UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

OFFICE OF NUCLEAR REACTOR REGULATION
Thomas E. Murley, Director

In the Matter of	)	
	)	
WOLF CREEK NUCLEAR OPERATING CORPORATION	)	Docket No. 50-482
	)	
	)	
(Wolf Creek Generating Station)	)	(10 CFR 2.206)

DIRECTOR'S DECISION UNDER 10 CFR 2.206

I. INTRODUCTION

By Petition dated January 30, 1989 (hereafter referred to as the Petition), submitted to the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR 2.206, the Kansas Chapter of the Sierra Club (hereafter referred to as the Petitioners) requested immediate NRC action to prevent undue risks to the public health and safety posed by the operation of the Wolf Creek Generating Station (Wolf Creek) in Burlington, Kansas. The Petition requested the NRC to suspend the operating license issued to the Wolf Creek Nuclear Operating Corporation (WCNOC or licensee) until the licensee takes the corrective actions requested in the Petition to achieve assurance of adequate protection of the public health and safety. Specifically, the Petitioners allege that (1) from the inception of its Quality Assurance program to date, management at Wolf Creek has ignored real safety concerns; (2) from the inception of operations at Wolf Creek, management has repeatedly failed to safeguard the integrity of its quality assurance programs and has failed to demonstrate management competence to address and resolve real safety concerns; and (3) the NRC's actions to date

provide no reason to conclude that the acknowledged safety problems at Wolf Creek have been resolved or will be resolved within a reasonable period of time.

The Petitioners requested that the NRC accomplish the following:

1. Suspend WCNOC's operating license for Wolf Creek.
2. Before reinstating the operating license:
   a. Reopen its Office of Investigations (OI) Case No. 4-86-004 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate in spite of all of its investigative conclusions regarding quality assurance problems.
   b. Review all of its information on quality assurance at Wolf Creek developed subsequent to the issuance of Case No. 4-86-004 and covering operations at Wolf Creek through 1989 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate.
   c. Modify WCNOC's license to operate Wolf Creek by incorporating license conditions that require all corrective actions determined by NRC to be necessary to achieve a level of operating safety that complies with Federal regulations, and if these conditions are not met, revoke the operating license.
   d. Bar the following persons, whose activities were detailed in the Office of Investigations Case No. 4-86-004 because of their alleged failures to safeguard the integrity of Wolf Creek quality assurance programs and their alleged lack of competence to identify and resolve real safety concerns, from any and all

involvement or participation in activities at Wolf Creek Generating Station whether as a salaried employee, a contract employee, a consultant, a volunteer, a manager or in any other position:

(i) William Rudolph

(ii) Glenn Koester

(iii) Robert L. Scott

(iv) Charles Snyder

(v) Any other individual who the NRC determines has prevented Wolf Creek Generating Station from complying with Federal quality assurance regulations in a culpable manner.

By letter dated March 23, 1989, I acknowledged receipt of the Petition and informed the Petitioners that the matters identified in their Petition did not require any immediate action to protect the health and safety of the public. I also stated that appropriate action would be taken on the Petition within a reasonable time.

I have now completed my evaluation of the Petition.[1/] For the reasons set forth in the discussion below, the Petitioners' requests for action are denied.

II. BACKGROUND

Every NRC licensee is required by regulation to have a quality assurance program, as described in 10 CFR Part 50, Appendix B, which applies to all activities affecting the safety-related functions of all structures, systems, and components. These activities include designing, purchasing, fabricating, handling, shipping, storing, cleaning, erecting, installing, inspecting,

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[1/] By letter dated June 20, 1989, the licensee submitted a response in opposition to Petitioners' request. While I did not have the licensee's letter while I was evaluating the Petition, it is consistent with this Decision and raises no new information.

testing, operating, maintaining, repairing, refueling and modifying, and apply to both construction and operation. Appendix B contains 18 separate criteria that licensees must satisfy, including design control (criterion III), material control (criteria VII, VIII, X, and XV), and corrective action (criterion XVI). Licensees satisfy these criteria by following procedures that ensure that Appendix B requirements are satisfied on a continual basis throughout the normal course of construction and operation of the facility.

In early 1984, the licensee initiated the Quality First (Q1) program at Wolf Creek to establish "the necessary administrative and investigative measures to ensure that all quality concerns related to safe plant operations, quality of work, compliance with requirements or management are appropriately evaluated, investigated, dispositioned, verified, and documented."[2/] The Q1 program provided an independent route for Wolf Creek employees to raise quality concerns.[3/] The Q1 program evaluated concerns brought to it and referred those concerns appearing to have merit back to the licensee's appropriate organization. These organizations then resolved the technical issues pursuant to the strict requirements of Appendix B. The Q1 program, which was entirely separate from the licensee's required quality assurance program, was not intended to resolve concerns pursuant to Appendix B and its actions were not intended as a substitute for satisfaction of Appendix B requirements. Regardless of whether or not the licensee had a Q1 program, or, if so, how well or poorly it functioned, the

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[2/] Kansas Gas & Electric Company's (KG&E's) Quality Concern Reporting System, Procedure No. III.29, Revision 0, dated February 24, 1984.

[3/] NRC resident inspectors are always available to receive employees' concerns about safety, whether the licensee has an independent program such as Q1 or not.

licensee always was required by NRC regulations to comply with the quality assurance criteria of Appendix B. Appendix B does not require licensees to have programs like Q1, but the NRC does encourage its licensees to develop and implement them. The program, available to all site employees, affords them an opportunity to report concerns personally to Q1 investigators or anonymously by a telephone "hot line." Information about the program and instructions for reporting concerns are posted at the site and made available to site employees. In addition, employees are interviewed by Q1 personnel when they terminate their employment at Wolf Creek and asked if they have any quality concerns to report for Q1 investigation.

In May 1985, acting on behalf of the Nuclear Awareness Network (NAN), the Government Accountability Project (GAP) filed a Petition pursuant to 10 CFR 2.206 alleging that safety concerns raised through the Q1 program were being either "ignored or buried" by both KG&E management and the NRC. In addition, GAP asserted that the NRC should have taken possession of the Q1 files but did not do so, and alleged that the NRC staff had provided an inaccurate presentation to the Commission during the Wolf Creek operating license proceedings. The GAP Petition alluded to over 700 alleged safety concerns from over 240 individuals in the Q1 files and requested the NRC to accomplish the following:

1. Take possession of the Q1 files and provide the Commission and the public an analysis of why the alleged significant safety-related deficiencies identified for the previous year (i.e., the year preceding May 15, 1985) by members of the work force do not pose a danger to the public health and safety.
2. Conduct an inquiry on the ramifications of the collective safety significance and/or adequacy of the quality assurance program in light of the information contained in the Q1 files.

3. Provide an explanation from both NRR and Region IV as to why they allegedly allowed the allegations to be exempt from the regulatory analysis for determination of safety significance.
4. Initiate an OI investigation into the alleged compromise of the Q1 program by William Rudolph, site Quality Assurance (QA) manager.

The GAP Petition was addressed in Director's Decision DD-88-14, dated August 22, 1988, a copy of which was forwarded to you in my letter of March 23, 1989, that acknowledged receipt of your Petition. Briefly stated, Director's Decision DD-88-14 responded to the GAP Petition in the following manner (numbering corresponds to the above allegations):

1. During May 1985, a special 16-member NRC staff team reviewed in depth all Q1 files (271 case files containing a total of 752 concerns) to determine whether licensee management had properly dealt with the concerns brought to the organization. After a careful review, the team concluded that a number of programmatic aspects of the Q1 program were deficient, but did not identify any violations of, or deviations from, NRC requirements, nor did it find any indications that the Q1 program failed to properly assess and resolve any significant safety concerns.
2. Despite critical comments regarding programmatic elements of the Q1 program, the NRC review team found the Q1 program effective in investigating and resolving identified safety concerns. The NRC team found that Q1 management investigated, resolved, and corrected, as appropriate, all technical safety concerns and that there was no evidence to support the allegation that either the licensee or the NRC staff "ignored or buried" any safety concern.

3. The NRC staff discussed the results of its review of the Q1 program case files with the Commission during the public meeting on June 3, 1985, regarding issuance of a full-power license for the Wolf Creek Generating Station. Nine issues arising from the Q1 program were identified as requiring supplemental work. This work was performed by the staff and the issues were satisfactorily resolved. The staff concluded that there were no technical issues that would cause it to recommend against issuing a full-power license.

4. The OI investigation completed in November 1987 concluded that a substantial number of concerns that merited a thorough investigation were given only superficial attention, were inadequately investigated, and accepted by Q1 management. Despite the number of shortcomings identified in the Q1 program, OI concluded that the evidence did not establish wrongdoing on the part of KG&E management. Although the NRC staff was well aware of the limitations of the Q1 investigative program, independent inspections regarding the adequacy of Q1's treatment of each technical safety concern concluded that each concern was properly resolved and that there were no issues that would be a restraint to a full-power operating license for the Wolf Creek Generating Station.

III. DISCUSSION

The following discussion will analyze the Petitioners' bases to determine whether to take action on the Petitioners' requests. I note that the Petitioners requested that the Wolf Creek Generating Station operating license be suspended and that prior to reinstating the operating license certain actions be taken by the NRC. For the reasons explained in my letter dated March 23, 1989,

immediate suspension of the Wolf Creek operating license was not warranted. After further consideration of the petition, and for the reasons explained below, no sufficient basis has been provided to suspend the Wolf Creek operating license. As further explained below, neither is there a sufficient basis to take any of the other actions requested by the Petitioners.

The requests of the Petitioners are treated as follows:

1. "Suspension of the operating license for Wolf Creek Generating Station, Burlington, Kansas."

The Petitioners request license suspension for alleged inadequacies in WCNOC's Q1 program. As discussed in Director's Decision DD-88-14, the staff reviewed 100 percent of the Q1 files during May 1985 and found no substantial safety concerns that would be a restraint to full-power operation of the Wolf Creek Generating Station. In addition, in a separate staff review of the OI report, the staff concluded that the OI report did not raise any issues requiring further staff actions.

The Petition does not raise any new issues regarding OI Report No. 4-86-004 or the substantive staff review of Q1. The Commission does not require licensees to implement programs with purposes similar to Q1. Furthermore, the Commission does not rely on results yielded by programs like Q1 in its licensing decisions. Therefore, in consideration of the information concerning WCNOC's Q1 program provided by the Petition, the staff finds no basis to suspend the operating license for Wolf Creek.

The Petitioners also base their request for suspension of WCNOC's license on NRC's citation of WCNOC for various violations of NRC requirements and on the NRC's Systematic Assessment of Licensee Performance (SALP) for Wolf Creek. For the Petitioners' information, I have enclosed the Notices of Violation

(Notices) and their associated cover letters regarding the $100,000 civil penalty and the violations relating to the reactor vessel O-ring seals on which the Petition is based. The Notice of Violation concerning controlling access to restricted areas that was also referenced in the Petition contains safeguards information and is not available for public disclosure.

The NRC agrees that WCNOC violated some NRC requirements, as documented in these Notices. The NRC issued the Notices in accordance with its regulations in 10 CFR Part 2 and the General Statement of Policy and Procedure for NRC Enforcement Actions, 10 CFR Part 2, Appendix C (Enforcement Policy); the Notices explain the significance of the violations, consistent with the Enforcement Policy. In accordance with the Enforcement Policy, none of these violations is a basis for suspending WCNOC's license to operate Wolf Creek. Moreover, these violations are isolated incidents and do not show a pattern of inadequate management oversight of WCNOC's Quality Assurance (QA) program. Although management at Wolf Creek has not always taken timely action to correct identified problems, as reflected by the low rating in the QA area in the SALP dated June 23, 1988 (Inspection Report 50-482/88-14) for Wolf Creek and as discussed in Section 2.b below, this problem, combined with the isolated violations cited, does not establish a pattern of inadequate management at Wolf Creek. Also, the Petitioners have submitted no new information relating to these concerns, and therefore, the Petitioners have not presented the NRC with facts on which to reevaluate these concerns. Accordingly, I find no basis to suspend the operating license for Wolf Creek.

2.a "Prior to reinstating the operating license the NRC should reopen its Office of Investigations Case No. 4-86-004 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate in spite of all of its investigative conclusions regarding quality assurance problems."

I will treat this as a separate request that is not dependent on granting the Petitioners' request to suspend WCNOC's license to operate Wolf Creek. As explained in Section 1 of this discussion, the NRC's review of the Q1 files revealed no technical reason for questioning the safety of operation at Wolf Creek. I have, nevertheless, considered the Petitioners' specific concerns.

The OI investigation in Case No. 4-86-004 began in June 1986 and focused on the Q1 program from late August 1984 to the initial fuel load date of December 1984. The purpose of the investigation was to determine whether utility management used the Q1 program in such a way as to suppress employee concerns from being fully investigated and for having appropriate corrective actions implemented so that employee concerns would not interfere with the issuance of the Wolf Creek Generating Station operating license.

The Petition is based upon information taken from the OI investigation. The following allegations, taken from the OI investigation report, are being used as the bases for reopening OI Case No. 4-86-004:

- An incident of document shredding and blackballing of a former inspector by Q1 management
- Improper reorganization of Q1 management
- Pressure on Q1 investigators to close out cases
- Confiscation of Q1 tape recorders
- Imposition of improper limits on Q1 investigations by Q1 supervisors
- Q1's mishandling of allegations concerning falsified documents
- Muzzling of Q1 investigators
- Q1's ignoring wrongdoing
- Improper changing of Q1 investigator's conclusions by Q1 supervisors
- Improper firing of Q1 investigators by management

- Conflicts of interest within Q1
- Q1's failure to deal with drug allegations

Our review of the Petition shows that it does not disclose any new information that was not available to OI during its preparation of Case No. 4-86-004. The bases provided by the Petitioners simply reiterate previously known information. The staff has known about the programmatic deficiencies of the Q1 program and this knowledge is discussed in Director's Decision DD-88-14.

OI Case No. 4-86-004 considered 12 allegations received from Q1 investigators and other employees regarding the manner in which the Q1 program had been conducted. Although the OI investigation identified many shortcomings in the Q1 program, including the bases reiterated in the Petition, the NRC concluded that no technical safety issues arose from them. OI Case No. 4-86-004 concluded that

(1) Q1 had not been given a mandate to close all cases before fuel load.

(2) Q1 Action Requests referred to other organizational elements were addressed before fuel load even though the verification of corrective action by Q1 was not meaningful.

(3) Q1 organizational procedures were changed to require that new items discovered during an investigation be referred back to the operating organization rather than expand the Q1 investigation.

(4) A significant number of allegations were closed with superficial investigative effort; however, there was no evidence to suggest wholesale discarding of allegations.

(5) The practice of summarizing Q1 allegations in one or two sentences resulted in insufficient information for the Q1 investigators to use in pursuing their investigations, leading to meaningless closures of issues which merited further investigation.

(6) Q1 management had changed the investigative findings made by a Q1 reviewer and had refused to accept significant investigative findings made by another investigator.

(7) There was little evidence that Q1 management had changed investigators' conclusions; however, there were instances in which substantiated allegations were listed as having no merit.

(8) Some Q1 investigators were removed from the program because of their aggressive investigations, their resistance to limiting the scope of investigations, or management's unwillingness to accept their investigative findings.

(9) Q1 procedures were changed to require that investigators remain within the parameters of the original allegation and not expand the investigation into new areas.

(10) The new Q1 manager's decision to close an investigation into pipe cleanliness, an area for which he had previous responsibility, was inconsistent with the objectivity necessary in an effective and meaningful investigative program.

(11) Drug allegations made to Q1 were referred to Security for action; however, Security did not investigate these allegations but merely viewed them as an additional source of information.

The overall OI investigation drew the following conclusion: "Despite substantial shortcomings identified in the Q1 program, it is concluded that the

evidence gathered does not substantiate wrongdoing on the part of KG&E management in their conduct of this voluntary program." The NRC staff has independently reviewed the conclusions reached by OI and is in agreement with OI's overall findings that the Q1 program was not used to prevent the NRC staff from becoming aware of the Q1 allegations.

It again should be noted that the NRC staff did not rely on the results of the Q1 program to make decisions related to the licensing of Wolf Creek. The staff was fully cognizant of the content of the Q1 program based on six inspections carried out by regional and NRR personnel before licensing between September 25, 1984, and May 31, 1985. The staff concluded that no technical safety issue arose from the Q1 program's shortcomings. Moreover, the NRC's decision to license the Wolf Creek plant was based on the staff's normal program of independent inspections and licensing reviews, including those of the licensee's quality assurance program required by Appendix B, not the separate Q1 program.

I reiterate that Q1 is a voluntary program run by the licensee, is not required by NRC regulations and does not serve the purpose of demonstrating compliance with Appendix B to 10 CFR Part 50, "Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants." The deficiencies that OI identified in the Q1 program in no way constituted violations of Appendix B. Moreover, with the exception of the violation discussed above, for which the NRC has already taken enforcement action by imposing a civil penalty, the licensee's Quality Assurance organization has properly implemented Appendix B. The NRC staff's review of the licensee's Quality Assurance program is included in the Wolf Creek Safety Evaluation Report (NUREG-0881). Finally, and as stated above, in May 1985 the NRC comprehensively inspected the Q1 program. I repeat that this inspection found that the licensee's Quality Assurance and other

appropriate organizations had properly resolved, pursuant to the strict requirements of Appendix B, the concerns relating to plant quality referred to them by Q1.

In summary, a review by the staff supports the conclusions made by the OI report. Considering that the Petition does not offer any new information or additional insights into the available data, the staff sees no basis for reopening OI Case No. 4-86-004.

2.b "Prior to reinstating the operating license the NRC should review all of its information on quality assurance at Wolf Creek developed subsequent to the issuance of Case No. 4-86-004 and covering operations at Wolf Creek through 1989 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate."

NRC has in place a program to periodically monitor and assess available licensee performance information in selected functional areas. The Systematic Assessment of Licensee Performance (SALP) program is an integrated NRC staff effort to collect available observations and data on a periodic basis and to evaluate licensee performance based upon this information. The SALP is designed to provide a rational basis for allocating NRC resources and to provide meaningful guidance to the licensee's management to promote the quality and safety of plant operation. Additional information regarding NRC's SALP program, including areas of review, evaluation criteria, and performance categories, is discussed in the enclosed NRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance."

SALP reviews at the Wolf Creek Generating Station have been ongoing since August 1981. The Petition refers to the SALP performed at Wolf Creek for the period between March 1, 1987, and March 31, 1988. This document provides the staff's assessment of both the licensee's quality assurance and operations programs for that period. The following discussion was taken from this SALP report:

Quality Programs and Administrative Controls Affecting Quality

The assessment of this area includes all management control, verification and oversight activities which affect or assure the quality of plant activities, structures, systems, and components. This area may be viewed as a comprehensive management system for controlling the quality of verification activities that confirm that the work was performed correctly. The evaluation of the effectiveness of the quality assurance system is based on the results of management actions to ensure that necessary people, procedures, facilities, and materials are provided and used during the operation of the nuclear power plant. Principal emphasis is given to evaluation of the effectiveness and involvement of management in establishing and assuring the effective implementation of the quality assurance program along with evaluation of the history of licensee performance in the key areas of: committee activities, design and procurement control, control of design change processes, inspections, audits, corrective action systems, and records.

Conclusions

The assessment of this functional area indicates that management has not been effective in timely resolution of important issues. Corporate management oversight of plant activities does not always ensure adequate involvement of the quality and engineering organizations in plant operations. When problems are identified by the quality and engineering organizations they are not always acted upon in a timely manner.

The licensee is considered to be in Performance Category 3 for an overall rating of the SALP area of quality programs and administrative controls affecting quality.

Plant Operations

The assessment of this area consists chiefly of the activities of the licensee's operational staff (e.g., licensed operators and nuclear station operators). It is intended to be limited to operating activities such as: plant startup, power operation, plant shutdown, and system lineups. Thus, it includes activities such as reading and logging plant conditions, responding to off-normal conditions, manipulating the reactor and auxiliary controls, plant-wide housekeeping, and control room professionalism.

Conclusions

The overall assessment of this area indicates that improvements need to be made. As stated in the previous SALP report, licensee attention to detail in this area can be improved. The use of procedures in operations was noted to improve; however, this occurred only after the situation had been allowed to deteriorate to an unacceptable level.

The examples of inattention to detail and the lack of effective operations interface with other departments reflect an ineffective management oversight in this functional area.

Staffing in this area is considered a strength, along with good control room professionalism during power operations.

The licensee is considered to be in Performance Category 2 in this area, with a declining trend.

A trending of SALP results for these two functional areas[4/] subsequent to the issuance of OI Case No. 4-86-004 is as follows:

Functional Area	Performance Period		
	(10/2/84-1/31/86)	(2/1/86-2/28/87)	(3/1/87-3/31/88)
Quality Programs and Administrative Controls Affecting Quality	1	2	3
Plant Operations	2	2	2

As previously discussed, the above Wolf Creek SALP ratings are not the most desirable but are acceptable in terms of allowing continued operation of the facility. The Petition cites the SALP, violations of NRC requirements, and the Q1 program as bases for the NRC to review all its information on the Wolf Creek QA program. As discussed in Section 1 of this discussion, the Petition presents no new information on these subjects. Therefore, the staff finds no basis to initiate new reviews to justify continued operations.

[4/] It should be noted that functional areas have been redefined pursuant to NRC Manual Chapter 0516, revised June 6, 1988, titled, "Systematic Assessment of Licensee Performance." Consequently the rating tabulated above for the functional area Quality Programs and Administration Controls Affecting Quality does not correlate directly with the staff's most recent SALP report which covered the period between April 1, 1988 and March 31, 1989. The staff's most recent SALP report, dated June 2, 1989, does not contradict any of the findings made in this Director's Decision. In this most recent report the staff found the overall performance at the Wolf Creek Generating Station to be satisfactory with an overall improving trend.

2.c "Prior to reinstating the operating license all corrective actions determined by NRC to be necessary to achieve a level of operating safety that complies with federal regulations should be incorporated as conditions of the operating license and if they are not met the operating license should be revoked."

In consideration of the information provided in the Petition, and as discussed in Section 1 above, the staff does not find a basis to impose corrective actions on the licensee. Existing applicable regulations, enforceable to the same extent as license conditions, already require the identification and correction of conditions adverse to quality. Therefore, imposing license conditions to require actions already required by regulation would be meaningless.

2d. "Prior to reinstating the operating license that the following persons whose activities were detailed in Mr. Griffin's report of Case No. 4-86-004 so as to show their failure to safeguard the integrity of Wolf Creek quality assurance programs and their lack of competence to identify and resolve real safety concerns, be barred from any and all involvement or participation in activities at Wolf Creek Generating Station whether as a salaried employee, a contract employee, a consultant, a volunteer, a management or any other position:

(i) William Rudolph
(ii) Glenn Koester
(iii) Robert L. Scott
(iv) Charles Snyder
(v) any other individual who the NRC determines has prevented Wolf Creek Generating Station from complying with federal quality assurance regulations in a culpable manner."

The conclusion of OI Case No. 4-86-004 states that "the evidence gathered does not substantiate wrongdoing on the part of KG&E management in their conduct of this voluntary program." The NRC's technical staff review of the OI report supported this conclusion. Considering that the Petition does not provide any new information to the staff, the staff does not find a basis to prohibit the named individuals from licensed activities at the Wolf Creek Generating Station. Moreover, no information has been presented identifying any other individuals who have prevented Wolf Creek Generating Station from complying with NRC regulations.

IV. CONCLUSION

The institution of proceedings pursuant to 10 CFR 2.202 is appropriate only where 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 N.R.C. 173, 175 (1975); Washington Public Power System ((WPPS) Nuclear Project No. 2), DD-84-7, 19 N.R.C. 899, 924 (1984)). This is the standard that I have applied to the concerns raised by the Petitioners in this decision to determine whether enforcement action is warranted.

For the reasons discussed above, I find no basis for taking the actions requested by the Petitioners. Rather, based on the NRC staff's inspections relating to the concerns raised in the Petition and its subsequent evaluation of those inspections, I conclude that no substantial health and safety issues have been raised by the Petitioners. Accordingly, the Petitioners' requests for action pursuant to 10 CFR 2.206 are denied as described in this Decision. As provided by 10 CFR 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

Thomas E Murley

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland,
this 26th day of June 1989.

5/ Enclosures:
1. Letter from R. Martin, USNRC, to B. Withers, WCNOC, dated March 17, 1988
2. Letter from L. Callan, USNRC, to B. Withers, WCNOC, dated March 7, 1988
3. USNRC Manual Chapter 0516, "Systematic Assessment of Licensee Performance"

5/ The enclosures consist of previously docketed information and are only being forwarded to the addressee, Kansas Chapter Sierra Club.