dispositive Motions and Filings Concerning Consolidation and Discovery) (July 1, 1994) at 1 (unpublished), both the Staff and Dr. Bauer filed dispositive motions regarding a number of those issues, as well as responses and replies to those motions. See NRC Staff Motion for Summary Disposition and NRC Staff Motion for Dismissal (July 29, 1994) [hereinafter Staff Dispositive Motions]; Motion to Eliminate Basis for Suspension (July 29, 1994) [hereinafter Bauer Dispositive Motion]; Response to NRC Staff Motion for Summary Disposition and NRC Staff Motion for Dismissal (Aug. 29, 1994) [hereinafter Bauer Response]; NRC Staff’s Response to Motion to Eliminate Basis for Suspension (Aug. 29, 1994) [hereinafter Staff Response]; NRC Staff’s Reply to James E. Bauer’s Response to NRC Staff’s Motions (Sept. 12, 1994); Reply to NRC Staff’s Response to Motion to Eliminate Basis for Suspension (Sept. 12, 1994) [hereinafter Bauer Reply].

In their dispositive motions, Dr. Bauer and the Staff seek a ruling on the jointly identified central issue of whether, as a legal matter, the Staff can rely on Dr. Bauer’s purported involvement in the incidents concerning OSC’s iridium-192 license and IRCC’s strontium-90 license as bases for its May 1994 order barring him from all NRC-licensed activities for a five-year period (Joint Issue 4). Additionally, the Staff requests that we enter summary disposition in its favor on the jointly identified issue of whether the treatment of superficial skin

1 Although the Board was considering whether to consolidate this proceeding with the IRCC proceeding, see Order (Establishing Schedule for Prediscovery Dispositive Motions and Filings Concerning Consolidation and Discovery) (July 1, 1994) at 1-2 (unpublished), the dismissal of the IRCC case renders that question moot.
lesions with strontium-90 constitutes a violation of the terms of IRCC's license (Joint Issue 1).

Finally, the Staff asks that we dismiss eight of Dr. Bauer's proposed litigation issues. This includes issues concerning the medical appropriateness of using strontium-90 as a skin lesion treatment (Bauer Issue 16); the risk to the public health and safety from using strontium-90 for skin lesion treatments (Bauer Issue 17); the possibility that the Omnitron 2000 brachytherapy afterloader machine used during the November 1992 incident was defective (Bauer Issue 35); Omnitron's duty to notify Dr. Bauer and OSC about Omnitron 2000 source wire deterioration (Bauer Issue 37); Omnitron 2000 design, manufacturing, and/or warning defects as the cause of the November 1992 incident (Bauer Issue 38); unanticipated Omnitron 2000 retraction mechanism failure and Dr. Bauer's reliance on Omnitron procedures that did not anticipate such an emergency as causes of the November 1992 incident (Bauer Issue 40); the applicability of 10 C.F.R. Part 35, Subpart G to the use of iridium-192 as a brachytherapy remote afterloader sealed source in human HDR treatments (Bauer Issue 48); and, if 10 C.F.R. Part 35, Subpart G applies to the use of iridium-192 as a remote afterloader sealed source in human HDR treatments, the applicability of the specific survey requirement of 10 C.F.R. § 35.404(a) to such treatments (Bauer Issue 49).

II. ANALYSIS

A. Dr. Bauer Motion to Eliminate Basis and Staff Motion for Summary Disposition of Joint Issue 4

1. The Improper Bases Issue

The parties' prehearing report jointly identifies the following as the fourth issue for litigation in this proceeding:

Whether conduct which is subject to pending litigation, i.e., Dr. Bauer's alleged conduct under License No. 37-28540-01 (HDR license) and under License No. 37-28179-01 (strontium-90 license), can, as a matter of law, be a basis for the [May 10, 1994] Order Prohibiting Involvement in NRC-Licensed Activities.

Joint Prehearing Report at 2. Both the Staff and Dr. Bauer seek a dispositive ruling in their favor on this issue.

In a pleading called "Motion to Eliminate Basis for Suspension," IRCC and Dr. Bauer contended in the IRCC proceeding that it was inappropriate to use allegations set forth in the OSC proceeding relating to activities under OSC's iridium-192 license as a basis for the November 1993 order regarding IRCC and Dr. Bauer's activities under the separate strontium-90 license because the

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allegations (1) had not been adjudicated; (2) were based solely upon hearsay; and (3) lacked any substantive relationship to the license suspension/modification at issue in the proceeding. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC 22, 28-31 (1994). In an identically titled pleading, Dr. Bauer essentially reprises these themes. He asserts that the Staff should be prevented from utilizing any of the allegations from either the January 1993 OSC order or the November 1993 IRCC order in support of the May 1994 order because (1) constitutional due process bars the use of unlitigated, hearsay allegations as the basis for an agency enforcement action; (2) Dr. Bauer has been deprived of his due process right to a timely opportunity to litigate these allegations; and (3) the allegations do not relate in any substantive way to the penalty in the May 1994 order, which bars Dr. Bauer from participating in all NRC-licensed activities. See Bauer Dispositive Motion at 4-11; see also Bauer Reply at 2-5.

Declaring that there are no material issues of fact relative to Joint Issue 4, the NRC Staff asserts that it is entitled to summary disposition on this issue. According to the Staff, the Commission’s wide-ranging authority under the Atomic Energy Act to protect the public health and safety, in conjunction with its authority under 10 C.F.R. § 2.202(a)(1) to consider any facts deemed sufficient grounds for a proposed action, is more than adequate to permit it to base the May 1994 order on Dr. Bauer’s alleged conduct under the separate iridium-192 and strontium-90 licenses. In addition, the Staff declares that the “unlitigated” or “hearsay” nature of the allegations is no bar to their use because, in accordance with the requirements of due process, Dr. Bauer has been presented with understandable charges and a fair, timely opportunity to litigate those charges. The Staff further maintains that Dr. Bauer’s activities under the two licenses cannot be labelled as irrelevant or immaterial to the prohibition on participation in all licensed activities imposed by the May 1994 enforcement order because there is a sufficient nexus between his alleged actions and that sanction. See Staff Dispositive Motions at 8-12; Staff Response at 3-9. Finally, the Staff asserts that if we agree with its arguments regarding Joint Issue 4, three related litigation issues propounded by Dr. Bauer — Issues 19, 20, and 22 — also must be summarily resolved in the Staff’s favor. See Staff Dispositive Motions at 8 n.3. Dr. Bauer has recorded those issues as follows:

19. Whether admission of evidence regarding Dr. Bauer's conduct on November 16, 1992 is improperly prejudicial given the posture of this proceeding and the confusion of issues likely to arise from the admission of that evidence?

2 In two of its statements of material fact, the Staff references the pendency of the OSC and IRCC litigation. See Staff Dispositive Motions at 5-6. As we noted above, however, those cases have been dismissed at the parties' request. See supra p. 327.
20. Whether the admission of evidence regarding Dr. Bauer's conduct on November 16, 1992 amounts per se to a denial of the due process rights of Dr. Bauer?

22. Whether allegations regarding Dr. Bauer's conduct on November 16, 1992 are admissible in this proceeding in that Dr. Bauer has [not] yet had the opportunity to contest any implication of fault at a hearing and there has been no finding of fault against him?

Joint Prehearing Report at 3-4.

2. The Board's Determination

As the Staff points out, we previously have dealt with most of the substance of Dr. Bauer's claims regarding this issue in the IRCC proceeding. There we found that the "unlitigated" and "hearsay" nature of the Staff's allegations concerning the November 1992 iridium-192 misadministration incident were not sufficient to bar their use as a basis for an enforcement order directed to IRCC and Dr. Bauer relative to IRCC's strontium-90 license. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 30-31. Those findings are applicable here, and need not be repeated.

Two aspects of Dr. Bauer's claims do merit additional discussion, however. The first is his concern that he (along with licensees OSC and IRCC) has not been afforded a timely opportunity to contest the Staff's allegations regarding the November 1992 misadministration incident and his alleged improper activities under the IRCC strontium-90 license. In this regard, Dr. Bauer correctly notes that some of these allegations involve events that occurred more than two years ago and that their validity has not yet been litigated despite being the basis for several contested Staff enforcement orders.

We conclude, however, that given the basis for and the current length of this delay, dismissal of the Staff's allegations on constitutional due process grounds is not warranted. Claiming a constitutional deprivation arising from a delayed adjudication generally requires some showing of prejudice. See Oncology Services Corp., CLI-93-17, 38 NRC 44, 50-51 (1993). As the Commission already has noted in this regard, "[i]t is certainly conceivable that the passage of time may affect some witnesses' memories. However, the extent of prejudice from any potentially faded memories is far from clear." Id. at 59.

Dr. Bauer has not made any assertion regarding the memory of any particular witness or, indeed, made any other specific claim of prejudice arising from the delay. Moreover, it has been recognized that the pendency of a related criminal investigation — the principal reason for the delay here, see Order (Granting Stay of Discovery) (July 18, 1994) (unpublished) — provides an appropriate basis for
postponing this litigation. See Oncology Services Corp., CLI-93-17, 38 NRC at 53-56. We thus are unable to conclude at this juncture that the delay that has accrued in adjudicating the Staff’s allegations constitutes a constitutional violation or mandates, as a matter of law, that we refuse to consider the Staff’s allegations.

The other matter that requires some explication is the question of the relationship of the Staff’s allegations to the penalty imposed. In our prior IRCC determination, we considered the issue of whether Staff allegations regarding the November 1992 brachytherapy misadministration incident could be used as a basis for the November 1993 enforcement order regarding IRCC’s strontium-90 license. We concluded there was a “sufficient nexus” between those allegations and the regulated activities that formed the focus of the Staff’s order such that we would not, as a matter of law, preclude the Staff’s use of the allegations. Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 31.

Dr. Bauer’s concern here is somewhat different — i.e., that the allegations regarding his activities under licenses involving only iridium-192 and strontium-90 cannot be used as a basis to preclude him from all regulated activities. Analyzing this contention, however, we find that it warrants the same resolution we reached in the IRCC proceeding. If, for the purpose of ruling on Dr. Bauer’s motion, we accept what has been pled by the Staff in the order as true, the factual circumstances set forth in the order regarding Dr. Bauer’s involvement in the November 1992 incident and his activities under the strontium-90 license have a sufficient link to the challenged penalty to permit them to provide a basis for that penalty.

For both sets of allegations and the proposed penalty, the central connecting factor is Dr. Bauer and his activities with licensed materials. In each instance, it is alleged that Dr. Bauer, as an authorized user under the license in question, was substantially involved (either as a supervisor or the administering physician) in providing treatments employing licensed materials in a manner that the Staff concludes was not in conformance with agency requirements. And, contrary to Dr. Bauer’s assertion, the fact that the Staff’s allegations concern Dr. Bauer’s activities under two separate licenses does not attenuate this link. Indeed, this broader base for the allegations seemingly provides more support for suspending Dr. Bauer’s authority for “all” licensed activities than might be the case with allegations relating to activities under only one license.

Consequently, we deny Dr. Bauer’s motion to eliminate the allegations regarding the November 1992 incident and Dr. Bauer’s activities under the IRCC iridium-192 license as bases for the May 1994 enforcement order. Further, there being no material factual issues in dispute concerning Joint Issue 4, we find in

3 Indeed, in this instance Dr. Bauer has relied upon the pending criminal investigation as a basis for obtaining the postponement of Staff discovery. See Request to Stay Proceeding and Discovery (July 13, 1994) at 2-3.

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favor of the Staff on that issue. Of course, the Staff continues to bear the burden of demonstrating that the allegations it has put forward in support of its May 1994 order are sufficient to sustain that enforcement order, including the penalties imposed under the order. In turn, Dr. Bauer may offer any appropriate legal or factual information challenging those allegations in an effort to show that they are insufficient to sustain the order.

Finally, regarding the Staff’s assertion that the three related Dr. Bauer issues should be dismissed, as we found previously in the IRCC proceeding, those issues embody particular arguments about why Dr. Bauer should prevail on the general issue set forth in Joint Issue 4. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 32. As there, we conclude that by addressing those assertions in ruling in the Staff’s favor on Joint Issue 4, those particular issues are for all practical purposes moot and so can be dismissed from this proceeding.

B. Staff Motion for Summary Disposition of Joint Issue 1

In addition to the improper bases issue, the Staff seeks summary disposition concerning the first issue jointly identified by the parties for litigation in this proceeding. The parties delineate this issue as “whether the treatment of superficial skin lesions with strontium-90 is a violation of License No. 37-28179-01?” Joint Prehearing Report at 1.

In support of its motion for summary disposition on this issue, the Staff sets forth two statements of material fact not in issue. The first declares that section 9 of the license, which is entitled “Authorized Use,” contains the following statement regarding the licensed strontium-90: “For use in Atlantic Research Corporation Model B1 Medical Eye Applicator for treatment of superficial eye conditions.” See Staff Dispositive Motion at 5. The second Staff statement asserts that “[t]here are no other authorized uses for the strontium-90 in License No. 37-28179-01.” Id. The Staff argues that because these statements are true, it is entitled to summary disposition in its favor on Joint Issue 1.

In response, Dr. Bauer points to section 13 of the license, which states that “[t]his license is based on the licensee’s statements and representations listed below: A. Application dated March 28, 1988.” Dr. Bauer asserts that because paragraph 6 in the attachment to IRCC’s March 1988 application states that the purpose for which licensed material will be used is “[t]reatment of superficial tissues of the eye and skin,” the Staff’s section 13 declaration that the license was based on the IRCC application means that the application’s statement of purpose was incorporated into the license in its entirety and cannot now be disavowed by the Staff. See Bauer Response at 2.

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4 A copy of NRC License No. 37-28179-01 containing this provision and IRCC’s March 1988 application for the license are included as Attachments 1 and 2, respectively, to the Staff’s motion.
In reviewing the parties' arguments, we find that neither has addressed a matter that may be pivotal in resolving their conflicting interpretations. Section 2.103(b) of 10 C.F.R. provides that if the Staff determines that an application for a materials license does not meet statutory or regulatory requirements, the Staff is to issue a notice of denial or proposed denial that informs the applicant of the reasons for the Staff's action and offers the opportunity for a hearing on the denial or proposed denial. In this instance, as we have noted, IRCC applied for the authority to provide both eye and skin treatments. If, as the Staff asserts, it intended that IRCC should not receive the requested authority to provide skin treatments, the following questions merit further exploration:

1. Under 10 C.F.R. § 2.103(b), was IRCC entitled to notice that its request for authority to provide skin treatments was not being granted and that it had a right to a hearing on that determination?

2. If IRCC was entitled under section 2.103(b) to the notice described in question 1, was IRCC given that notice and how was that notice provided?

3. If IRCC was entitled under section 2.103(b) to the notice described in question 1 but that notice was not provided, what impact does the failure to provide that notice have on the Staff's assertion that License No. 37-28179-01 issued to IRCC does not provide authority for skin treatments?

As the proponent of the motion for summary disposition from which these questions arise, the Staff will have the initial opportunity to address them. Dr. Bauer will then have an opportunity to respond. The schedule for the parties' filings regarding these questions is set forth below.

C. Staff Motion to Dismiss

In addition to its summary disposition requests, the Staff has moved for dismissal of eight issues identified by Dr. Bauer as central to this litigation. Dr. Bauer has delineated these issues as follows:

16. Whether the use of strontium-90 as treatment for skin lesions on the two identified patients was medically appropriate treatment?

17. Whether there was any risk to the public health, safety or other interest by virtue of the use of strontium-90 as treatment for skin lesions on the two identified patients?

35. Whether the Omnitron 2000 HDR unit was defective?

37. Whether despite Omnitron's knowledge of deterioration of the source wire due to a chemical reaction resulting from its packaging, Omnitron failed to notify Dr.
Bauer of the defect and OSC was not otherwise informed of the possibility of deterioration?

38. Whether any of the Omnitron 2000 design, manufacturing and/or warning defects was a cause of the November 16, 1992 incident?

40. Whether the November 16, 1992 incident at IRCC occurred because of an unanticipated failure of the Omnitron 2000 retraction mechanism and a reliance by Dr. Bauer on Omnitron procedures which did not anticipate or cover this emergency?

48. Whether the regulations in 10 C.F.R. Part 35 Subpart G "Sources for Brachytherapy" apply to the use of Iridium-192 as a sealed source in a brachytherapy remote afterloader for the High Dose Radiation treatment of humans ("HDR").

49. Whether the regulations in 10 [C.F.R.) Part 35 Subpart G "Sources for Brachytherapy" apply to the use of Iridium-192 as a sealed source in a brachytherapy remote afterloader for the treatment of humans (HDR) then whether the specific survey requirement of 10 C.F.R. § 35.404(a) applies to Iridium-192 HDR.

Joint Prehearing Report at 3-6. As we have previously established in the OSC and IRCC proceedings, if it can be shown there is no set of facts that would entitle Dr. Bauer to relief relative to these proposed issues, then dismissal is appropriate. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 33 & n.4; Oncology Services Corp., LBP-94-2, 39 NRC 11, 23 & n.8 (1994).

1. Bauer Issues 16 and 17

Bauer Issues 16 and 17 concerning the medical appropriateness and public health and safety risk of using strontium-90 as a skin lesion treatment are identical to issues posed in the IRCC proceeding. See Indiana Regional Cancer Center, LBP-94-21, 40 NRC at 32-33. There, we refused to dismiss these issues, finding that in assessing whether the bases assigned support an order in terms of both the type and duration of the enforcement action, a relevant factor may be the public health and safety significance, including the medical appropriateness, of the specified bases. See id. at 33-34. Because the same result obtains here, we decline to dismiss Bauer Issues 16 and 17 as well.
2. Bauer Issues 35, 37, 38, and 40

Bauer Issues 35, 37, and 38 regarding the Omnitron 2000 remote afterloader also are identical to issues previously specified for litigation, although in the OSC proceeding. See Oncology Services Corp., LBP-94-2, 39 NRC at 28. As was described earlier, the Omnitron 2000 afterloader was in use at the time of the November 1992 incident that resulted in an IRCC brachytherapy patient receiving a significant (and apparently fatal) radiation overdose. The focus of these issues is the condition of the machine at the time of the incident (i.e., was it defective) and the duties and actions of the manufacturer relative to that condition (i.e., did Omnitron know of any defect and fail to warn users, including OSC and IRCC personnel, about such an imperfection).

As in the OSC proceeding, in framing its May 1994 enforcement order relative to the November 1992 incident the Staff has not put forth any charges that dictate an inquiry into whether the Omnitron afterloader was defective or whether the machine’s manufacturer breached some duty to warn about the purported defect. Instead, looking to the time after the iridium-192 source became detached from the Omnitron machine and lodged in the patient, the Staff has charged that Dr. Bauer “failed to cause a survey to be performed which was required by 10 CFR 20.201 and which could have prevented the exposures [to the patient and other members of the public].” 59 Fed. Reg. at 25,673. As then effective, section 20.201 provided that “[e]ach licensee shall make or cause to be made such surveys as (1) may be necessary for the licensee to comply with the regulations in this part, and (2) are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present.” 10 C.F.R. § 20.201(b). Given the Staff’s reliance on this provision, a central matter in controversy thus becomes whether Dr. Bauer’s actions relative to such a survey were “reasonable under the circumstances.”

We concluded in the OSC proceeding that these “defect” issues focusing on the condition of the Omnitron afterloader at IRCC and the knowledge of Omnitron personnel about the afterloader’s condition had nothing to do with this question (or any other relevant matter regarding the Staff’s order). We found the pertinent “circumstances” were those existing at the time of the incident relative to the actual state of knowledge of OSC personnel, including Dr. Bauer.

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6 Beginning on January 1, 1994, section 20.201 and various other provisions of 10 C.F.R. Part 20 were replaced by revised standards. See 58 Fed. Reg. 67,657 (1993). Section 20.1501, the apparent analog to section 20.201, now provides in pertinent part:

(a) Each licensee shall make or cause to be made, surveys that —

(1) May be necessary for the licensee to comply with the regulations in this part; and

(2) Are reasonable under the circumstances to evaluate —

(i) The extent of radiation levels; and

(ii) Concentrations or quantities of radioactive materials; and

(iii) The potential radiological hazards that could be present.
about the Omnitron afterloader and any possible Omnitron afterloader defects and problems. As a consequence, the “defect” issues put forth by OSC (and by Dr. Bauer here) shed no light on any relevant issue. As we noted, “for the purposes of this action, even if it is assumed that the answers to each of these three ‘defect’ issues is ‘yes,’ we would be no closer to resolving the focal issue of whether the actions of OSC personnel regarding the survey were ‘reasonable under the circumstances.’” Oncology Services Corp., LBP-94-2, 39 NRC at 29. The same is true in this proceeding regarding these issues. We thus dismiss Bauer Issues 35, 37, and 38 as not relevant to this proceeding.

Bauer Issue 40, the wording of which was not the subject of litigation in the OSC proceeding, is stated somewhat differently than Issues 35, 37, and 38 in that it does not refer to “defects.” Instead, as the Staff points out, this issue would have us inquire into whether the November 1992 incident occurred because of (1) the “unanticipated failure” of the Omnitron 2000 retraction mechanism, and (2) Dr. Bauer’s reliance on Omnitron procedures that did not anticipate or cover that emergency. See Staff Dispositive Motion at 16. The Staff asserts that both portions should be dismissed, the first because it raises a “defect” issue and the second because it is better covered by other issues.

Viewing the two subparts of this issue separately, we conclude that the first suffers from the same problem plaguing Bauer Issues 35, 37, and 38. A “yes” answer would not provide any relevant information regarding the focal matter of whether Dr. Bauer acted reasonably under section 20.201 relative to taking a survey. Thus, this portion of the issue can be dismissed.

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7 In contesting the Staff’s request to dismiss these and other issues, Dr. Bauer also makes the general argument that his right to raise issues as part of his defense cannot be limited solely to those matters that directly contradict the bases set forth by the Staff in its enforcement order. According to Dr. Bauer, the Staff’s “Order does not state the entire universe of facts and issues relevant to determining the existence of any supposed violation of the HDR license or the IRCC strontium-90 license . . . .” Bauer Response at 8-9 (footnote omitted).

As we have noted elsewhere, the Commission has made it clear that in proceedings involving challenges to Staff enforcement orders, the overarching matter for consideration is whether the order should be sustained and “our authority pursuant to this directive is to consider ‘whether the facts in the order are true and whether the remedy selected is supported by those facts.’” Oncology Services Corp., LBP-94-2, 39 NRC at 25 (quoting Boston Edison Co. (Pilgrim Nuclear Power Station), CL1-82-16, 16 NRC 44, 45 (1982), aff’d, Bellotti v. NRC, 725 F.2d 1380 (D.C. Cir. 1983)). The bases asserted in an enforcement order thus do provide the principal framework for the proceeding. As a consequence, any legal or factual issue a party wants to propose in challenging (or supporting) an enforcement order must bear some relationship to those bases by tending to establish, either alone or with other issues, that some explicit or implicit legal or factual predicate to the order should not (or should) be sustained. Further, a party called upon to demonstrate this relationship must be able to do so by more than a bald pronouncement that the issue is “relevant.” Cf. Advanced Medical Systems, Inc. (One Factory Row, Geneva, Ohio 44041), CL1-94-6, 39 NRC 285, 308 (1994) (mere assertions of dispute over material facts do not invalidate grant of summary disposition).

8 As we have indicated previously, what Dr. Bauer knew about possible Omnitron 2000 defects and failures is generally relevant to determining whether his actions relative to any survey were reasonable under 10 C.F.R. § 20.201(b). See supra pp. 335-36. Although it might be argued that the use of the term “unanticipated” in the first part of Bauer Issue 40 is directed at such an inquiry, the question of Dr. Bauer’s knowledge about and reasonable reliance regarding the performance of the Omnitron 2000 is more properly framed in Bauer Issue 36, as it refers to reliance on the “specific features of the Omnitron,” and Bauer Issue 33, which refers to purported Omnitron training that the Omnitron 2000 “source wire could not break.” Joint Prehearing Report at 5.
The second segment of Issue 40 must be treated somewhat differently. As we noted in the OSC proceeding, Dr. Bauer's actual state of knowledge about the afterloader may be relevant in determining whether his actions relative to taking a survey were “reasonable under the circumstances.” As the Staff recognizes in its dismissal motion, see Staff Dispositive Motion at 16, under this formulation it is possible that information regarding Dr. Bauer’s reliance on Omnitrion procedures could be relevant to this litigation. The Staff also asserts, however, that the second statement in Bauer Issue 40 is duplicative of other issues that the Staff has not made part of its dismissal request and so should be dismissed. See id. at 16-17. We agree. Nonetheless, to ensure that the particular theme of this issue is not lost, we include certain of its language in another concern — Bauer Issue 36 — to incorporate fully the concept behind this portion of Issue 40. The wording of this amended issue is set forth below.9

3. Bauer Issues 48 and 49

Bauer Issues 48 and 49 present the questions whether the provisions of Subpart G of 10 C.F.R. Part 35 apply generally to the use of iridium-192 as a brachytherapy remote afterloader sealed source in human HDR treatments and, if so, whether the specific survey requirement of 10 C.F.R. § 35.404(a) applies to iridium-192 HDR treatments. In the OSC proceeding, we dismissed these issues because we found that the matters they sought to raise were better stated in other specified issues. See LBP-94-2, 39 NRC at 26-27. The Staff asks that we dismiss those issues from this proceeding as well.

In this case, as in the OSC proceeding, whether compliance with 10 C.F.R. Part 35, Subpart G, and in particular section 35.404(a), would satisfy any survey requirement under 10 C.F.R. Part 20, including section 20.201, has been identified as an issue that the party contesting the Staff enforcement order wants to raise.10 We found in the OSC proceeding that dismissal was appropriate because this matter was more clearly articulated through other issues; however, Dr. Bauer has not incorporated all those other issues here. To ensure again that the relevant issues for litigation are stated as clearly as possible, in this instance we sanction a somewhat different approach. Because Bauer Issues 48 and 49, in combination with Bauer Issue 8, best articulate this “section 35.404(a) compliance” issue, we incorporate their essential elements into Issue 8. The terms of amended Issue 8 are set forth below.

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9 If either party disagrees with our formulation of this issue (or Bauer Issue 8 discussed below), it is free to seek timely reconsideration of the matter. See 10 C.F.R. § 2.771.

10 As is evidenced by his Issues 9, 45, and 47, to complete his “section 35.404(a) compliance” rationale, Dr. Bauer apparently will seek to establish that a PrimAlert radiation monitor mounted on the wall of the IRCC brachytherapy treatment room was a “radiation survey detection instrument” within the meaning of section 35.404(a) that afforded compliance with 10 C.F.R. § 20.201.
III. CONCLUSION

After considering the parties' filings, we have concluded that under the particular circumstances here, there is no current legal impediment to the Staff relying upon allegedly improper conduct detailed in one enforcement action as a basis for a different enforcement action. We thus deny Dr. Bauer's request that the Staff be precluded from using the cited circumstances regarding the November 1992 incident and his actions concerning the IRCC strontium-90 license as bases for its May 1994 enforcement order. Moreover, finding no material issues in dispute, we grant the Staff's summary disposition motion on the same point. This ruling in favor of the Staff also compels us to dismiss related Bauer Issues 19, 20, and 22 as moot.

In contrast, we find that we now are unable to resolve the Staff's request for summary disposition on Joint Issue 1. To aid us in reaching that determination, however, we ask the parties to address several questions regarding the applicability and impact of 10 C.F.R. § 2.103(b) to the issue of what medical conditions Dr. Bauer was authorized to treat under the IRCC strontium-90 license.

Finally, acting on the Staff's motion to dismiss, we grant the Staff request relative to Bauer Issues 35, 37, 38, 40, 48, and 49, albeit with the condition that Bauer Issues 8 and 36 are to be reworded to incorporate certain concepts from Bauer Issues 40, 48, and 49. On the other hand, having found they involve matters that may entitle Dr. Bauer to some relief, we deny the Staff's motion to dismiss Bauer Issues 16 and 17.

For the foregoing reasons, it is this ninth day of December 1994, ORDERED, that

1. Dr. Bauer's July 29, 1994 motion to eliminate basis is denied.
2. The Staff's July 29, 1994 motion for summary disposition is granted as to Joint Issue 4, and related Bauer Issues 19, 20, and 22 are dismissed as moot.
3. Regarding Joint Issue 1 that is the subject of the Staff's July 29, 1994 motion for summary disposition, on or before Friday, January 6, 1995, the Staff shall file a pleading addressing the questions set forth at page 333 supra. Dr. Bauer shall have up to and including Friday, February 3, 1995, within which to file a response to that pleading. In addition to regular service by mail on each Board member and the opposing party, each party should send a copy of its pleading to the Board and the opposing party by facsimile transmission or other means that will ensure receipt by 4:30 p.m. EST on the day of filing.
4. The Staff's July 29, 1994 motion to dismiss is granted as to Bauer Issues 35, 37, 38, 40, 48, and 49, and is denied as to Bauer Issues 16 and 17.
5. Bauer Issue 36 is amended to incorporate language from Bauer Issue 40 so that Issue 36 reads as follows:
36. Whether reliance by Dr. Bauer on specific features of the Omnitron and on Omnitron procedures that did not anticipate or cover a failure of the Omnitron 2000 retraction mechanism was reasonable in November 1992?

6. Dr. Bauer Issue 8 is amended to incorporate language from Bauer Issues 48 and 49 so that Issue 8 reads as follows:

8. Regarding the use of Iridium-192 as a sealed source in a brachytherapy remote afterloader for the High Dose Radiation treatment of humans ("HDR"):
   a. Is 10 C.F.R. Part 35, Subpart G, including the specific survey requirement in section 35.404(a), applicable?
   b. As a matter of law, does fulfilling any of the applicable survey requirements in 10 C.F.R. Part 35, Subpart G, control and/or satisfy the reasonableness standard in 10 C.F.R. §20.201?

THE ATOMIC SAFETY AND LICENSING BOARD

G. Paul Bollwerk, III, Chairman
ADMINISTRATIVE JUDGE

Charles N. Kelber
ADMINISTRATIVE JUDGE

Peter S. Lam
ADMINISTRATIVE JUDGE

Rockville, Maryland
December 9, 1994

11 Copies of this memorandum and order are being sent this date to counsel for Dr. Bauer by facsimile transmission and to Staff counsel by E-mail transmission through the agency's wide area network system.
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

Thomas S. Moore, Chairman
Frederick J. Shon
James H. Carpenter

In the Matter of

Docket Nos. 030-05980-OM&OM-2
030-05981-OM&OM-2
030-05982-OM&OM-2
030-08335-OM&OM-2
030-08444-OM&OM-2
030-05980-ML&ML-2
030-05982-ML&ML-2
030-05980-EA
030-05982-EA

(ASLBP Nos. 89-590-01-OM
90-598-01-OM-2
92-659-01-ML
92-664-02-ML-2
93-675-04-EA)

SAFETY LIGHT CORPORATION, et al.
(Bloomsburg Site Decontamination,
Decommissioning, License Renewal
Denials, and Transfer of Assets)

December 28, 1994

ORDER
(Approving Settlement Agreement and Terminating Proceedings)

On September 20, 1994, the NRC Staff, Safety Light Corporation ("SLC"),
Metreal, Inc., and USR Industries, Inc., USR Lighting Products, Inc., USR
Chemical Products, Inc., USR Metals, Inc., and U.S. Natural Resources, Inc. ("USR Companies"), filed a joint motion for approval of a settlement agreement in the five pending Safety Light proceedings. Thereafter, on October 18, 1994, we held a brief hearing on the parties' joint motion and the proposed settlement agreement. At the hearing, the parties requested that we withhold final action on the joint motion until all outstanding matters relating to the Trust Agreement referenced in the Settlement Agreement had been resolved. On December 22, 1994, Staff counsel informed us that the Trust Agreement had been executed.

Upon consideration of the joint motion and the proffered settlement agreement, we find that the settlement agreement comports fully with the public interest. See 10 C.F.R. § 2.203. Accordingly, we approve the attached settlement agreement and incorporate its terms into this order with the following minor amendments agreed to by the parties:

1. In line 7 of numbered paragraph 7, the date "May 31, 1995" should be amended to read "September 30, 1995."
2. In the second sentence of numbered paragraph 8, the portion of the sentence beginning with the word "unless" should be amended to read "unless otherwise prohibited by law or court order."
3. In numbered paragraph 9, subparagraph (a), line 13, the word "February" should be amended to read "March."
4. In numbered paragraph 14, the language inside the parentheses should be amended to read "(except as modified by the letters referenced in Footnote 6 above)."

Further, the request of SLC and the USR Companies to withdraw their requests for hearing on the Staff's orders of March 16, 1989, August 21, 1989, and January 29, 1993, and their request that they be dismissed as parties to the proceedings on those orders is granted. The proceedings on these three Staff orders are hereby dismissed with prejudice.

In view of the Staff's rescission of its denial of SLC's applications to renew License Nos. 37-00030-02 and 37-00030-08 ("the 02 and 08 Licenses"), the Staff's rescission of its decommissioning order of February 7, 1992, and the Staff's commitment to renew the 02 and 08 Licenses for a 5-year period following the issuance of this order, the request of SLC and the USR Companies to withdraw their requests for hearing on the license renewal denials and the February 7, 1992 decommissioning order is granted. The proceedings on the license renewal denials and the decommissioning order are hereby dismissed with prejudice.

Finally, the parties are directed to revise the dates specified in the settlement agreement so that the monthly obligations of SLC and USR Industries will commence on the first day of the month immediately following the date of this order. The parties are also directed to revise the 5-year license renewal period
specified in the agreement to commence on the first business day of the month immediately following the date of this order.

It is so ORDERED.

THE ATOMIC SAFETY AND LICENSING BOARD

Thomas S. Moore
ADMINISTRATIVE JUDGE

Frederick J. Shon
ADMINISTRATIVE JUDGE

James H. Carpenter
ADMINISTRATIVE JUDGE

Rockville, Maryland
December 28, 1994

SETTLEMENT AGREEMENT

THIS AGREEMENT is made by and between Safety Light Corporation ("SLC"); USR Industries, Inc., USR Lighting, Inc., USR Chemical Products, Inc., USR Metals, Inc., and U.S. Natural Resources, Inc. (the "USR Companies"); Metreal, Inc.;¹ and the Staff of the United States Nuclear Regulatory Commission ("NRC Staff" or "Staff"), to wit:

WHEREAS SLC is the named licensee on Byproduct Material License Nos. 37-00030-02 (the "-02 License"), 37-00030-08 (the "-08 License"), 37-00030-09G, and 37-00030-10G, issued by the NRC, which licenses authorize the possession and use of byproduct material at SLC’s facility located at 4150-A Old Berwick Road, Bloomsburg, PA 17815 (the "Bloomsburg facility" or "Bloomsburg site"); and

WHEREAS the -02 License, as amended on August 5, 1969, authorizes the possession, storage, and use of any byproduct material for purposes of decontamination, clean-up, and disposal of equipment and facilities previously used for research, development, manufacturing, and processing at the Bloomsburg

¹ SLC, the USR Companies, United States Radium Corporation, Lime Ridge Industries, Inc., and Metreal, Inc. are collectively referred to herein as the "Respondents"; however, the parties recognize that United States Radium Corporation and Lime Ridge Industries, Inc. have ceased to exist as corporate entities.
site, which license was last renewed on January 25, 1979, and which license has been under timely renewal since February 29, 1984; and

WHEREAS the -08 License authorizes research and development activities and the manufacture of various devices containing tritium, which license was last renewed on January 6, 1983, and which license has been under timely renewal since December 31, 1987; and

WHEREAS on March 16, 1989, the Staff issued an Order to the Respondents, requiring them, inter alia, to control access to the Bloomsburg site, prepare and implement a site characterization plan, and prepare and implement a site decontamination plan, due to the presence of radiological contamination in the soil, groundwater, buildings and equipment at the Bloomsburg facility;2 and

WHEREAS on August 21, 1989, the Staff issued a second Order, requiring the Respondents, inter alia, to set up a trust fund and to deposit $1,000,000 into that fund according to a specified schedule to cover the cost of implementing a site characterization plan and of taking necessary immediate actions to remediate any significant health and safety problems that might be identified during site characterization;3 and

WHEREAS on February 7, 1992, the Staff denied the applications submitted by SLC to renew the -02 License and the -08 License, based on the Staff’s determination that the Respondents had failed to comply with the Commission’s regulations requiring financial assurance for decommissioning funding as set forth in 10 C.F.R. § 30.35;4 and

WHEREAS also on February 7, 1992, the Staff issued an Order requiring the Respondents, inter alia, to decommission the Bloomsburg site in accordance with the requirements of 10 C.F.R. § 30.36 and the schedule and criteria provided with that Order, so that the site may be released for unrestricted use;5 and

WHEREAS on January 29, 1993, the Staff issued an Order which, inter alia, prohibited SLC from implementing its Asset Purchase Agreement of January 4, 1993, prohibited SLC from implementing any transfer of major assets other than in the normal course of business for full fair value, and required SLC to set aside in a separate account any and all funds which it received or may receive under the above-mentioned Asset Purchase Agreement;6 and

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4 Letter from Robert M. Bernero (Director, Office of Nuclear Material Safety and Safeguards), to Jack Miller (President, Safety Light Corporation), et al., dated February 7, 1992.

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WHEREAS SLC and/or the USR Companies have requested a hearing on each and every one of the Staff’s Orders and license renewal denials described above, in response to which proceedings have been convened and remain pending before a Licensing Board at this time; and

WHEREAS the undersigned parties recognize that certain advantages and benefits may be obtained by each of them through settlement and compromise of some or all of the matters now pending in litigation between them, including, without limitation, the completion of a radiological characterization study of the Bloomsburg site, the dedication and expenditure of certain funds for the purposes specified herein, the elimination of further litigation expenses, uncertainty and delay, and other tangible and intangible benefits, which the parties recognize and believe to be in the public interest;

IT IS NOW, THEREFORE, AGREED AS FOLLOWS:

1. The Staff hereby agrees, as set forth in Paragraph 9 below, (a) to rescind its denial of SLC’s applications to renew the -02 and -08 Licenses, and to grant a renewal of those licenses for a period of five years (until August 31, 1999), upon SLC’s satisfaction of the Respondent(s)’ obligations with respect to all outstanding fees and charges that have been assessed or levied by the NRC, and (b) in connection with the issuance of said renewal, to issue an exemption from the requirements of 10 C.F.R. §§ 30.32(h) and 30.35 limited to the five-year renewal period, in accordance with the following provisions.

2. SLC and the USR Companies hereby agree that during the five-year renewal period, they will (a) set aside from operating revenues (or any source other than their insurance litigation, any judgments or settlements they may receive with respect thereto, or amounts they may receive as a result of any claims they may have against agencies or departments of the U.S. Government), certain sums as set forth in Paragraph 3 below, to be paid on the first day of each successive month commencing September 1, 1994 (for a total of $396,000), to be used for the purposes specified in Paragraph 17 below, (b) complete a site characterization study, to be performed by Monserco Limited (“Monserco”), a Canadian corporation, or any other company selected by SLC and approved by the Staff, which adequately describes the nature, extent, quantities, and location of the contamination present at the Bloomsburg site in accordance with an approved site characterization plan, as set forth in Paragraph 7 herein, (c) vigorously pursue their claims in any present or future insurance litigation pertaining to the Bloomsburg site, and any other claims against third parties which they may believe themselves to have, the proceeds of which are to be set aside in accordance with the terms of this Agreement as set forth below,
and submit quarterly reports to the NRC Staff describing in detail the progress and accomplishments achieved in that litigation during each preceding 90-day period.

3. Pursuant to Paragraph 2 herein, SLC and the USR Companies agree to set aside and deposit the following sums in an escrow account or trust fund approved by the NRC Staff, in accordance with the following schedule:

(a) **SLC**

<table>
<thead>
<tr>
<th>Date</th>
<th>Sum ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 1, 1994</td>
<td>$5,000</td>
</tr>
<tr>
<td>First day of each month thereafter, for 24 months</td>
<td></td>
</tr>
<tr>
<td>September 1, 1996</td>
<td>$6,000</td>
</tr>
<tr>
<td>First day of each month thereafter, for 24 months</td>
<td></td>
</tr>
<tr>
<td>September 1, 1998</td>
<td>$7,000</td>
</tr>
<tr>
<td>First day of each month thereafter, for 12 months</td>
<td></td>
</tr>
</tbody>
</table>

(For a total of $348,000)

(b) **The USR Companies**

<table>
<thead>
<tr>
<th>Date</th>
<th>Sum ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 1, 1994</td>
<td>$1,000</td>
</tr>
<tr>
<td>First day of each month thereafter, for 48 months</td>
<td></td>
</tr>
</tbody>
</table>

(For a total of $48,000)

In connection herewith, it is expressly understood and agreed that the financial contributions specified herein do not in any manner represent or reflect the NRC Staff’s view of the Respondents’ respective responsibility or liability for the Bloomsburg site, the contamination present there, or the NRC licenses issued with respect thereto, nor do they represent or reflect any admission by the USR Companies of NRC jurisdiction over the USR Companies, as set forth in Paragraphs 10 and 15 herein.

4. It is expressly understood and agreed that no further renewal of the -02 License or the -08 License beyond the five-year renewal period will be issued, unless the Respondents, or any of them, have, in addition to demonstrating compliance with all other applicable requirements, first submitted a decommissioning funding plan, including financial assurance for decommissioning, which complies with the requirements of 10 C.F.R. § 30.35 to the satisfaction of the NRC Staff, or have obtained a further exemption from the requirements of that regulation. The failure to submit such a decommissioning funding plan to the satisfaction of the NRC Staff or to obtain a further exemption will result in
expiration, revocation or suspension of the -02 and -08 Licenses as of August 31, 1999, and will cause the requirements of 10 C.F.R. § 30.36 to apply.

5. SLC agrees to be responsible for undertaking all necessary and proper radiation safety precautions, or assuring that such precautions are taken, and to implement an adequate radiation safety program during the performance of the site characterization study, regardless of whether that study is performed by SLC or a third party acting under contract to SLC.

6. SLC has submitted to the Staff for its review and approval, a plan for a site characterization study, developed by Monserco, to determine the nature, extent, quantities, and location of the contamination present at the Bloomsburg site, which plan, as revised in written communications between the parties, has been approved by the Staff. SLC represents that it and Monserco have contracted for the performance of a site characterization study consistent with the aforesaid plan, contingent upon the Licensing Board's approval of this Agreement, and it is further understood and agreed that SLC and the USR Companies hereby consent to the use of funds previously set aside from the proceeds of their insurance litigation in Princeton Bank and Trust Company, Custodial Account 44-01-000-8690771, up to a maximum of $450,000, as may be necessary to complete the site characterization study.

7. SLC agrees that it will undertake to conduct the aforesaid site characterization study, to be performed by Monserco or any other company selected by SLC and approved by the Staff, sufficient to determine the nature, extent, quantities, and location of the contamination present at the Bloomsburg site, which study it agrees to complete and submit for NRC Staff approval on or before May 31, 1995, and thereafter to promptly modify or supplement that study in accordance with any Staff requests, comments or conclusions, so long as the cost of such modified or supplemental studies, together with the original study, does not exceed $450,000 plus any sums set aside pursuant to Paragraphs 3 and 8 herein.

8. SLC and the USR Companies agree to use their best efforts to set aside and deposit in a trust fund or escrow account, as set forth in Paragraph 16 below, from the proceeds of their insurance litigation and claims against third parties, as specified herein, realized during the five-year license renewal period and the subsequent decommissioning period, including any judgments or settlements pertaining thereto (after deduction of legal fees and expenses directly related to such litigation), a percentage equal to 25% of such amounts, or any larger percentage of such amounts as may be specified in said judgments or settlements to pertain to the Bloomsburg site. Notwithstanding anything to the contrary which may be contained in this Agreement, it is further understood and agreed that SLC and the USR Companies shall deposit and set aside said 25% or other portion of such proceeds unless prohibited from doing so by the insurers or other parties to such litigation or claims.
9. The parties agree that, as an integral part of this Agreement, they will take the following actions with respect to the adjudicatory proceedings now pending before the Licensing Board:

(a) Upon execution of this Agreement, and subject to its approval by the Licensing Board, (1) SLC and the USR Companies will withdraw their requests for hearing on the Staff’s Orders of March 16, 1989, August 21, 1989, and January 29, 1993, and request that they be dismissed as parties in the proceedings pertaining to those Orders, and (2) the parties will file a joint request for dismissal of the proceedings on those Orders, with prejudice, it being understood and agreed that the parties shall oppose any vacation of the prior rulings and decisions on jurisdiction entered in these proceedings, and it being further understood and agreed that this Agreement resolves all outstanding issues with respect to the Staff’s Orders of February and August 1989, and the Staff will take no enforcement or other action against SLC and the USR Companies in connection with those Orders;

(b) Also upon execution of this Agreement, and subject to its approval by the Licensing Board, (1) the Staff will rescind its license renewal denials and decommissioning order of February 7, 1992, (2) SLC and the USR Companies will withdraw their requests for hearing on the license renewal denials and the Staff’s decommissioning order of February 7, 1992; and (3) the parties will file a joint request that the Licensing Board dismiss, with prejudice, all matters pertaining to the denials and decommissioning order of February 7, 1992; and

(c) Also upon execution of this Agreement, and subject to its approval by the Licensing Board, the Staff will grant a renewal of the -02 and -08 Licenses as set forth in Paragraph 1.

10. It is understood and agreed that, notwithstanding any other provision in this Agreement, following execution of this Agreement, SLC and the USR Companies will pursue no other litigation or claim in connection with any Staff Order or other action referenced herein, and it is further understood and agreed that the USR Companies hereby agree not to contest the NRC’s jurisdiction to take enforcement or other actions with respect to the terms of this Agreement, provided, however, that nothing contained in this Agreement shall be understood or construed to otherwise preclude, prejudice or restrict the USR Companies’

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7 The parties recognize that, following execution of this Agreement and its approval by the Licensing Board, the USR Companies may seek to reach a separate agreement with the NRC Solicitor’s Office, whereby the USR Companies and the NRC would stipulate to the withdrawal of those Companies’ Petitions for Review filed in Appeal Nos. 89-1638 and 90-1407 in the U.S. Court of Appeals (D.C. Circuit) without prejudice to the re-filing of such Petitions within 90 days after completion of the five-year license renewal period. However, the parties agree that whether or not such actions are taken does not affect the validity and finality of this Settlement Agreement.
right to challenge the NRC's jurisdiction to take enforcement actions against them as to other matters.

11. SLC and the USR Companies hereby agree to waive any and all rights or opportunity they may have to request a hearing in the event that the Respondents fail to demonstrate compliance with 10 C.F.R. § 30.35 to the satisfaction of the NRC Staff by the conclusion of the five-year renewal period, or in the event that SLC or the USR Companies fail to make monthly payments in the manner and at the times set forth herein or to otherwise comply with any of the foregoing requirements which the Director of the Office of Nuclear Material Safety and Safeguards may determine in his sole discretion to be a material breach of this Agreement, or in the event that the Staff declines to renew the -02 and -08 Licenses after the five-year renewal period due to SLC’s non-compliance with 10 C.F.R. § 30.35, or in the event the Staff determines to deny any further request for exemption from the requirements of 10 C.F.R. § 30.35. In this regard, it is explicitly understood and agreed that the Staff’s determination of compliance or non-compliance with 10 C.F.R. § 30.35, and its determination whether to grant or deny any further request for exemption from 10 C.F.R. § 30.35, shall be binding for all purposes, and SLC and the USR Companies hereby agree that such Staff determination shall not be the subject of any request for hearing or adjudicatory review. It is further understood and agreed, however, that if the Staff determines to deny any renewal application for reasons other than a failure to comply with the requirements of 10 C.F.R. § 30.35, the Respondents shall have the right to request a hearing with respect to such determination on grounds other than whether they have complied with 10 C.F.R. § 30.35, prior to the effective date of such Staff action, in accordance with the Commission’s Rules of Practice in 10 C.F.R. Part 2.

12. It is further understood and agreed that in the event the Staff determines at the conclusion of the five-year renewal period that the Respondents have failed to demonstrate compliance with 10 C.F.R. § 30.35, as set forth in Paragraph 4 above, and that any further request for exemption from 10 C.F.R. § 30.35 should be denied, the Respondents shall not be eligible for any further renewal of the -02 and -08 Licenses, and they shall thenceforth be obligated to satisfy the provisions in 10 C.F.R. § 30.36 (“[e]xpiration and termination of licenses”), provided, however, that the USR Companies reserve the right to contest the NRC's jurisdiction to compel the USR Companies to comply with 10 C.F.R. § 30.36.

13. In the event the Director of the Office of Nuclear Material Safety and Safeguards determines, in his sole discretion, that the Respondents have acted, or failed to act, in a manner which constitutes a material breach of this Agreement, or that the Respondents have failed to demonstrate compliance with 10 C.F.R. § 30.35 upon the conclusion of the five-year renewal period and that no further exemption from 10 C.F.R. § 30.35 should be granted, in addition to
the requirements of 10 C.F.R. § 30.36, SLC and the USR Companies hereby agree (a) not to contest any decommissioning order which the Staff may then issue (provided that any such order does not contain terms which are more restrictive or burdensome than those contained in the decommissioning order of February 7, 1992 and/or any NRC regulations which may then be in place), (b) to comply with any requirement which the Staff may then issue that they safely remove or dispose of all radioactive materials and devices which may be present at the Bloomsburg site, and (c) to maintain the existing perimeter fence and warning signs, as set forth in Paragraphs 17 and 18 below, provided, however, that nothing contained in this Agreement shall be understood or construed to preclude, prejudice or restrict the USR Companies' right to challenge the NRC's jurisdiction with respect to those Companies in the future, as stated above in Paragraph 10.

14. The provisions of the Staff's Order of January 29, 1993, are expressly incorporated herein by reference and SLC hereby agrees to comply with the requirements of that Order (except as discussed in Footnote 6 above), unless and until such time as it is relieved of such obligations, in writing, by the NRC Staff.

15. It is understood and agreed that the USR Companies reserve the right to challenge the NRC's jurisdiction as to those companies, should they so desire (except as to their obligations under this Agreement), in any appropriate forum, notwithstanding the terms of any provision in this Agreement, as stated above in Paragraph 10. It is further understood and agreed that the Staff does not waive or relinquish its claim of NRC jurisdiction as to those companies, notwithstanding the terms of any provision in this Agreement.

16. SLC and the USR Companies hereby agree that any and all funds required to be set aside pursuant to this Agreement shall be set aside and maintained in an interest-bearing trust fund or escrow account to be established and governed in accordance with the Staff's guidance, in the form attached hereto. It is further agreed that no money deposited in this fund, and no interest earned thereon, shall be committed or spent without prior written approval of the Staff, during and after the five-year renewal period specified herein.

17. SLC and the USR Companies further agree that any and all funds required to be set aside pursuant to this Agreement shall be used exclusively for purposes of site decontamination, cleanup, decommissioning, satisfaction of 10 C.F.R. § 30.36, maintenance of the perimeter fence and warning signs, and such other measures as are appropriate and necessary to protect the public health and safety and are approved in advance, in writing, by the Staff. In addition, such funds may be used to pay for any additional costs required for completion of the site characterization study referred to herein, in the event and to the extent that such costs may exceed the cost of the study agreed to in advance by the parties hereto pursuant to Paragraph 6 herein. To the extent that any funds remain after
the completion of decommissioning and such other uses as specified herein, such funds shall be returned to the control of SLC and the USR Companies.

18. SLC hereby agrees to maintain the perimeter fence and warnings signs posted at the Bloomsburg site throughout the renewal period and for a period of ten (10) years thereafter, or until termination of the license with an NRC determination that the site can be released for unrestricted use, whichever occurs first.

19. SLC and the USR Companies hereby agree that they shall neither abandon nor transfer the Bloomsburg facility or any major equipment or assets located at the Bloomsburg site without prior written approval by the NRC Staff, which approval shall not be unreasonably withheld.

20. It is expressly understood and agreed that nothing contained in this Agreement shall relieve the Respondent(s) from complying with all applicable NRC regulations and the terms and conditions of the -02 and -08 Licenses during the renewal period, and, further, that nothing contained in this Agreement shall be binding on, or preclude lawful action by, any other Government agency or department.

21. SLC and the USR Companies hereby agree that any failure on their part to complete the site characterization study described above, to make the monthly payments described above when due (or within five days thereafter) or to comply with any other provision contained in this Agreement will constitute a material breach of this Agreement. Further, SLC and the USR Companies hereby agree that any such breach, or any failure to demonstrate compliance with 10 C.F.R. § 30.35 to the satisfaction of the Staff prior to expiration of the five-year renewal period specified herein, will result in the immediate expiration, revocation or suspension of the Licenses, effective immediately, without any right to or opportunity for hearing in connection therewith, provided, however, that the Staff hereby agrees that it will not revoke, suspend or declare an expiration of the Licenses in the event that any such breach involves solely a failure by the USR Companies to make monthly payments as required herein (in which case it is understood and agreed that the Staff may take such other legal actions against the USR Companies as the Staff may then deem to be appropriate including, without limitation, the right to resort immediately to a court of law in a collection action, and the USR Companies hereby waive any right they may have to seek an administrative remedy in connection therewith). In this regard, SLC and the USR Companies further consent to the entry of a Judgment providing (a) that the license expiration, revocation, suspension, or license renewal denials and any decommissioning order which the Staff may issue upon expiration, revocation or suspension of the Licenses (if such order does not contain terms which are more restrictive or burdensome than those contained in the decommissioning order of February 7, 1992, and/or any NRC regulations which may then be in place) shall be deemed to be immediately
effective in such event, with no right to or opportunity for hearing in connection therewith, subject only to the USR Companies' right to contest the NRC's jurisdiction over those Companies as set forth in Paragraphs 10 and 15 herein, and (b) that any amounts required hereunder, whether deposited or undeposited in the trust fund or escrow account established pursuant to this Agreement, or otherwise unpaid as specified herein, shall be due and payable immediately in the event of a material breach hereof (except that amounts required to be paid by SLC shall not be due and payable immediately in the event of a breach by the USR Companies alone), and shall be treated as funds set aside to partially satisfy regulatory requirements established by the U.S. Nuclear Regulatory Commission to protect the health and safety of the public from an ongoing and continuing threat.

22. It is understood and agreed that this Agreement is contingent upon (a) notification of SLC by the Staff that it has completed its review of and is prepared to act favorably upon SLC's license renewal application, consistent with the terms of this Agreement, and (b) prior approval by the Atomic Safety and Licensing Board.

23. This Agreement shall be binding upon the heirs, legal representatives, successors and assigns of the corporate entities that are parties hereto.

IN WITNESS WHEREOF, we set our hand and seal this day of August, 1994.

For Safety Light Corporation, and Metreal, Inc.:

C. Richter White, President 8/16/94


Ralph T. McElvenny, Jr., Chairman

For the NRC Staff:

Robert M. Bernero, Director 9/14/94
Office of Nuclear Material Safety and Safeguards

Attachment: Form of Trust
The Honorable Michael O. Leavitt, Governor of the State of Utah, and the Utah Legislature requested, by a letter dated May 2, 1994, and Utah Senate concurrent Resolution No. 11, "Resolution Regarding NRC Action Regarding Disposal of Uranium By-Product 1994 General Session," that the Nuclear Regulatory Commission modify Umetco Minerals Corporation Source Material License No. SUA-1358 (now held by Energy Fuels Nuclear, Inc.), to reflect the original request of the Licensee for authority to dispose of 5000 cubic yards of le(2) byproduct material per in situ leach facility at the White Mesa Uranium Mill facility. Petitioners also requested that the Commission confer with the State of Utah and provide opportunity for comment prior to the issuance of license amendments involving uranium mill tailings disposal in Utah, and that the NRC obtain the concurrence of the Governor and Legislature before issuing license amendments involving disposal of uranium mill tailings in Utah.

After careful consideration of Petitioners' requests, the Director of the Office of Nuclear Material Safety and Safeguards grants the request to modify Source Materials License No. SUA-1358 and the request to confer with the State of Utah insofar as the NRC shall provide direct and Federal Register notice of significant materials licensing actions in the State of Utah, and denies the request to obtain concurrence of Petitioners before issuing license amendments involving disposal of uranium mill tailings in Utah.
DIRECTOR'S DECISION UNDER 10 C.F.R. § 2.206

I. INTRODUCTION

The Honorable Michael O. Leavitt, Governor of the State of Utah, and the Utah Legislature (Petitioners) submitted a letter dated May 2, 1994, and a copy of Utah Senate Concurrent Resolution No. 11, "Resolution Regarding NRC Action Regarding Disposal of Uranium By-Product 1994 General Session" (Petition) pursuant to 10 C.F.R. § 2.206, in regard to Amendment No. 33 to Umetco Minerals Corporation (Umetco) Source Material License No. SUA-1358, which authorized disposal of up to 10,000 cubic yards (cy) of 11e(2) byproduct material per in situ leach (ISL) facility per year at the White Mesa Uranium Mill facility. Petitioners request that the “NRC reconsider the license amendment issued to Umetco and modify the amendment to reflect the original request of 5,000 cubic yards [cy] [per in situ facility].” Petitioners assert as the basis for this request that the NRC in effect created the equivalent of a commercial waste disposal facility for in situ mining waste unlicensed by Utah, while ignoring Utah’s waste policy and laws. Petitioners also urge the NRC to confer with the State of Utah and provide opportunity for comment prior to the issuance of license amendments involving uranium mill tailings disposal in Utah. Finally, Petitioners request that the NRC obtain the concurrence of the Utah Governor and Legislature before issuing license amendments involving disposal of uranium mill tailings in Utah. By letter dated May 13, 1994, the State of Utah was notified that the Petition was under review and that a response would be provided in a timely manner.

The Petition has been reviewed on its merits, and as a result of this review, for the reasons stated below, Petitioners’ request to modify Source Material License No. SUA-1358 is granted. Petitioners’ request that the NRC confer with Petitioners before taking action on future license amendments involving disposal of uranium mill tailings in Utah is granted, insofar as the NRC shall provide notice of significant materials licensing actions in the State of Utah, such as for authorization to dispose of in situ leach facility 11e(2) byproduct material or for approval of significant changes to an approved reclamation plan, and thereby provide an opportunity to comment. Petitioners’ request that the NRC obtain the concurrence of the State of Utah before issuing license amendments involving mill tailing disposal in the State of Utah is denied.

II. BACKGROUND

On February 6, 1978, Energy Fuels Nuclear, Inc. (EFN) submitted an application for a source material license for the proposed White Mesa Mill. The NRC issued an Environmental Impact Statement (EIS) for White Mesa Mill in
May 1979. In August of 1979, NRC issued Source Material License SUA-1358 to EFN. The White Mesa Mill operated on a continuous basis from August 1979 through February 1983 when operations were suspended. In January of 1984 Umetco purchased a controlling interest in the White Mesa Mill from EFN. The license was amended on December 5, 1984, to reflect the change in ownership and Umetco’s status as the licensee. Production resumed in October 1985 and the White Mesa Mill has alternately operated and been on standby mode until the present time. EFN recently repurchased the controlling interest in the White Mesa Mill, and on May 25, 1994, the NRC Staff issued License Amendment No. 35, authorizing the transfer of ownership to EFN, the current licensee.

By letter dated May 20, 1993, Umetco submitted an application for a license amendment to authorize the receipt and disposal of 11e(2) byproduct material from NRC-licensed and Agreement State-licensed in situ leach facilities. Byproduct material, under Section 11e(2) of the Atomic Energy Act of 1954, as amended, is defined as “the tailings or wastes produced by the extraction or concentration of uranium or thorium from any ore processed primarily for its source material content.” Specifically, Umetco requested that Source Material License No. SUA-1358 be amended to authorize:

- disposal of not more than 5,000 cubic yards of 11e(2) byproduct material per generating [in situ] licensee. If Umetco received a request to dispose of more than 5,000 cubic yards of 11e(2) byproduct material, Umetco would notify URFO [NRC’s Uranium Recovery Field Office] in writing so that the appropriate review and approval could be received from the URFO staff prior to executing a contact [contract].

The NRC Staff reviewed Umetco’s license amendment application and issued License Amendment 33 on August 2, 1993. License Amendment 33 authorized, through License Condition 55, the disposal of:

byproduct material generated at licensed in situ leach facilities, subject to the following condition that:

- A. Disposal of waste [11e(2) byproduct material] in excess of 10,000 cubic yards per year from single sources shall require specific approval from NRC.

The NRC Staff concluded that License Condition 55 would not result in significant impacts to the environment or to public health and safety. Further, the Staff concluded that License Condition 55 was consistent with 10 C.F.R. Part 40, Appendix A, Section I, Criterion 2, which is intended to avoid the

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1 The Uranium Recovery Field Office closed on August 3, 1994, and the responsibility for uranium recovery licensing was transferred to the NRC’s Office of Nuclear Material Safety and Safeguards, Division of Waste Management.

2 Envirocare of Utah, Inc., requested a hearing on License Amendment 33 which was denied on the grounds of timeliness. Umetco Minerals Corp., Memorandum and Order, ASLBP No. 94-688-01-MLA-2 (March 4, 1994).
proliferation of small waste disposal sites, which would result if disposal in large tailings systems were not authorized.

III. DISCUSSION

A. License Condition 55

Petitioners contend that License Condition 55, which allows Umetco to dispose of up to 10,000 cy of in situ leach 11e(2) byproduct material per year at the White Mesa facility annually from any source, in effect creates the equivalent of a commercial disposal facility for in situ leach 11e(2) byproduct material in Utah. Petitioners therefore requested that License Condition 55 be modified "to reflect the original request of 5,000 cubic yards [per in situ facility]."

The NRC Staff agrees with the Petitioners that the Licensee's authorization to dispose of 11e(2) byproduct material should be limited to the 5000 cy per in situ leach facility requested by the Licensee. By way of background, however, it should be noted that License Amendment No. 33 authorized disposal of 11e(2) byproduct material consistent with NRC regulations, which require that 11e(2) byproduct material from in situ leach mines be disposed of at uranium mill tailings facilities. 10 C.F.R. Part 40, Appendix A, Section I, Criterion 2. Also, the byproduct material authorized for disposal at the White Mesa Mill represents only a subset of radioactive waste materials. Specifically, White Mesa Mill is authorized to dispose of only 11e(2) byproduct material (mill tailings), and 11e(2) byproduct material only from in situ leach facilities. Before EFN could dispose of 11e(2) byproduct material other than that from its own operations or from in situ leach facilities, EFN would be required to seek licensing authority to do so. In addition, the 10,000 cy per in situ leach facility per year authorized for disposal by License Amendment 33 at White Mesa Mill was insubstantial in comparison to the 2000 tons [1481 cy] per day for 15 years contemplated in the original licensing of White Mesa Mill. NUREG-0556, "Final Environmental Statement Related to Operation of White Mesa Uranium Project" (May 1979), at iii.

Although License Amendment No. 33 would not have resulted in the disposal of byproduct waste material in amounts approaching that contemplated at the time of the original license grant for the White Mesa Mill facility, License Condition 55 did authorize disposal of more 11e(2) byproduct material than was requested by the Licensee. The NRC practice is, generally, to grant only the disposal authority requested by the license amendment application, and no more. During an October 20, 1994 discussion with the NRC Staff, the Licensee agreed to issuance of an order to modify the license to reflect the application for authority to dispose of 5000 cy of 11e(2) byproduct material per in situ facility. Accordingly, for the reasons stated above, the license will be so modified by a
"Confirmatory Order Modifying License Condition 55" to be issued concurrently with this Decision.

B. Requests to Confer with and to Obtain Concurrence of Petitioners

Petitioners request that the NRC confer with the State of Utah and provide opportunity to comment prior to the issuance of license amendments involving uranium mill tailings disposal in Utah. The same request was made previously by Mr. William J. Sinclair, Director of the Division Radiation Control, Utah Department of Environmental Quality, in his January 27, 1994 letter. In a February 25, 1994 response to Mr. Sinclair, the Director, Office of Nuclear Material Safety and Safeguards, made several commitments designed to foster better communication with the State of Utah concerning NRC regulation of uranium tail processing mills in Utah. Specifically, the NRC committed to notify the State directly, in addition to the issuance of a Federal Register Notice (FRN), upon the receipt of, and also upon the final resolution of license amendment applications for significant materials licensing actions in the State of Utah, such as for authorization to dispose of in situ leach facility 11e(2) byproduct material or for approval of significant changes to an approved reclamation plan. An FRN issued upon receipt of a significant license amendment application serves notice, under 10 C.F.R. § 2.1205(c)(1), that interested parties have 30 days to file a petition for hearing, and thus provides interested parties, such as the State of Utah, an opportunity to comment upon the license amendment application. The FRN issued at the final resolution of the license amendment is informational. In addition, where the license amendment application raises significant or controversial issues, NRC would be willing to attend public meetings, as appropriate. Accordingly, Petitioners' request for an opportunity to confer with the NRC and to comment before issuance of license amendments involving uranium mill tailings disposal in Utah is granted, to the extent indicated above.

As explained above, the NRC will make every effort to obtain the views and comments of the State of Utah before taking action upon license applications for authority to dispose of uranium mill tailings in Utah. Although the NRC welcomes and will closely consider the State of Utah's comments, it would be inconsistent with sections 63, 81, and 84 of the Atomic Energy Act of 1954, as amended, to grant Petitioners' request that the NRC obtain the concurrence of the Governor and the Legislature of the State of Utah before issuing license

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3 Although the NRC is not legally required to provide such notice, City of West Chicago v. NRC, 701 F.2d 632 (7th Cir. 1983), such notice would enhance communication with the State of Utah and material licensing decisions.
amendments authorizing disposal of uranium mill tailings in Utah. Accordingly, this request is denied.

IV. CONCLUSION

For the reasons discussed above, Petitioners' request to modify Source Material License No. SUA-1358 is granted, and will be effected by a "Confirmatory Order Modifying License Condition 55" to be issued concurrently with this Decision. Petitioners' request that the NRC confer with the State of Utah before issuing license amendments involving mill tailings disposal in Utah is granted to the extent that both direct and Federal Register notice of all applications for significant materials licensing actions in Utah will be given to the State of Utah, thus providing the State of Utah with an opportunity to comment. Petitioners' request that the NRC obtain the State of Utah's concurrence before issuing license amendments concerning uranium mill tailings disposal in Utah is denied for the reasons discussed above.

A copy of this Decision will be filed with the Secretary for the Commission to review as provided in 10 C.F.R. § 2.206(c). This Decision will become the final action of the Commission 25 days after issuance unless the Commission on its own motion, institutes review of the Decision in that time.

FOR THE NUCLEAR REGULATORY COMMISSION

Robert M. Bernero, Director
Office of Nuclear Material Safety and Safeguards

Dated at Rockville, Maryland, this 14th day of December 1994.

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4 Petitioners, nonetheless, may acquire authority to regulate section 11e(2) byproduct material, and thus to regulate the disposal of uranium mill tailings in Utah, through the agreement process pursuant to section 274 of the Atomic Energy Act, as amended.
In the Matter of
BATTELLE MEMORIAL INSTITUTE
COLUMBUS OPERATIONS
(Columbus, Ohio)

The Director, Office of Nuclear Material Safety and Safeguards, grants a petition filed by the Battelle Permit Opposition Committee for an investigation of certain audit findings involving Battelle Memorial Institute (BMI) and for enforcement action, as appropriate. Petitioner asserted that BMI appears to be a facility out of control in its handling of radioactive material, that a potential threat exists to the surrounding neighborhood through BMI's operations, and that the level of NRC oversight of BMI activities is of concern. The Director grants the petition in that the NRC Staff has investigated the audit findings and has taken appropriate enforcement and other actions and has taken appropriate action to address the concerns regarding NRC's oversight of BMI's licensed activities.

DIRECTOR'S DECISION UNDER 10 C.F.R. § 2.206

I. INTRODUCTION

On December 28, 1993, the Battelle Permit Opposition Committee (BPOC) filed a petition for an investigation1 of certain audit findings involving Battelle Memorial Institute (BMI) and for enforcement action, as appropriate. The

1 The NRC interprets "investigation" in this context to mean a review through inspection as opposed to assessing potential wrongdoing.
referenced audit findings are the product of an independent audit commissioned by BMI and performed by ATEC Associates, Inc. The petition states that BMI appears to be a facility out of control in its handling of radioactive material, a potential threat exists to the neighborhood through BMI's operations, and the level of Nuclear Regulatory Commission (NRC) oversight of BMI activities is of concern.

By letter dated March 17, 1994, the NRC acknowledged receipt of the request for an investigation and appropriate enforcement action, and informed the requester that the letter would be treated as a petition in accordance with the provisions of 10 C.F.R. § 2.206 of the Commission's regulations and that a decision would be issued within a reasonable time.

I have now completed my evaluation of the matters raised by the Petitioner and have determined that, for the reasons stated in this Decision, the Petitioner's request for an inspection and appropriate enforcement action for the deficiencies identified by the audit is granted.

II. BACKGROUND

In July 1992, BMI hired ATEC Associates, Inc., a contractor, to conduct an independent safety inspection or safety audit of BMI's radiation protection program. This audit focused on BMI's research and development program. The audit was self-initiated and was designed to be critical in nature. The audit evaluated the radiation protection program against NRC, Department of Energy (DOE), and Occupational Safety and Health Administration (OSHA) requirements, as well as other good control practices. Approximately 240 person-hours were devoted by the contractor in performing this audit. The audit identified 201 deficiencies or weaknesses in the program. The results were provided to the BPOC.

III. DISCUSSION

In the petition, the Petitioner requests the Commission to "investigate" (see note 1) the findings of the audit and to take appropriate enforcement action to ensure that the BMI's facility is operated in compliance with applicable requirements. In response, during the period January 31 through March 25, 1994, a special safety team inspection was conducted at the BMI's King Avenue, Columbus, Ohio, and West Jefferson, Ohio, facilities. Included in the inspection was a review of the three concerns cited by the BPOC in the Petition, as described below.
A. Control in Handling of Radioactive Material

The Petitioner states that BMI appears to be a facility out of control in its handling of radioactive material.

NRC Special Nuclear Materials License SNM-7 allows BMI to receive, possess, use, and transfer certain radioactive materials in the conduct of research and development, radiography, and decommissioning activities.

Compliance with license-required actions to control handling of radioactive material has been confirmed by NRC inspectors during safety inspections. This confirmation was achieved through direct observation of ongoing activities, interviews with Licensee staff, and examination of Licensee records. Specific areas examined included handling and storage of radioactive materials, disposition of waste and maintenance of records in support of licensed activities. In one area of research, BMI used animals for various studies on the effects of radioactive materials. NRC reviewed the disposition of the radioactive carcasses of these animals through incineration as general waste. Research records were reviewed (typically on a random spot-check basis) and calculations performed to confirm that the radiation levels of the carcasses were below NRC limits and were, therefore, acceptable for incineration as general waste. Confirmation was achieved. With regard to the accuracy of measurements of radioactive materials handled by BMI, a review of the data recorded on the Licensee’s liquid scintillation verification form (used to verify that general waste met 10 C.F.R. § 20.2005 levels for radioactive materials in unrestricted areas) indicated that the Licensee is meeting NRC requirements. (Results of these inspections were documented in Inspection Reports, including that described in special safety Inspection Report 070-00008/94001(DRSS) dated April 26, 1994.) Regarding storage, inspection tours of the King Avenue site (located in Columbus, Ohio) and West Jefferson, Ohio site, confirmed that radioactive and hazardous materials were stored adequately.

BMI is also decontaminating and decommissioning (D&D) a series of buildings at the West Jefferson, Ohio, and King Avenue sites. The D&D activities began in 1986 and are scheduled to continue through the year 2000. The facilities undergoing D&D were toured by NRC inspectors, facility workers were interviewed, procedures were reviewed, and several radiological surveys were conducted by the inspectors. The NRC has concluded that the D&D work is being conducted in accordance with BMI’s NRC license and applicable NRC regulations.

The July 1992 ATEC audit of BMI’s program did identify four potential violations of NRC requirements. The violations were reviewed by NRC during the special inspection, and it was determined by the inspectors that these potential violations met the criteria for noncited violations (as provided in 10 C.F.R. Part 2, Appendix C) in accordance with the Commission’s Enforcement
Policy. Specifically, (1) they were corrected in a reasonable time, (2) were not repetitive violations, (3) were not willful violations, (4) were identified by the Licensee, (5) were not violations that could reasonably be expected to have been prevented by the Licensee's corrective action from a previous violation or licensing finding, and (6) were of such a nature that they would normally have been classified as Severity Level IV or V, which are the least significant severity levels. The violations were related to minor reporting, recordkeeping, and posting deficiencies that are not indicative of significant programmatic weaknesses. Consequently, NRC exercised discretion and considered these as noncited violations. During the special inspection conducted during the period of January 31 through March 24, 1994, the NRC identified an additional Severity Level IV violation which involved a failure to properly secure or maintain surveillance over a radioactive source. This violation was in addition to those identified by the auditor. As a result of this additional finding, a Severity Level IV Notice of Violation (NOV) was issued on April 26, 1994, to BMI. A Severity Level IV violation is of relatively minor significance, but a potential exists for an adverse impact on health and safety. BMI responded with appropriate corrective actions as described in correspondence dated May 24, 1994.

The Staff has concluded on the basis of the NRC's inspection and evaluation of BMI's radiological control program and ongoing D&D activities, that the Licensee has implemented and is maintaining a radioactive materials handling program and radioactive waste management program that are adequate to protect the radiological safety of employees and the public. Although the ATEC audit reported 201 deficiencies and weaknesses, the NRC found that only a few were of regulatory significance, and the NRC took appropriate action, including enforcement action for the repetitive violation for failure to secure a laboratory. In order to identify deficiencies and correct them in a timely manner in the future, the Staff supports licensees' efforts to aggressively perform self-assessments such as the ATEC audit.

B. Threat to the Neighborhoods

The Petitioner states that a potential threat exists to the neighborhoods through BMI's operations.

As stated earlier, BMI uses radioactive materials in the conduct of research and development, radiography, tracer studies, and conducts decommissioning activities. The research and development activities include the use of small amounts of radioactive materials for tracer studies and the use of gas chromatographs that contain small amounts of radioactive materials. The radiography activities include the use of two sealed radioactive sources. An additional sealed source is possessed but is kept in storage for future use.
The decommissioning activities are a result of research work conducted as far back as the 1940s. BMI was contracted to perform research activities regarding the use of nuclear fuel and other nuclear materials. During the conduct of these research activities, small amounts of nuclear materials were unintentionally deposited on floors, walls, machines, and other items involved in the research. BMI is currently in the process of performing D&D on the equipment, work areas, and other items. This extensive effort is expected to be ongoing for several years.

With approval from the NRC and the DOE, BMI has developed and implemented procedures to safely D&D these items. The D&D activities are routinely inspected (average of once per year) by the NRC and DOE (through the DOE resident inspector) to ensure the safety of employees and the public. The inspections have shown that BMI is performing the D&D activities in accordance with its license.

Environmental monitors are located on the fence line of the BMI boundaries at the King Avenue site and the West Jefferson site. Results of BMI’s air monitoring, groundwater sampling, sediment sampling, and vegetation analysis indicate that they are well within NRC regulations in 10 C.F.R. Part 20 for release of radioactive materials. As such, the NRC has determined that the effluent releases pose no threat to the neighborhoods and are within NRC requirements.

Based on NRC’s evaluation of the radiological safety and environmental monitoring requirements in BMI’s license and confirmation of BMI’s compliance with those requirements through routine and special inspections, NRC Staff concludes that BMI’s radiological program is adequate to protect the radiological safety of employees and the public and is being conducted in accordance with applicable requirements.

C. NRC Oversight

The Petitioner states that because BMI has stated that it passed NRC inspections, the audit findings raise a concern over the level of oversight that BMI is receiving from the NRC. From the Petitioner’s point of view, the large number of BMI audit findings calls into question the effectiveness of the NRC inspections.

NRC inspections at BMI over the past 7 years have focused primarily on activities related to nuclear fuel-related issues and decommissioning activities, areas that were considered to be of the greatest health and safety significance. Twelve inspections were conducted at BMI from May 1986 until July 1993.
These inspections identified two violations and two areas of concern which were of minor health and safety significance. The items identified were evaluated and corrected in a timely manner. Two recent inspections, July and November 1993, identified no violations of NRC requirements.

During this 7-year period, a limited review was performed by the NRC of the other research and development activities and the radiography program. These reviews included evaluations of data derived from records related to environmental monitoring, personnel exposures, environmental protection, waste management, the use of radioactive materials in field studies, and tracer studies. These reviews identified no additional problems.

The special inspection performed at BMI during the period January 31 through March 25, 1994, did not identify any violations of major safety significance in any of BMI's licensed activities covered by the ATEC audit. However, the special inspection made an additional finding of one potential violation due to failure to secure a laboratory that was a violation similar to one identified in the ATEC audit findings, and which was also of minimal safety significance. A Severity Level IV Notice of Violation was issued for this violation on April 26, 1994, as previously mentioned.

The special inspection identified one concern, namely, that the structure of BMI's license led to the emphasis by NRC on nuclear fuel-related and decommissioning activities. NRC has decided that more in-depth review and inspection of BMI's research and development activities and radiography program are appropriate, thus increasing the NRC oversight of this Licensee. To effectively address these issues it was determined that responsibility for BMI's license should be transferred from NRC Headquarters to the Region III Office, and the license should be divided into three separate licenses, each addressing specific license areas. This decision was made when NRC Staff concluded

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2 May 12 through 16, 1986. One violation, no concerns:

One violation: 10 C.F.R. §71.5(a), 49 C.F.R. §173.441(b)(1) — greater than 200 mR/hr on outside of flatbed hauling radwaste to Barnwell. State of South Carolina identified the readings and the readings were corrected by BMI. NRC issued an NOV on June 12, 1986, after readings were identified by South Carolina and corrected by Battelle; therefore, no response to NOV was required because it was of minor health and safety significance and was immediately corrected once identified.

January 12 through 16, 1987. One violation, no concerns:

One violation: A retired reactor facility 10 C.F.R. §50.10(a) license expired without a timely renewal. NRC determined that this was an administrative issue and of minor health and safety concern. An NOV was issued February 10, 1987. The renewal was submitted subsequently.

October 23 through 25, 1991. No violations, two concerns:

First concern: The bioassay data reviewed by the NRC revealed that two individuals had positive uptakes of U-238. BMI showed that these levels were below the 10 C.F.R. Part 20 limits; therefore, no further action taken.

Second concern: An exit monitor was removed from a building being decontaminated. BMI replaced the monitor with friskers for personnel to use before leaving building. A portal monitor was then put in place for personnel to walk through prior to leaving the building. NRC determined that no further correspondence was necessary due to this corrective action.

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that previous inspections had been too sharply focussed on the nuclear fuel-related and decommissioning activities. Moving licensing responsibility to the Region III Office increased and diversified NRC inspection activities at the site. Responsibility was transferred on March 18, 1994.

With regard to the implications of previous oversight of BMI's licensed program, the NRC evaluated all 201 of the audit findings and determined that, as of the date of the special inspection (January 31 – March 25, 1994), BMI adequately addressed all 201 of the ATEC audit findings and adequately resolved all but two of them as discussed in the following paragraphs. The BMI staff, during their review of the ATEC audit findings, found that two of the audit findings had broader implications that required further investigation. Specifically, these involved failure to secure a laboratory and accounting of radioactive sources.

NRC's review of the ATEC audit documentation determined that the description of the audit findings was vague, thus making it difficult to determine if some findings were related to NRC regulations or license conditions. As a result, the NRC took a conservative approach to these findings, and any finding that could be remotely related to NRC regulations or license conditions was considered a potential violation. These potential violations identified from the ATEC audit findings were then grouped into six categories to facilitate a determination of whether there were any violations of NRC requirements. The potential violations are as follows:

(A) Failure to inform the NRC on a timely basis of a Radiation Safety Officer (RSO) change;
(B) Failure to provide training to personnel;
(C) Failure to calibrate a survey instrument at the proper frequency;
(D) Failure to secure laboratories that contained radioactive materials;
(E) Failure to utilize the proper radiation postings; and
(F) Failure to account for radioactive sources.

At the time of the special inspection, which was initiated on January 31, 1994, Items D and F remained unresolved. Items A, B, C, and E are addressed below. In regards to Item D, the inspection determined that the failure to secure laboratories containing radioactive material had been corrected for those laboratories identified in the audit. However, during the special inspection another separate laboratory, not identified in the ATEC audit findings, was identified which was not properly secured in accordance with 10 C.F.R. § 20.1801 (see discussion above). This matter is discussed in Inspection Report 070-00008/94001(DRSS) dated April 26, 1994.

Item F, the inability to account for several sources, was reviewed in detail with the Licensee. The BMI personnel contend that the sources were either properly disposed of as radioactive waste, transferred to an authorized recipient, or remain in storage in the hot cells awaiting decommissioning. Through the
efforts of both the BMI personnel and the NRC, information was gathered demonstrating that this appears to be a recordkeeping issue. The information accumulated was based on NRC review of BMI documents and interviews with BMI personnel and other NRC licensees working in conjunction with BMI in the conduct of research activities. Based on our review, NRC is confident that the sources are not in the public domain or in an unrestricted area of the facility. The NRC will continue to monitor this issue during future inspections.

The remaining potential violations (Items A, B, C, and E) are being treated as noncited violations and are detailed in the indicated sections of Inspection Report 070-00008/94001(DRSS) dated April 26, 1994, as discussed below:

**Item A** Failure to inform the NRC on a timely basis of an RSO change (Section 3);

The Licensee changed the RSO without prior notification to or approval by the NRC, although an amendment request was submitted at a later date and approved. The finding was considered to be of an administrative nature, an isolated violation, was identified by BMI, was not a violation that could reasonably be expected to have been prevented by the Licensee’s corrective actions by a previous violation or Licensee finding that occurred within the past 2 years of the inspection at issue, or the period within the last two inspections; was corrected in a reasonable time, and was not a willful violation. Accordingly, the NRC exercised discretion, and the finding was considered to be a noncited violation.

**Item B** Failure to provide training to personnel (Section 7);

The Licensee identified that training was not being provided to personnel, based upon the ATEC audit. That audit further identified that the training issue was a recordkeeping problem. For example, training was provided, but records were not kept adequately. At least thirty BMI employees interviewed indicated that they were provided initial radiation safety training but, through administrative error, the training was not properly recorded in the BMI records. The finding was considered to be of minor health and safety significance, was corrected in a reasonable time, was not a violation that could reasonably be expected to have been prevented by the Licensee’s corrective action for a previous violation or Licensee finding that occurred within the past 2 years of the inspection at issue, or the period within the last two inspections; and was not a willful
violation. Accordingly, the NRC exercised discretion and the finding was considered to be a noncited violation.

Item C  Failure to calibrate a survey instrument at the proper frequency (Section 9);

The BMI ATEC audit identified that one survey instrument out of approximately fifty possessed by BMI had not been calibrated for approximately one year. The Licensee inventoried all survey instruments and initiated tracking of their calibration dates. The NRC reviewed and confirmed the Licensee inventory. The finding was considered to be of an administrative nature, was not a violation that could reasonably be expected to have been prevented by the Licensee's corrective action for a previous violation or Licensee finding that occurred within the past 2 years of the inspection at issue, or the period within the last two inspections; was corrected in a reasonable time, and was not a willful violation. Accordingly, the NRC exercised discretion, and the finding was considered to be a noncited violation.

Item E  Failure to utilize the proper radiation postings (Section 16).

The ATEC audit identified a number of potential NRC-related posting deficiencies. Based upon that audit finding the license took an aggressive approach to post areas where required. NRC verified that the posting deficiencies were corrected. The finding was considered to be of minor health and safety significance, was corrected in a reasonable time, was not a violation that could reasonably be expected to have been prevented by the Licensee's corrective action for a previous violation or Licensee finding within the past 2 years of the inspection at issue, or the period within the last two inspections; and was not a willful violation. Accordingly, the NRC exercised discretion, and the finding was considered to be a noncited violation.

D. Remaining Audit Findings

The remaining audit findings were related to Battelle's research and development safety program. These findings involved questionable laboratory practices and portions of the radiation safety program where OSHA, not NRC, requirements applied. The NRC referred the findings concerning questionable labora-
tory practices and relevant radiation safety issues to OSHA for resolution. The ATEC auditor, in some cases, also did not have additional relevant information that would have mitigated some audit findings. BMI identified corrective actions for the audit findings by conducting reviews of the laboratory facilities; interviews with BMI employees; and a review of records and documents that were associated with the general health and safety of BMI employees and the public.

A copy of NRC Inspection Report 070-00008/94001(DRSS) dated April 26, 1994, was provided to the Petitioner on June 7, 1994. There will be no further action regarding this matter, since the NRC considers the concerns resolved. Future NRC inspections will be directed to specific program areas, consistent with the restructured license, to focus inspections by the type of nuclear material and activity involved, i.e., special nuclear material, byproduct material, and broad-scope license activities such as radiography and tracer studies. NRC will continue to support efforts by licensees, including BMI, to implement effective self-assessments and implement timely corrective actions when deficiencies and weaknesses are identified.

The Petitioner’s concern regarding NRC oversight was substantiated. As described above, action has been taken to enhance NRC oversight of BMI’s licensed program.

IV. CONCLUSION

The Staff has carefully considered the request of the Petitioner. In addition, the Staff has evaluated the bases for the Petitioner’s request. For the reasons discussed above, I conclude that the Petitioner has raised valid issues related to BMI’s compliance with NRC requirements and the NRC’s licensing and oversight of the BMI facility. Accordingly, the Petitioner’s request for an investigation and enforcement action pursuant to 10 C.F.R. § 2.206 is granted as described in this Decision, and appropriate enforcement and other actions for the ATEC audit-related deficiencies have been taken as described above. In addition, as described above, appropriate action has been taken by the NRC Staff to address the NRC’s oversight of BMI’s licensed activities.

As provided by 10 C.F.R. § 2.206(c), a copy of this Decision will be filed with the Secretary of the Commission for the Commission’s review. The Decision will become the final action of the Commission twenty-five (25) days after
issuance unless the Commission, on its own motion, institutes review of the Decision within that time.

FOR THE NUCLEAR REGULATORY COMMISSION

Robert M. Bernero, Director
Office of Nuclear Material Safety and Safeguards

Dated at Rockville, Maryland, this 14th day of December 1994.

[The enclosure, "NRC Inspection Report 070-00008/94001(DRSS)," has been omitted from this publication but can be found in the NRC Public Document Room, 2120 L Street, NW, Washington, DC.]
UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

OFFICE OF NUCLEAR REACTOR REGULATION

William T. Russell, Director

In the Matter of Docket No. 99900271

ROSEMOUNT NUCLEAR INSTRUMENTS, INCORPORATED (formerly Rosemount, Incorporated) (Eden Prairie, Minnesota) December 15, 1994

The Director of Nuclear Reactor Regulation grants, in part, petitions filed by Paul M. Blanch requesting immediate enforcement action against Rosemount Nuclear Instruments, Inc., for failing to notify the Commission of defects in pressure transmitters as required by 10 C.F.R. Part 21, and asking the NRC to notify all users of Rosemount transmitters and trip devices of "significant safety problems" found during an NRC inspection.

DIRECTOR'S DECISION UNDER 10 C.F.R. § 2.206

I. INTRODUCTION

On December 31, 1992, Mr. Paul M. Blanch (the Petitioner) filed a petition with the Executive Director for Operations, pursuant to section 2.206 of Title 10 of the Code of Federal Regulations (10 C.F.R. § 2.206), in which he requested that the U.S. Nuclear Regulatory Commission (NRC) impose immediate enforcement action against Rosemount for a knowing and intentional failure to submit, as required by 10 C.F.R. Part 21, a notice to the Commission that "basic components supplied" to its customers "contained defects," as defined by 10 C.F.R. § 21.3. On March 2, 1993, the Petitioner sent a letter to the NRC in which he stated, in part, that he "was requesting enforcement action against Rosemount for failing to report defects as required by 10 C.F.R. Part 21," and
making "a simple request that [the NRC] investigate a potential cover-up and a failure to report a defect in accordance with the requirements of 10 C.F.R. 21." On March 28, 1994, the Petitioner filed a second petition in which he requested that the NRC inform all users of Rosemount 1150-series pressure transmitters and series 510 and 710 DU trip devices of "significant safety problems" identified in NRC Inspection Report 99900271/93-01 (which addressed principally the NRC Staff inspection of Rosemount's Part 21 and Appendix B to 10 C.F.R. Part 50 established programs), and that the NRC take "prompt and vigorous" enforcement action against Rosemount for careless disregard of the reporting requirements of Part 21. In a letter dated May 2, 1994, the Petitioner reiterated his request that the NRC take action to inform all users of Rosemount 1150-series pressure transmitters and series 510 and 710 DU trip devices of the "significant safety problems" identified in NRC Inspection Report 99900271/93-01.

By letters dated February 2 and April 7, 1993, in response to the Petition of December 31, 1992, and Letter of March 2, 1993, the NRC Staff stated that the request for immediate action was denied because the actions it had already taken to address the problems with Rosemount transmitters were sufficient to ensure that the problems did not constitute an immediate safety concern for any nuclear power plant. The NRC Staff also stated in those letters that, as provided by section 2.206, action would be taken on the petition within a reasonable time. By letters dated April 25 and June 3, 1994, in response to the Petitioner's letters of March 28 and May 2, 1994, the NRC Staff stated that the NRC inspection report was included in the April 1994 publication of NUREG-0040,¹ "which is sent to all nuclear power plant licensees,"² and that none of the identified issues were considered significant enough to warrant immediate notification of the nuclear industry.

In regard to the Petitioner's second request, "to take prompt and vigorous enforcement action against Rosemount for careless disregard of 10 C.F.R. Part 21 requirements," the Petitioner was informed in the April 25, 1994 letter, that "[t]he NRC will make its determination as to enforcement action, [against Rosemount] should such enforcement action be warranted, following the enforcement conference."

The Director of the Office of Nuclear Reactor Regulation (NRR) has granted these petitions in part. Specifically, pursuant to the "General Statement of

¹NUREG-0040, "Licensee Contractor and Vendor Inspection Status Report," is distributed to NRC-licensed facilities, manufacturers, suppliers, architect-engineer firms, nuclear steam supply system suppliers and is publicly available at NRC public document rooms, National Technical Information Service (NTIS), and through the Government Printing Office (GPO) sales office.

²Subsequently, NRC Staff identified that NUREG-0040 was not distributed to "all nuclear power plant licensees" as stated to the Petitioner by letter dated April 25, 1994, because of an NRC Staff error that was made concerning the NUREG-0040 distribution process. Therefore, the NRC Staff directed in October 1994 that Inspection Report 99900271/93-01 be sent to all power reactor licensees and construction permit holders. NRC Staff has verified that the distribution of the inspection reports was completed.
Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), 10 C.F.R. Part 2, Appendix C, a Severity Level II notice of violation was issued to Rosemount on November 15, 1994. On the basis of the conclusions and findings in NRC Office of Investigations (OI) Investigation Report 4-90-009, dated November 12, 1993, in NRC Inspection Report 9900271/93-01, and NRC Staff deliberations on a Rosemount presentation of its relevant information regarding the Rosemount pressure transmitter sensor cell oil-loss problem during the enforcement conference on June 23, 1994, the NRC Staff concluded that Rosemount acted in careless disregard of Part 21 requirements and its own procedures by failing to adequately evaluate or to inform its customers of the potential for degraded transmitter operation as a result of the oil-loss problem.

Additionally, on October 11, 1994, the NRC Staff received an unsolicited letter from Rosemount, dated September 28, 1994. In this letter, Rosemount stated that it agreed with the NRC "views" expressed at the June 23, 1994 enforcement conference on the importance of Part 21. However, Rosemount stated that it could not concur in the view that Rosemount acted in careless disregard of NRC requirements by failing to adequately identify and report potential defects in its Model 1153 pressure transmitters prior to December 1988. Rosemount attached a 40-page enclosure to its letter that takes exception to a number of statements and conclusions delineated in the NRC inspection report. These exceptions included Rosemount's position that early (1984) transmitter failure mechanisms were never established as resulting from oil loss, and the oil loss problem could have resulted from other factors unrelated to transmitter design. Rosemount additionally disagreed with the position in the inspection report that early nonnuclear-grade Model 1151 transmitter failures should have made Rosemount aware of a potentially generic problem affecting its nuclear-grade transmitters. Further, Rosemount disagreed with the portion of the inspection report that identifies the time that Rosemount began to track field returns of failed transmitters.

The Staff reviewed the information in the Rosemount letter and determined that the letter did not provide new information or arguments that would cause any change in the Staff's position. The inspection report and the OI investigation identified numerous instances where problems with transmitters implicating the transmitter design, manufacturing, or test processes were brought to Rosemount's attention but were not properly addressed by Rosemount for their generic or common-mode failure implications. The Staff concluded that Rosemount failed to address these generic or common-mode failure implications, initially because it improperly dispositioned the failures as random rather than

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3 During this particular period of time, the sensor cell for both Model 1151 nonnuclear-grade transmitters and Models 1152 and 1153 nuclear-grade transmitters were manufactured in the same production line, utilizing the same manufacturing and production-line process controls.
using available information to identify deviations that clearly, in the Staff’s view, represented a common-mode failure potential. Despite having, as the OI investigation identified, multiple examples of transmitter failures and several members of the Rosemount staff convinced that the failures were a result of manufacturing problems common to all the transmitter sensor cells, Rosemount failed to inform NRC licensees of the deviation. The Staff concluded that Rosemount’s knowledge of this deviation, coupled with its failure to inform licensees, constituted careless disregard for the requirements of Part 21.

II. BACKGROUND

Since the mid-1980s, the NRC Staff had been aware of several potential problems with Rosemount Models 1152, 1153, and 1154 transmitters (1150-series transmitters). In 1987, the NRC conducted an inspection at Rosemount because of a potential generic problem concerning degraded transmitter operation associated with contaminants in sensor cell oil, a condition referred to as “latch-up” identified in the early 1980s. During the same period that Rosemount was trying to resolve the latch-up problem, another sensor-cell-related problem was identified that also caused degraded transmitter operation. The second problem involved transmitter sensor-cell oil loss, which was not readily detectable because the sensor cell was sealed inside the transmitter. Rosemount pressure transmitter sensor-cell oil-loss problems in nuclear applications occurred in a number of instances and at varying frequencies from 1984 on, indicating a potential generic problem with the transmitters. Rosemount nevertheless treated each licensee or Rosemount-identified oil-loss problem as an isolated occurrence, and handled the problems essentially on an individual basis as they arose. Although Rosemount indicated to the NRC Staff and licensees that the failures resulting from oil loss appeared to be random and unrelated to any generic problem with Rosemount 1150-series transmitters, the Staff nevertheless issued NRC Information Notice 89-42, “Failure of Rosemount Models 1153 and 1154 Transmitters,” on April 21, 1989, to alert licensees to this potentially generic problem. On May 10, 1989, Rosemount issued the first of four technical bulletins in which it discussed loss of oil in its pressure transmitters. The NRC Staff continued to monitor the oil-loss problem and discuss the potentially generic problem with Rosemount and the industry.

The NRC Staff remained concerned that the transmitter oil-loss problem did not appear to be isolated, as Rosemount had been informing licensees.

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4 As defined in 10 C.F.R. § 21.3, deviation means a departure from the technical requirements included in a procurement document. The identified oil-loss problem was considered a deviation because sensor-cell oil loss caused Rosemount transmitters to depart from technical performance specifications that were delineated in Rosemount product data sheets.
Therefore, on March 9, 1990, it issued Bulletin 90-01, "Loss of Fill-Oil in Transmitters Manufactured by Rosemont," to ensure that all licensees were adequately informed about the problem and would take appropriate corrective action. After obtaining additional information, the Staff issued "Supplement 1 to Bulletin 90-01" on December 22, 1992.

In February and March 1993, NRC Staff performed an inspection at Rosemount. On March 4, 1994, the Staff issued Inspection Report 99900271/93-01, in which it identified an apparent violation of Part 21 regarding the transmitter oil-loss problem and asked Rosemount to participate in as enforcement conference on the matter. In the report, the Staff also identified several other violations of Part 21 and several nonconformances regarding Appendix B to Part 50. On June 23, 1994, an enforcement conference was held at NRC headquarters in Rockville, Maryland.

III. DISCUSSION

On the basis of the evidence developed during the investigation, OI determined that two allegations were partially substantiated. Regarding the first partially substantiated allegation, OI determined that Rosemount presented incomplete and inaccurate information to the NRC during a public meeting on April 13, 1989. However, the evidence developed during OI's investigation did not substantiate that this presentation of incomplete and inaccurate information was deliberate. Although the NRC Staff recognized that the inaccurate and incomplete statements made to the NRC during the public meeting on April 13, 1989, were not deliberate, it had substantial concerns about this matter and emphasized to Rosemount in the letter of November 15, 1994, that the submittal of inaccurate and incomplete information to the NRC is unacceptable and that the NRC expects all licensee and vendor communications to be complete and accurate and to properly reflect situations that could have implications for public health and safety.

Regarding the second partially substantiated allegation, OI determined that Rosemount acted with careless disregard when, in violation of Part 21, it failed to adequately identify and report a deviation regarding sensor-cell oil loss that was known to Rosemount staff and to inform its customers of the problem.

This violation was of concern because Rosemount did not fulfill its basic 10 C.F.R. § 21.21 responsibility of "informing the licensee or purchaser of the [transmitter oil-loss] deviation in order that the licensee or purchaser may cause the deviation to be evaluated unless the deviation has been corrected." Rosemount was aware that its manufacturing processes and testing were causing and allowing slow-leaking sensor cells to be used in nuclear transmitters, but Rosemont did not apprise NRC licensees of those circumstances. Although the
different causes of the oil-loss problem were known to the Rosemont staff, that information was not accurately or completely transmitted to individual licensees for their use in performing an evaluation pursuant to Part 21. As a result, the licensee Part 21 evaluations that were performed with the information that was provided to them by Rosemount did not encompass all of the known circumstances surrounding the oil-loss problem. The objective evidence indicated that Rosemount field service staff became concerned after the discovery of several transmitters with degraded operation that exhibited oil loss at one NRC-licensed facility in 1984. Additional instances of oil loss in the nuclear transmitters continued to be documented by Rosemont between 1984 and 1988. It appeared to the NRC Staff that Rosemont's emphasis was on correcting the manufacturing and testing weaknesses that allowed degraded transmitter operation due to oil loss without much consideration of candidly informing NRC licensees of the potential for degraded operation of Rosemont transmitters installed in safety-related applications at NRC-licensed operating nuclear power plants. Between 1984 and 1988, Rosemont received many of the failed units from its nuclear customers, performed failure analyses, and determined that the degraded operation of these units was caused from sensor-cell oil loss. Despite these numerous indications of potential problems with the Rosemont Model 1152, 1153, and 1154 transmitters, Rosemont failed to comply with Part 21 requirements and its own internal policy and procedure and inform its customers of the potential problem in a timely fashion. The NRC inspectors concluded, partly on the basis of Rosemont internal memoranda, discussions with past and present Rosemont staff, and correspondence between Rosemont and licensees, that weaknesses in Rosemont's Part 50, Appendix B quality assurance (QA) program and the reluctance of Rosemont managers to be candid in their communications with customers contributed to Rosemont’s failure to promptly inform customers of the oil-loss problem. If Rosemont had established effective measures to ensure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, and nonconformances, were promptly identified and corrected, Rosemont management could have seen the developing trend of degraded transmitter response caused by inadequate or inconsistent controls over the sensor-cell manufacturing process. Rosemont did not begin to inform its nuclear power plant customers, as required by Part 21 and its own procedures, of the deviation regarding the oil-loss problem until December 1988. The NRC Staff believes that Rosemont’s failure to take action between 1984 and 1988 — as a result of its failure to avail itself of the multiple opportunities to recognize the generic implications of sensor-cell oil loss in its 1150-series transmitters, repeated failure to recognize the problems identified by experienced Rosemont personnel, and the reluctance of Rosemont personnel to allow candid communications with customers of the circumstances surrounding the deviations — reflects careless disregard of the requirements of Part 21.
In summary, the NRC Staff concluded that the failure of Rosemount to provide timely and complete notification of NRC licensees in the more than 4 years that the company was aware, or should have been aware, of the problem indicates a careless disregard of the reporting requirements of Part 21. In accordance with the Enforcement Policy, Supplement VII, section C.5, the failure either to perform an adequate Part 21 review or to inform Rosemount customers about the problem would be classified as a Severity Level III violation. However, in accordance with section IV.C of the Enforcement Policy, the severity level was increased to Severity Level II because of the careless disregard of Part 21 by the Rosemount nuclear department management between 1984 and 1988. No civil penalty was proposed because the Staff had not found that the requirements of 10 C.F.R. §21.61 for issuance of a civil penalty — that a director or other responsible officer knowingly and consciously failed to provide the notice required by 10 C.F.R. §21.21 — have been met in this case.

IV. CONCLUSIONS

The Petitioner's requests were granted, in part, and denied, in part, as discussed herein. As provided in 10 C.F.R. §2.206(c), a copy of this Decision will be filed with the Secretary of the Commission for the Commission's review.

FOR THE NUCLEAR REGULATORY COMMISSION

William T. Russell, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland, this 15th day of December 1994.
The Director of the Office of Nuclear Reactor Regulation grants in part and denies in part a petition submitted pursuant to 10 C.F.R. § 2.206 by Mr. Thomas J. Saporito (Petitioner) requesting action with regard to the South Texas Project (STP), Units 1 and 2, of the Houston Power and Lighting Company (HL&P or the Licensee).

Petitioner requested the NRC to issue civil penalties against the Licensee and/or Licensee management personnel at STP for discrimination. This request has been granted insofar as the NRC on October 26, 1994, issued HL&P a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $100,000 for a violation of 10 C.F.R. § 50.7.

With regard to the Petitioner’s request for the NRC to institute a show-cause action pursuant to 10 C.F.R. § 2.202 to modify, suspend, or revoke HL&P’s NRC operating licenses authorizing the operation of STP, Units 1 and 2, and that the NRC take appropriate actions to cause the immediate shutdown of the two reactor cores at STP, the Director finds that the Petitioner has not raised substantial health or safety issues in the petition and denies those portions of the petition.
DIRECTOR'S DECISION UNDER 10 C.F.R. § 2.206

I. INTRODUCTION

On May 5, 1993, Mr. Thomas J. Saporito, Jr. (the Petitioner) filed a petition with the U.S. Nuclear Regulatory Commission (NRC) pursuant to 10 C.F.R. § 2.206. The Petitioner requested that the NRC institute a show-cause proceeding pursuant to 10 C.F.R. § 2.202 to modify, suspend, or revoke the Houston Lighting & Power Company’s (HL&P’s or the Licensee’s) NRC operating licenses authorizing operation of South Texas Project (STP), Units 1 and 2; that the NRC initiate appropriate actions to cause the immediate shutdown of the two reactor cores at STP; and that the NRC issue civil penalties against the Licensee and/or Licensee management personnel at HL&P’s STP. The specific requests were based on fourteen alleged managerial, security, and human performance problems at STP.

On July 8, 1993, Thomas E. Murley, then Director of the Office of Nuclear Reactor Regulation, informed the Petitioner that the petition had been referred to this Office for action pursuant to section 2.206 of the Commission’s regulations and that the Petitioner’s request for the immediate shutdown of the STP units was denied. He also informed the Petitioner that the NRC would take appropriate action within a reasonable time regarding the Petitioner’s request.

My Decision in this matter follows.

II. BACKGROUND

The Petitioner asserts as grounds for the request that there is no “reasonable assurance” of safe operation of STP, because the NRC has referred four cases of discrimination against whistleblowers to the U.S. Department of Justice (DOJ) and DOJ is seeking indictments against Licensee officials for retaliation against the whistleblowers; the Licensee’s actions against workers have instilled a “chilling effect” at STP; the Licensee’s physical plant nuclear security program is of questionable effectiveness; the NRC Inspector General found that the process used to justify the terminations of three former STP employees was prejudicial to them; and NRC investigators found that management was aware that these workers had made allegations to “Speakout” and/or to NRC officials; Licensee officials may be held liable for allegedly misleading the NRC about certain security-related matters; the Licensee’s failure to reduce a huge maintenance backlog has led to repeated human errors and equipment failures; the Licensee maintains an autocratic, vindictive management team at STP, which has further instilled a chilling effect; the Licensee has twelve U.S. Department of Labor (DOL) discrimination cases pending regarding alleged retaliatory actions taken
at STP; the Director, NRC Office of Investigations (OI), stated that if the NRC cannot rely on the Licensee to be truthful or candid then there is a major safety issue; a former security supervisor at STP has stated that "nobody wanted to hear that there were any problems"; the NRC Chairman has stated that the NRC has become much more aggressive in pursuit of utilities that retaliate against whistleblowers; the Director, OI, has said that he has no qualms about referring a case of alleged utility wrongdoing to the Department of Justice; the NRC is investigating allegations that the Licensee has used surveillance devices to spy on employees, and possibly NRC resident inspectors, at STP; and on March 30, 1993, a Licensee executive was involved in an incident that appears to be a form of intimidation.

III. DISCUSSION

A. Enforcement Action Based on Discrimination

The Petitioner asserts that HL&P's employment actions against himself and three other individuals are violations of 10 C.F.R. § 50.7. The Petitioner, and the three other individuals were employed at South Texas Project when they raised safety concerns and were subsequently terminated.

OI began an investigation to review the circumstances surrounding the termination of plant access to the Petitioner after he had made allegations to the NRC. OI concluded that the Licensee was inconsistent in adjudicating access authorization decisions. Furthermore, OI concluded that the managers involved in the decision to revoke the Petitioner's unescorted access to STP were prompted by his having made allegations to the NRC. DOL is reviewing the Petitioner's case. On June 30, 1992, the District Director of the Wage and Hour Division of the DOL found that the Petitioner had engaged in a protected activity and that the action against him constituted a violation of section 210 (now section 211) of the Energy Reorganization Act of 1974, as amended. HL&P has appealed this decision and a hearing will be held before a DOL Administrative Law Judge. The NRC had not taken enforcement action on the Petitioner's case earlier because it was waiting for a decision by DOL. NRC understands that the DOL hearing has been postponed. Therefore, NRC proceeded with enforcement action based on the conclusions of the OI investigation. On October 26, 1994, the NRC issued HL&P a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $100,000 for a violation of section 50.7 (Enforcement Action 93-056 (EA 93-056)). NRC took this action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," Appendix C to 10 C.F.R. Part 2. The NRC has allowed HL&P to defer payment of the civil penalty and response to the Notice of Violation until 30 days after the decision of the DOL's Administrative Law Judge. NRC also asked HL&P
to submit (1) a description of the current duties of the managers involved; (2) an explanation of why the NRC can have confidence that HL&P will ensure an environment that is free from harassment, intimidation, and discrimination; and (3) an explanation of why the NRC can have confidence that the managers involved will comply with NRC requirements if they are involved in NRC-licensed activities in the future. The Licensee is required to respond to this request by December 25, 1994. The NRC considered the violation to be a Severity Level II violation, because the discrimination involved managers whose positions were above first-line supervisors. NRC issued EA 93-056 to send a strong message to the Licensee that discrimination by HL&P management will not be tolerated.

The NRC also issued Demands for Information to the managers involved. These managers are no longer affiliated with STP and are not involved in NRC-licensed activities. Therefore, no immediate action by the NRC is necessary to ensure continued safety at STP. NRC will take appropriate action against the managers, if necessary, after reviewing their responses to the Demands for Information.

The NRC is reviewing the cases of the three other individuals and these cases are also pending with DOL. NRC will consider further enforcement action against HL&P or individual employees of HL&P after doing a thorough review of these cases.

B. Intimidation and Chilling Effect

The Petitioner asserts that the actions against the three other individuals instilled a pervasive "chilling effect" at STP, dissuading other workers from voicing safety concerns.

The NRC is committed to ensuring that the programs through which employees can voice safety concerns are responsive and nondiscriminatory. The program at South Texas, in particular, has been thoroughly inspected. In April 1993, the NRC conducted a diagnostic evaluation team (DET) inspection at South Texas while the units were shut down for various problems found by NRC and the Licensee. A DET is a broadly structured evaluation to assess overall plant operations and the adequacy of the Licensee's programs for supporting safe plant operation. The DET for South Texas was the result of an apparent decline in performance and a need for NRC managers to have more information to make an informed decision on performance. One of the issues that the team investigated was the effectiveness of the employee concerns program. The team found that employees perceived that the program did not always protect the allegor's identity and that management was not always interested in employee concerns, as demonstrated by the lack of results. However, the team did not detect any reluctance by employees to report issues perceived as immediate safety
concerns. The NRC required the Licensee to address the effectiveness of its employee concerns program as a condition of NRC approval for restart of either unit. After the DET inspection, the Licensee replaced the South Texas program, which was formerly called "Speakout," with a new employee concerns program, the Nuclear Safety and Quality Concerns Program (NSQCP). The Licensee has taken several steps to make employees feel more comfortable using the new program including: increasing confidentiality, hiring an employee advocate, and holding meetings between employees and management to encourage employees to raise concerns. NRC inspected the facility again in December 1993 (Inspection Report 93-52, January 24, 1994). This inspection began on the day that Speakout was replaced with the new program. The inspectors found that employees still expressed some reservation about the confidentiality of the program. However, most employees who expressed fear of harassment and intimidation based their opinions on rumors, or newspaper articles, rather than on direct evidence. The inspectors found that senior managers were taking strong measures to improve employee comfort in bringing forth concerns. In May 1994, NRC did a followup inspection and found that the revised program addressed the deficiencies described in previous inspections and that Licensee managers were promoting the new program and were committed to its success (Inspection Report 94-21, June 6, 1994). The inspectors interviewed approximately thirty STP employees, with emphasis on employees who had previously submitted nuclear safety concerns to the Speakout program. They found that virtually all of the employees would submit nuclear safety concerns either to their supervisor or to the NSQCP. Overall, the inspections showed that the new managers and revised program have made progress in resolving any "chilling effect" that may have been present at STP.

The Petitioner also asserts that the management team at STP is "autocratic and vindictive," instilling a "chilling effect" at STP. The DET reviewed management and organizational issues at STP during its inspection in April 1993 and found the management and organization weak, with ineffective management direction and oversight, poor use of support and resources, weak communications and teamwork, ineffective corrective action processes, ineffective use of self-assessment and quality oversight, and inadequate information systems. While the team did not specifically find a "chilled" work force, it found the weaknesses discussed above to be in themselves significant. The NRC has determined that the Licensee may not have always wanted to hear bad news and that managers ineffectively addressed problems and issues found by plant personnel through quality assurance self-assessment. In May 1994, the NRC did a followup inspection to evaluate improvements by the Licensee managers in finding, pursuing, and correcting plant problems. The inspectors found that several initiatives by plant management to improve plant performance were effective. These included: the addition of a second supervisor for each maintenance crew,
a revised station problem report process, an operations work control group, and the implementation of the technical support engineering group. The inspectors also reviewed management self-assessments and assessments performed by the independent assessment organization and found these to be adequate. The inspection report states that

a significant change in plant culture was clearly underway throughout the organization. The attitude expressed by virtually all interviewees was that senior management encouraged ownership of problems and expected plant personnel to identify and correct problems in a quality manner. There did not appear to be a reluctance on the part of operators and maintenance personnel to raise concerns to management as had apparently existed in the past.


Although the NRC has not reviewed the management style at STP, the findings of the DET gave the NRC sufficient information to address the problems in STP management that had reduced the effectiveness of programs designed to implement the findings and recommendations of plant staff. Inspections since the DET indicate that plant management has taken steps to ensure that an atmosphere exists in which employees can raise concerns. Therefore, the NRC does not have a reason to suspect that the current management style instills a pervasive "chilling effect" at the facility. The information provided by the Petitioner gives the NRC no new information and does not provide an adequate basis for the request.

The Petitioner asserts that the work force was intimidated by an incident that occurred on March 30, 1993, involving a Licensee executive. The Licensee's executive encountered several labor union protesters distributing leaflets on HL&P's property. According to a newspaper article, he became enraged, drove into the plant, summoned several armed guards and returned to the gate area where he ordered the guards to photograph the protesters and/or employees who took leaflets. The NRC Region IV office reviewed the incident in question. These leaflets were designed to inform labor union members that HL&P employed non-union labor from out of state during the current outage. Security guards were dispatched to the scene to ask the protesters to leave HL&P's property. NRC determined that the executive's actions were not a violation of Title 10 of the Code of Federal Regulations and do not raise a significant health and safety issue. The newspaper article referenced by the Petitioner does not reveal any health and safety issues.

The Petitioner asserts that there have been allegations that the Licensee has used surveillance devices to spy on employees and NRC resident inspectors at the STP nuclear station. The NRC investigated the various allegations. In April 1993, OI performed a sweep of the resident inspectors' offices and found no surveillance devices. This allegation was found to be groundless. The NRC
Inspector General investigated the allegation of spying on HL&P employees and has found no evidence to support this allegation. Therefore, this issue is considered closed for the NRC.

In summary, the Staff has reviewed the Petitioner’s concerns regarding intimidation of plant employees and has determined that the Petitioner does not raise a significant health or safety issue.

C. Referrals to Other Government Agencies

The Petitioner asserts that the Licensee can no longer provide reasonable assurance to the NRC that STP will be safely operated because the NRC has referred four cases of whistleblower discrimination to DOJ. The Petitioner also asserts that the Licensee has twelve DOL discrimination cases pending as a result of alleged retaliatory actions taken at STP.

Referrals to DOJ do not necessarily indicate challenges to the public health and safety. Consistent with the Memorandum of Understanding Between the Nuclear Regulatory Commission and the Department of Justice (53 Fed. Reg. 50,317 (Dec. 14, 1988), hereafter “MOU”), the NRC will refer cases to DOJ when the Staff suspects criminal wrongdoing. Such referral to the DOJ does not prevent the NRC Staff from taking action to safeguard the public health and safety. If the NRC concludes that immediate action is required to protect the public health and safety, it will proceed with such action as is necessary to abate the immediate problem and then notify the DOJ. Upon learning of the alleged discrimination in the four cases mentioned above, the NRC investigated and found that, although the alleged chilling effect did not present an immediate threat to public health and safety, these cases indicated that the Licensee’s employee concerns program (Speakout program) was ineffective. The NRC required HL&P to address the effectiveness of the Speakout program before restarting either unit from the extended outage in 1993. This decision is documented in Supplement 2 to the Confirmatory Action Letter of October 15, 1993.

The Petitioner does not give an adequate basis for maintaining that the “Licensee can no longer provide reasonable assurance for the safe operation” of the facility as a result of a referral to DOJ. The Petitioner cited a newspaper article (Houston Chronicle, March 28, 1993) as the reference for this allegation. The article gives NRC no additional facts and does not provide an adequate basis for the request.

In accordance with the MOU between the Department of Labor and the NRC (47 Fed. Reg. 54,585 (Dec. 3, 1982)), DOL advises the NRC of the status of pending cases. The NRC reviews DOL filings and decisions and may take enforcement action based on DOL decisions if the NRC has not conducted its own investigation. DOL discrimination cases as a result of alleged
retaliatory actions are not, in themselves, evidence of improper conduct sufficient to jeopardize nuclear safety. The fact that a discrimination case is pending before the DOL does not prohibit the NRC from taking any immediate enforcement action that it believes is necessary.

The NRC takes alleged retaliatory action and discrimination by licensees seriously and has taken enforcement action against the Licensee for one of these cases. (See Section III.A, above) NRC may take further enforcement action as it completes its own investigation of the remaining cases. The Staff has concluded that the DOL filings and DOJ referrals do not raise a significant health or safety issue.

D. Submission of Misleading Information to the NRC

The Petitioner asserts that there has been an allegation that the Licensee misled the NRC concerning security-related matters. The Petitioner alleges that STP officials may have misled the NRC about power failures that disabled parts of a security intrusion detection field. The NRC received allegations about this event and reviewed this issue as part of a safeguards inspection at South Texas Project in August 1991. The inspectors determined that the Unit 2 perimeter and vital area alarms were inoperable, because both primary and backup power sources were rendered inoperable on March 9, 15, and 21, 1991. The inspectors found that the power failures lasted from a minimum of 20 minutes to a maximum of 2 hours and 50 minutes. However, contrary to allegations, compensatory measures were taken within 10 minutes. The Licensee did operational tests of the alarms at the time of power restart, but did not do functional tests, as required by the Physical Security Plan. The NRC issued a Severity Level IV violation for failure to conduct functional testing. OI reviewed the case to determine if the Licensee had misled the NRC regarding these power failures. In September 1991, OI closed its investigation after determining that the Licensee committed no wrongdoing. The Petitioner gives no additional facts other than those already known by the NRC and does not present a substantial health or safety issue that would call into question the continued safe operation of STP.

E. Maintenance Backlog

The Petitioner asserts that the Licensee failed to reduce a “huge maintenance backlog” of corrective work that has led to repeated human errors and equipment failures. In its April 1993 inspection, the DET reviewed the maintenance backlog in detail and found that the work control process at STP was inefficient and manpower-intensive, which contributed to the poor material condition of the
plant. However, the inspectors found no instances of equipment failure that could be attributed to delayed maintenance. The DET’s findings are documented in a report of June 10, 1993.

NRC discussed the maintenance backlog in a supplement to the Confirmatory Action Letter of May 7, 1993, as an issue that had to be addressed before restarting either unit. Since the DET inspection, the Licensee has developed a management plan to reduce the backlog. The Licensee developed a new classification system for service requests to improve productivity. The Licensee also developed the Maintenance Rover Work Program to improve the timely resolution of low-priority service requests that did not require detailed work planning. The NRC reviewed these corrective actions and considers them good initiatives. The Licensee significantly reduced the Unit 1 and common service request backlog from approximately 3000 at the beginning of 1993 to 961 service requests prior to restart in February 1994. Unit 2 had a backlog of 615 service requests prior to its restart in May 1994. In January 1994, NRC did an inspection to determine the effectiveness of the Licensee’s efforts to reduce and maintain an acceptable maintenance backlog. The inspectors found that the Licensee was quickly addressing high-priority work. The inspectors concluded that, with the current maintenance programs in place, the Licensee should be able to keep the service request backlog manageable. The backlog as of October 31, 1994, was 717 service requests for Unit 1 and common, and 433 for Unit 2. The inspectors also reviewed the service request backlog to ensure that maintenance activities that were deferred did not compromise the reliability of safety-related equipment. They concluded that the maintenance actions that are deferred have adequate technical basis for such deferral. Therefore, the Licensee has sufficient control of its maintenance program to ensure that safety-significant repairs are completed in a timely manner. Inspection Report 94-20, June 10, 1994, includes a discussion of the NRC’s evaluation of the service request backlog. The inspectors concluded that the Licensee was maintaining control of service request backlog levels and had taken sufficient actions to control the backlogs in the foreseeable future.

The Petitioner refers to a newspaper article (*Houston Chronicle*, March 28, 1993) which gives no additional facts other than those already known by the NRC and does not provide an adequate basis for the request. In summary, the Petitioner does not present a substantial health or safety issue that would call into question the safe operation of STP.

F. Effectiveness of the Physical Security Plan

The Petitioner asserts that the Licensee’s physical plant nuclear security program is of questionable effectiveness because a simulated terrorist team was able to penetrate the vital area of STP during a training exercise in 1992 as cited
in a newspaper article (Houston Chronicle, March 28, 1993). The Licensee had an NRC-approved training and qualification plan in effect and was conducting training in compliance with that plan when the incident occurred. One purpose of training is to find weaknesses in personnel, tactics, and procedures. The training revealed one security exercise weakness for which the Licensee took corrective actions. During an operational safeguards response evaluation (OSRE) conducted in January 1993, the Licensee successfully demonstrated its capability to protect against a design-basis threat. The OSRE team documented its conclusions in an OSRE report of March 17, 1993.

The NRC conducts OSREs to evaluate a licensee's ability to protect against the design-basis threat of radiological sabotage and to ensure that the safeguards measures do not adversely affect the safe operation of the plant. The OSRE team was established to do reviews to help resolve generic safeguards issues and to evaluate the twenty-eight sites where the regulatory effectiveness review team had not observed contingency drills. STP was one of these sites. The OSRE team consists of a nuclear engineer, safeguards specialists from the Office of Nuclear Reactor Regulation and NRC's regional office, the resident inspector, and active-duty U.S. Army Special Forces personnel acting in a support and advisory role under an interagency agreement.

The OSRE team at STP noted in the March 17, 1993 report the overall soundness and use of response capabilities and the rapid, intense, and generally effective execution of the security strategy by the total response force. These findings were based on discussions with security force members and observations of response force drills and critiques. The OSRE team found no significant deficiencies and found a high level of safeguards effectiveness at STP. The newspaper article referred to above by the Petitioner gives no additional facts other than those already known by the NRC and does not provide an adequate basis for the request. The Staff has concluded that the issues raised concerning the security program have been satisfactorily addressed by the Licensee and are not significant to health and safety.

G. Request for Institution of Proceedings Under Section 2.206

The Petitioner requests that the NRC initiate a show-cause proceeding to revoke, modify and/or suspend South Texas Project's operating licenses. The institution of proceedings in response to a request for action under 10 C.F.R. §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 Arizona Public Service Co. (Palo Verde Nuclear Generating Station, Units 1, 2, and 3), DD-92-1, 35 NRC 133, 143-44 (1992). The allegations contained in the instant petition do not raise substantial health and safety issues that would justify revoking, suspending, or
modifying the South Texas licenses. Accordingly, I have concluded that no adequate basis exists for initiating a proceeding as requested by the Petitioner.

IV. CONCLUSION

The NRC Staff has reviewed the basis and justification stated to support the Petitioner's request that the NRC institute a show-cause proceeding pursuant to 10 C.F.R. § 2.202 to modify, suspend, or revoke HL&'P's NRC operating licenses authorizing the operation of South Texas Project, Units 1 and 2, and that the NRC take appropriate actions to cause the immediate shutdown of the two reactor cores at South Texas Project. The Staff finds that no adequate basis exists for granting the Petitioner's request for immediate shutdown of South Texas Project, Units 1 and 2, or for a proceeding to show cause why the operating licenses should not be modified, suspended, or revoked, as no substantial health or safety issues have been raised by the petition. The Petitioner also requested that the NRC issue civil penalties against the Licensee and/or Licensee management personnel at HL&'P's South Texas Project. This request has been granted insofar as the NRC has issued a proposed civil penalty to HL&'P for a violation of section 50.7.

A copy of this Decision will be filed with the Secretary of the Commission for review in accordance with 10 C.F.R. § 2.206(c). The Decision will become final action of the Commission twenty-five (25) days after issuance unless the Commission, on its own motion, institutes review of the Decision within that time.

FOR THE NUCLEAR REGULATORY COMMISSION

William T. Russell, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland, this 20th day of December 1994.
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