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Chief, Rules and Directives Branch
Division of Administrative Services
Office of Administration, mail Stop T-6 D59
United States Nuclear Regulatory Commission
Washington, DC 20555-0001

SUBJECT: COMMENTS ON THE REACTOR OVERSIGHT PROCESS

Good Day:

On behalf of the Union of Concerned Scientists, I respectfully submit the attached comments on the pilot program for the NRC's revised reactor oversight process. These comments are submitted per the guidance in the July 26, 1999, publication of the *Federal Register* and NRC News Release No. 99-164 dated August 4, 1999.

Sincerely,



David A. Lochbaum
Nuclear Safety Engineer
Union of Concerned Scientists

cc: Mr. Frank P. Gillespie
Mr. Paul Gunter
Mr. Alan Madison
Mr. James P. Riccio
Mr. Mohan C. Thadani

Attachment: as stated

PDR 64FR 40394

UCS Comments on Reactor Oversight Process Pilot Program

NOTE: Comment numbering is sequential and not reset for new sections.

NOTE: The following comments are based on information posted on the NRC's website on October 28, 1999.

GENERAL COMMENTS:

1. *Problem:* The color-coding of performance indicators can be easily distinguished when viewed on a computer screen. When the performance indicator is printed out using a black and white printer, the GREEN and RED colors become almost the same shade of dark gray while the WHITE and YELLOW colors become almost the same shade of light gray. For the trend charts, this color-blindness is not a problem because of the same relative location of the color bands. However, the color-blindness affects both the PI and Inspection Finding matrices.

Recommendation: The color-coded boxes in both the Performance Indicator and Inspection Finding matrices should be revised. One option would be to lightly cross-hatch the RED and YELLOW boxes to differentiate them from the GREEN and WHITE boxes respectively. Another option would be to place a small initial (e.g., G for GREEN, R for RED, etc.) in the lower right corner of each box similar to the convention used in the PLANT ISSUES MATRIX.

2. *Problem:* The data table for the ERO DRILL PARTICIPATION performance indicator is structured opposite the data tables for other PIs. For example, in SAFETY SYSTEM UNAVAILABILITY, the unavailable hours are listed in rows above the required hours row. In REACTOR COOLANT SYSTEM LEAKAGE, the maximum leakage row is listed above the Technical Specification limit row. But, that convention is flipped for ERO DRILL PARTICIPATION because the total key personnel row is listed above the participating key personnel row.

Recommendation: Revise the ERO DRILL PARTICIPATION data table to list participating key personnel above total key personnel.

3. *Problem:* The data table for the PROTECTED AREA SECURITY PERFORMANCE INDEX performance indicator makes it unclear how the PI value is obtained. The table lists IDS and CCTV compensatory hours along with their respective normalization factors (which are explained at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/cornerstone.html>). In other data tables, the "bad things" are provided along with the applicable limit. It is easy to see that the "bad things" become the numerator and the limit becomes the denominator in the equation used to calculate the PI value. The data table for the PROTECTED AREA SECURITY PERFORMANCE INDEX seems to only have "bad things" listed. It is assumed that the missing limit is the number of hours in the quarter.

Recommendation: Add information to the data table for the PROTECTED AREA SECURITY PERFORMANCE INDEX performance indicator that explains how the PI value is determined.

4. *Problem:* The reason for the SAFETY SYSTEM FUNCTIONAL FAILURES performance indicator not having a YELLOW or RED band is not clear. No such explanation is provided at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/cornerstone.html>.

Recommendation: The SAFETY SYSTEM FUNCTIONAL FAILURES performance indicator should be provided with WHITE to YELLOW and YELLOW to RED thresholds. Alternatively, an explanation should be made publicly available why no YELLOW and RED bands are deemed necessary.

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5. *Problem:* The GREEN to WHITE threshold for both the REACTOR COOLANT SYSTEM LEAKAGE and CONTAINMENT LEAKAGE performance indicators is established at 50 percent of the Technical Specification limit, which appears non-conservative. Industry experience with leak before break does not support a theory of gradual, linear increased leakage towards the Technical Specification limit. Instead, there is typically nominal leakage followed by a step increase in leakage.

Recommendation: The GREEN to WHITE threshold for the REACTOR COOLANT SYSTEM LEAKAGE performance indicator should be dropped from 50 percent to 20-25 percent. The GREEN to WHITE threshold for the CONTAINMENT LEAKAGE performance indicator should be dropped from 50 percent to 40 percent.

6. *Problem:* The reason for the DRILL/EXERCISE PERFORMANCE, ERO DRILL PARTICIPATION, ALERT & NOTIFICATION SYSTEM performance indicators not having a RED band is not clear. No such explanation is provided at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/cornerstone.html>.

Recommendation: These performance indicators should be provided with YELLOW to RED thresholds. Alternatively, an explanation should be made publicly available why no RED bands are deemed necessary.

7. *Problem:* The reason for the OCCUPATIONAL EXPOSURE CONTROL EFFECTIVENESS and RETS/ODCM RADIOLOGICAL EFFLUENT performance indicators not having a RED band is not clear. No such explanation is provided at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/cornerstone.html>.

Recommendation: These performance indicators should be provided with YELLOW to RED thresholds. Alternatively, an explanation should be made publicly available why no RED bands are deemed necessary.

8. *Problem:* The reason for the PROTECTED AREA SECURITY PERFORMANCE INDEX, PERSONNEL SCREENING PROGRAM, and FFD/PERSONNEL RELIABILITY performance indicators not having a RED band is not clear. No such explanation is provided at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/cornerstone.html>.

Recommendation: These performance indicators should be provided with YELLOW to RED thresholds. Alternatively, an explanation should be made publicly available why no RED bands are deemed necessary.

9. *Problem:* Page 8 of NUREG-1649 Rev. 1, "New NRC Reactor Inspection and Oversight Program," contains a section titled, "Making Performance Information Available to the Public." For each of the pilot plants, as noted below, the NRC staff has NOT, repeat NOT, made all of its inspection findings available to the public. The scant inspection finding information that has been made available was only posted on the NRC website within the past three weeks. Essentially, the pilot program is testing the industry's interface with the NRC. It is NOT – by any stretch of the imagination – testing the NRC's interface with the public. Page 8 of NUREG-1649 Rev. 1 also contains a section titled, "How This Oversight Program Differs from the Current System." With respect to the NRC staff's regard for the public in the process, there is no discernable change.

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COOPER COMMENTS:

10. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in five (5) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Cooper should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

FITZPATRICK COMMENTS:

11. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in four (4) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at FitzPatrick should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

12. *Problem:* The data table for the SAFETY SYSTEM UNAVAILABILITY, EMERGENCY AC POWER performance indicator contains unusual information. For example, the planned unavailable hours for Train 1 for 3Q/99 is 9.005 hours. The nine (9) hours is understandable, but the 0.005 hours is not. The 0.005 hours corresponds to 18 seconds. It is highly unlikely unlikely that this licensee is using synchronized time pieces such that discrimination down to seconds is possible.

Recommendation: The information presented in the data tables must be realistic, not fictional.

13. *Problem:* The NRC inspection findings provided in the MITIGATING SYSTEMS cornerstone as of October 28, 1999, have a date of July 17, 1999 assigned to them. However, according to the associated inspection report (50-333/99-06 dated August 12, 1999), that date corresponds to the end of the inspection period. It appears that a more accurate date for the inspection findings would be the inspection report date (August 12, 1999) instead of the end-of-inspection date (July 17, 1999).

Recommendation: Adopt the policy of placing the inspection report dates instead of the inspection completion dates beside the inspection findings posted on the internet.

14. *Problem:* In the first NRC inspection finding under the MITIGATING SYSTEMS cornerstone (on the October 28, 1999 website), there is commentary about emergency diesel generator equipment failures. This finding is coded GREEN based because the safety determination process "concluded that the increase in risk was very low." Section 1RO3.1 of NRC Inspection Report No. 50-333/99-06 dated August 12, 1999, provided additional information on the failures, but not on the significance determination process. The problem is not that the GREEN label is disputed, but rather that there is insufficient information to understand why the significance level is low. The justification provided essentially restates the definition for GREEN, much as many 50.59 evaluations years ago used to say NO without sufficient justification.

Recommendation: In the future, the logic behind the significance determination process's conclusion should be explained better than in the above cited example. As an example of a more completely justified significance determination process, refer to the second NRC inspection finding under the

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MITIGATING SYSTEMS cornerstone (on the October 28, 1999, website) for Prairie Island Unit 1. This finding involved excessive out-of-service time on D2 diesel generator and was also judged to be GREEN. However, the basis for this determination is clear, concise, and well-justified.

15. *Problem:* NRC Daily Event Report No. 35662 dated April 30, 1999, involved the loss of the normal phone system for the Emergency Operations Facility and the Radiological Emergency Communications System due to a cut fiber optic cable. Equipment failures such as these, which impair the ability of the facility to cope with an accident, are not captured within the existing performance indicators for the EMERGENCY PREPAREDNESS cornerstone.

Recommendation: The ALERT AND NOTIFICATION SYSTEM RELIABILITY performance indicator should be expanded to include communication systems (phone and data links) between required emergency response facilities.

16. *Problem:* NRC Daily Event Report No. 35810 as updated at 2228 on June 9, 1999, reported that a loss of control power caused residual heat removal pumps 'A' and 'B' to be declared inoperable from 1737 to 2219 on June 9, 1999. However, the SAFETY SYSTEM UNAVAILABILITY, RESIDUAL HEAT REMOVAL SYSTEM performance indicator reported 0 unplanned available hours and 0 fault exposure hours for RHR Train 1 during both 2Q/99 and 3Q/99. Assuming that RHR pumps 'A' and 'B' are within RHR Train 1, this PI appears to non-conservatively neglect this event duration.

Recommendation: The potential link between DER No. 35810 and the SAFETY SYSTEM UNAVAILABILITY, RESIDUAL HEAT REMOVAL SYSTEM performance indicator should be evaluated and the PI revised if appropriate.

17. *Problem:* NRC Daily Event Report No. 36290 dated October 14, 1999, involved the standby gas treatment system being declared inoperable. The operability and reliability of this safety system, which functions to significantly reduce radiation levels to control room operators and members of the public, is not covered by the existing performance indicators.

Recommendation: As UCS commented during the development phase of the performance indicators, the CONTAINMENT LEAKAGE performance indicator is virtually useless. UCS commented then, and repeats now, that a far, far better performance indicator would be one that covered the operability and reliability of the systems comprising primary and secondary containment. This new and improved indicator would have CONTAINMENT LEAKAGE as an element, but it would also have data on essential containment systems such as containment spray, containment cooling, and standby gas treatment.

FORT CALHOUN COMMENTS:

18. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in six (6) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Fort Calhoun should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

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HARRIS COMMENTS:

19. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in six (6) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Harris should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

20. *Problem:* The ALERT & NOTIFICATION SYSTEM performance indicator stated values of 98.9%, 98.8%, 98.5%, 98.2% and 98.2% for 3Q/98, 4Q/98, 1Q/99, 2Q/99, and 3Q/99 respectively based on simply dividing the number of successful siren tests by the total number of siren tests. NRC Daily Event Report No. 35435 dated March 3, 1999, stated that more than 20% of the sirens remained out of service for at least 3 hours 53 minutes due to severe weather. NRC Daily Event Report No. 35990 dated August 3, 1999, stated that all 28 sirens in Chatham County were inoperable due to a repeater failure and that this outage lasted 11 hours 15 minutes. NRC Daily Event Report No. 36036 dated August 16, 1999, stated that all seven (7) sirens in Harnett County were inoperable due to a lightning strike and that the outage lasted 42 hours 30 minutes. NRC Daily Event Report No. 36090 dated August 30, 1999, stated that all seven (7) sirens in Harnett County were inoperable for ten (10) minutes due to severe weather. NRC Daily Event Report No. 36170 stated that 22 of 81 sirens were disabled by a loss of power resulting from Hurricane Floyd and that the outage lasted at least 12 hours 5 minutes.

The ALERT & NOTIFICATION SYSTEM performance indicator is non-conservatively based exclusively on test results. It fails to account for sirens that are inoperable and repaired between scheduled tests.

Recommendation: The ALERT & NOTIFICATION SYSTEM performance indicator must be revised to account for alert and notification system failures detected between scheduled tests.

HOPE CREEK COMMENTS:

21. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in five (5) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Hope Creek should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

22. *Problem:* In the second NRC inspection finding under the MITIGATING SYSTEMS cornerstone (on the October 28, 1999 website), there is commentary about a longstanding degraded fire protection barrier in the cable spreading room. This finding is coded GREEN based because the safety determination process concluded "alternative safe shutdown and additional firefighting capabilities ... existed ... and the low likelihood of a fire in the CSR [cable spreading room]." This conclusion is disputed because it failed to determine, or at least document, whether the alternative safe shutdown and additional firefighting capabilities existed at all times during the longstanding deficiency. According to NRC Daily Event Report No. 36039 dated August 18, 1999, this deficiency may have existed "for the life of the plant."

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Recommendation: Whenever longstanding safety problems are discounted based on redundant components, there must be documentation that these redundant components were in fact capable of functioning during the period in question. Otherwise, it is theoretically possible to excuse both a broken safety system and its backup safety system on unverified assumptions.

23. *Problem:* The ALERT & NOTIFICATION SYSTEM performance indicator stated values of 99.3%, 99.1%, 99.1%, 98.7%, and 99.0% for 3Q/98, 4Q/98, 1Q/99, 2Q/99, and 3Q/99 respectively based on simply dividing the number of successful siren tests by the total number of siren tests. NRC Daily Event Report No. 36183 dated September 16, 1999, stated that 34 of 71 sirens were disabled by a power outage and that this outage lasted at least 1 hour 2 minutes.

The ALERT & NOTIFICATION SYSTEM performance indicator is non-conservatively based exclusively on test results. It fails to account for sirens that are inoperable and repaired between scheduled tests.

Recommendation: The ALERT & NOTIFICATION SYSTEM performance indicator must be revised to account for alert and notification system failures detected between scheduled tests.

PRAIRIE ISLAND COMMENTS:

24. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in three (3) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Prairie Island should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

QUAD CITIES COMMENTS:

25. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in three (3) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Quad Cities should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

26. *Problem:* The first NRC inspection finding under the INITIATING EVENTS cornerstone for Quad Cities Unit 1 describes an operational problem on Quad Cities Unit 2. There is no discussion here, or in Section 1R03 of the cited NRC inspection report, that this problem affects Unit 1 in any way. The first NRC inspection finding under the MITIGATING SYSTEMS cornerstone for Quad Cities Unit 2 describes a paperwork glitch affecting Quad Cities Unit 1. The discussion here, and in NRC Inspection Report 50-254/99017, stated that the problem did not apply to Unit 2.

Recommendation: NRC inspection findings that pertain to a specific unit should be included in the assessment data for only that specific unit.

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27. *Problem:* In the third NRC inspection finding under the MITIGATING SYSTEMS cornerstone (on the October 28, 1999 website), there is commentary about corrective actions not taken to address emergency diesel generator failures. This finding is coded GREEN based because the safety determination process "of low risk significance based on occasional EDG start failures, redundant EDGs and available offsite power." Section 4OA1.3 of NRC Inspection Report No. 50-254/99012 dated August 13, 1999, provided additional information on the failure to take corrective actions, but not on the significance determination process. The problem is not that the GREEN label is disputed, but rather that there is insufficient information to understand why the significance level is low. The justification provided essentially restates the definition for GREEN, much as many 50.59 evaluations years ago used to say NO without sufficient justification.

Recommendation: In the future, the logic behind the significance determination process's conclusion should be explained better than in the above cited example. As an example of a more completely justified significance determination process, refer to the second NRC inspection finding under the MITIGATING SYSTEMS cornerstone (on the October 28, 1999, website) for Prairie Island Unit 1. This finding involved excessive out-of-service time on D2 diesel generator and was also judged to be GREEN. However, the basis for this determination is clear, concise, and well-justified. As another example of a more completely justified significance determination, refer to the only NRC inspection finding under the BARRIER INTEGRITY cornerstone (on the October 28, 1999, website) for Quad Cities Unit 1. This finding involved a 1-inch diameter secondary containment penetration that went unsealed from 1981 to May 1997. The finding was colored GREEN based on a review of standby gas treatment system test results which demonstrated that negative pressure could be established and maintained in secondary containment despite the unsealed opening.

SALEM COMMENTS:

28. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in four (4) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Salem should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

29. *Problem:* The first NRC inspection finding under the MITIGATING SYSTEMS cornerstone (on the October 28, 1999 website) for Salem Unit 1 comments about the auxiliary feedwater (AFW) pump surveillance procedure that "did not ensure that the pump performance was capable of meeting accident analysis performance or pump operability criteria found in the Unit 1 and 2 Technical Specifications." This finding is coded GREEN based because the deficiency did not have an immediate impact on AFW system operability. Perhaps, but the Salem units recently restarted following a prolonged outage. There was allegedly substantial utility and NRC effort aimed at ensuring that the plant matched its design and licensing bases. The AFW system was certified to be free from deficiencies such as this one. A GREEN coloration for this error at this plant at this time is absolutely unacceptable.

Recommendation: Revise the coloration of this finding to reflect reality.

30. *Problem:* The first NRC inspection finding under the PHYSICAL PROTECTION cornerstone (on the October 28, 1999 website) for Salem Unit 1 comments about a failure to conduct package search in accordance with security plan. A search of the package was later made. According to Section 3PP1 of NRC Inspection Report No. 50-272/99007 dated September 28, 1999, the search was only

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made after NRC inspectors went to Security Management with their concerns. They had observed security personnel failing to search the package and immediately discussed the failure with the security personnel. The security personnel defended their failure. The NRC characterized this event GREEN "since no contraband was identified in the package which was not searched [when it was finally searched]."

The GREEN coloration for this event is absurd. If a handgun was found in the control room, would it be colored GREEN if it contained no bullets? If a bomb was found taped to the reactor vessel, would it be considered GREEN because it had not detonated? If marijuana was found inside the protected area, would it be considered GREEN if it wasn't burning?

Recommendation: Revise the coloration of this finding to reflect reality.

31. *Problem:* The data trend table for the REACTOR COOLANT SYSTEM LEAKAGE performance indicator for Salem Unit 1 contains a footnote which stated: "The RCS [reactor coolant system] leak on September 8, 1999 was not required to be included in the Identified Leakage calculation for that day is therefore is not reflected in this PI." According to NRC Daily Event Report No. 36138 dated September 8, 1999, the "neglected" leak rate was approximately 80 gallons per minute. It is not clear why this event was excluded from the performance indicator.

Recommendation: When 'bad' data points are tossed out, the explanation must clearly explain why this is permitted. The footnote to the data trend table for the REACTOR COOLANT SYSTEM LEAKAGE performance indicator should be revised accordingly.

32. *Problem:* The ALERT & NOTIFICATION SYSTEM performance indicator for Salem Unit 1 stated values of 99.3%, 99.1%, 99.1%, 98.7%, and 99.0% for 3Q/98, 4Q/98, 1Q/99, 2Q/99, and 3Q/99 respectively based on simply dividing the number of successful siren tests by the total number of siren tests. NRC Daily Event Report No. 36182 dated September 16, 1999, stated that 34 of 71 sirens were disabled by a power outage and that this outage lasted at least 1 hour 2 minutes.

The ALERT & NOTIFICATION SYSTEM performance indicator is non-conservatively based exclusively on test results. It fails to account for sirens that are inoperable and repaired between scheduled tests.

Recommendation: The ALERT & NOTIFICATION SYSTEM performance indicator must be revised to account for alert and notification system failures detected between scheduled tests.

33. *Problem:* NRC Daily Event Report No. 36249 dated October 1, 1999, reported that residual heat removal pump #12 was inoperable because its discharge valve failed to closed. The DER stated that the plant's emergency operating procedures require this valve to be closed during cold leg recirculation to provide long term containment spray. On October 15, 1999, this report was retracted. The plant's owner maintained that the valve failure was okay because that RHR train could be used for cold leg injection and the redundant RHR train could be used for containment spray. The plant's owner maintained that NUREG-1022 page 66 contained NRC guidance such that additional random failures did not have to be considered.

Perhaps, but there are other reasons that the redundant RHR train may not be available. For example, the data trend table for the SAFETY SYSTEM UNAVAILABILITY, RESIDUAL HEAT REMOVAL performance indicator on Salem Unit 1 stated that RHR Train 1 was unavailable for 11.1 hours in 4Q/98, 17.8 hours in 1Q/99, and 8.72 hours in 2Q/99 while RHR Train 2 was unavailable for 10.08 hours in 2Q/99. All were attributed to "Planned unavailable hours." Thus,

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while NUREG-1022 page 66 may not require additional random failures to be considered, it does not excuse or exempt non-random failures caused by "Planned unavailability." Consequently, it appears that the plant's owner is non-conservatively considering RHR to be operable.

Recommendation: Both RHR trains at Salem Unit 1 must be considered inoperable when one train with the busted discharge valve and the other train is unavailable for planned maintenance/testing.

34. *Problem:* The third NRC inspection finding listed under the INITIATING EVENTS cornerstone for Salem Unit 2 reported that operators violated the Technical Specifications because the oxygen concentration in the waste gas decay tank remained in the explosive range longer than allowed. This finding was colored GREEN because "all fire protection equipment in the area remained available." Section 1R24 of NRC Inspection Report No. 50-311/99007 dated September 28, 1999, portrayed this event as a potential threat to fire protection equipment in the area.

The logic behind the coloration of this event is truly baffling. The fire protection equipment is placed in the vicinity of the waste gas decay tanks to fight fires that may degrade the integrity of the tanks. The tanks contain radioactive gas that may escape if the tank's integrity is breached. This finding, and the associated inspection report, fail completely to discuss the potential uncontrolled release of radiation from a ruptured waste gas decay tank. That's the real reason for the Technical Specification on oxygen concentration. It's really not to protect the fire protection equipment.

Recommendation: The GREEN coloration for this finding must either be better justified (including some discussion of potential release of radiation from the waste gas decay tank following an explosion) or revised to a more appropriate color.

35. *Problem:* The first NRC inspection finding under the OCCUPATIONAL RADIATION SAFETY cornerstone for Salem Unit 2 reported that operators had "inadvertently vented radioactive gas [from the 23 waste gas decay tank] into the Unit 2 auxiliary building." This finding was colored GREEN because "the increased radiation levels in the auxiliary building were well below regulatory limits." Section 2OS2 of NRC Inspection Report No. 50-311/99007 dated September 28, 1999, reported that this event occurred on August 12, 1999. The inspection report stated that the venting resulted from errors by the operators in the auxiliary building and by errors of the operators in the control room. The inspection report additionally stated that the operators did not properly enter the emergency procedures in response to this event.

That workers in the auxiliary building at the time of this misadventure were not overexposed to radiation appears more due to luck than the [lack of] skill of the operators. Yet, this finding is GREEN.

Recommendation: Revise the coloration of this finding to reflect reality.

SEQUOYAH COMMENTS:

36. *Problem:* As of October 28, 1999, there were no significant inspection findings posted on the internet in three (3) of the seven (7) cornerstone areas. The paucity of information prevents meaningful public review and comment on this important element of the oversight program.

Recommendation: Information from NRC inspections at Sequoyah should be made available on the internet as soon as possible and the public provided with at least 30 days after the information is posted to review and comment on it.

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37. *Problem:* The first NRC inspection finding under the BARRIER INTEGRITY cornerstone for Salem Unit 2 covered “loss of containment closure during refueling.” Section 1R20 of NRC Inspection Report No. 5050-328/99-04 dated August 13, 1999, reported that at 2:14am on April 29, 1999, the plant’s owner suspended fuel movements during a refueling outage after ice blowing piping became disconnected from a containment penetration. Fuel movements resumed at 2:59am after the piping was re-connected. The NRC’s subsequent evaluation of this incident determined that Technical Specifications did not permit fuel movements in that configuration whether the ice blowing piping was connected or not. This finding was colored GREEN because “the probability of fuel damage during fuel movement is low and the potential for any substantial off-site release through these paths was also low.”

The coloration for this finding is inadequately justified. The probability of any design basis accident is low. The conclusion about potential releases is not supported by any of the text in the cited inspection report. This conclusion just appears out of no where as if conjured up.

Recommendation: Statements justifying GREEN, WHITE, YELLOW, or RED findings cannot be made unless they are supported by the information in the cited inspection reports. This finding has no such support and must be revised so that the coloration and the justification are based on objective, available information.