MAR 3 0 1990

Radioactive Waste Management Associates
ATTN: Marvin Resnikoff, Ph.D,
Senior Associate
306 West 38th Street, Room 1508
New York, New York 10018

Dear Dr. Resnikoff:

I am responding to your letter of March 5, 1990, concerning the Nine Mile Point Unit 1 reactor. In your letter you stated that two aspects of the incident where Niagara Mohawk used the Radwaste Building sub-basement as a long-term liquid waste retention facility should be more fully examined by the Nuclear Regulatory Commission. Further, you raised several specific points regarding the NRC's regulatory actions. Below they are addressed.

In your Item A you correctly point out that the flooding of the radwaste building sub-basement ultimately resulted in the need to release water to Lake Ontario. The releases that were made by the licensee were allowed by federal regulations and were properly reported to the NRC. The releases were made in a controlled manner at very low concentrations thus ensuring protection of public health and safety and protection of the environment.

Your Item A also states that the total amount of excess water released to the sub-basement was 90,000 gallons and that NRC may not have been aware of this amount of water. The Augmented Inspection Team (AIT) reviewed all water released to the sub-basement during the inspection conducted in August, 1989. The water was disposed of by one of two means, either by release to Lake Ontario as described above, or by temporary storage onsite and subsequent evaporation. Residue from the evaporation process was shipped to an authorized disposal site as solid radwaste. Such shipments were made in accordance with NRC and the Department of Transportation regulations, thus public health and safety was ensured. All releases to the sub-basement and licensee notifications were covered in the AIT Report and in subsequent enforcement actions.

In your Item B you suggested that, associated with the 1981 radwaste building flooding event, the evaporator was being directly vented to the environment. The design of the evaporator precludes the presence of a direct non-filtered pathway to the environment. The vapor that is generated during operation of the evaporator is condensed in the vapor condenser. The distillate is then cooled and routed to floor drains which lead back to the radwaste building for storage, and further processing and reuse. The non-condensables are routed to the ventilation system where they are monitored and filtered. All releases

from the building ventilation system are controlled by federal regulations and are reported to the NRC. Our review of licensee's records in this area indicates that releases have been within regulatory limits thus ensuring protection of public health and safety and protection of the environment. Regarding radioactive cesium detected in milk samples during 1981, this issue was addressed in Section 6.0 of the AIT inspection report. As described in the AIT report, it is the conclusion of the inspection team that the elevated concentrations of radioactive cesium measured in milk were not a result of releases from the facility.

Regarding your comments in the area of the enforcement action taken by the NRC, these subjects were addressed in NRC's Notice of Violation issued to Niagara Mohawk on February 23, 1990. A copy of that action is enclosed. Please refer to that document for an explanation of the considerations that were taken in arriving at the regulatory conclusions for this event.

With regard to your comment concerning the records of the barrel contents, those records primarily are required for preparation of documentation at the time of shipment for disposal. They became unusable because of the flooding of the sub-basement. The licensee will have to requantify the contents of the drums and reconstruct the records prior to such shipment, but no violation of regulatory requirements occurred due to the inadvertent loss of the records.

With regard to your comment that the incident should have been reported to the NRC under 10 CFR 20.403, the staff carefully considered this as a potential violation. It was concluded that the incident was not required to have been reported. As a result, there is no basis for concluding that the licensee was involved in a "cover-up," as you suggested.

I hope this letter addresses your concerns to your satisfaction.

Sincerely,

Original Signed by:

Ronald R. Bellamy, Chief
Facilities Radiological Safety
and Safeguards Branch
Division of Radiation Safety
and Safeguards

Encl: As stated

cc w/encl:
M. Knapp
R. Pollard
Representative Louise M. Slaughter
Public Document Room (PDR)
Local Public Document Room (LPDR)
Region I Docket Room (w/concurrences) (50-220)

MAR 3 0 1990

*SEE PREVIOUS CONCURRENCE

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