Final Director's Decision under 10 CFR 2.206

April 13, 2000

Mr. David A. Lochbaum
Union of Concerned Scientists
1616 P Street, Suite 310
Washington, DC 20036

Dear Mr. Lochbaum:

I am responding to the Petition you filed on September 15, 1999, pursuant to Section 2.206 of Title 10 of the **Code of Federal Regulations** (10 CFR 2.206), as acknowledged in our letter to you on October 8, 1999. In your Petition, you requested that the U.S. Nuclear Regulatory Commission (Commission or NRC) take enforcement action to modify or suspend the operating license for the Indian Point Nuclear Generating Unit No. 2 (IP2), operated by Consolidated Edison Company of New York, Inc. (Con Ed), the licensee, to prevent the reactor from resuming operation until the five issues identified in the attachment to the Petition had been fully resolved. As an acceptable alternative in lieu of a suspension or modification of the license, you requested that the NRC issue a confirmatory action letter or an order requiring these issues to be fully resolved before unit restart. The five issues raised in the Petition are (1) the apparent violation of station battery design and licensing bases, (2) the apparent failure to adequately correct circuit breaker problems, (3) the apparent unreliability of emergency diesel generators (EDGs), (4) the potentially unjustified license amendment for undervoltage and degraded voltage relay surveillance intervals, and (5) the apparent errors and nonconservatisms in individual plant examinations (IPEs). Along with the last issue, you stated that the event on August 31, 1999, at IP2 revealed potential problems with the plant-specific risk assessment developed by the licensee and now used to establish priorities for maintenance and inspections. In a transcribed telephone conversation between the Petitioner and the members of the NRC's Petition Review Board on September 22, 1999, you further clarified two of the issues in the Petition. First, you stated that because of an apparent failure to accomplish the commitment in the NRC's safety evaluation for the license amendment mentioned in the Petition, you were concerned that past licensing commitments may not have been implemented. Second, you questioned whether the amount of time the licensee took to perform certain actions during the event on August 31, 1999, was consistent with the times expected if a station blackout (SBO) had occurred since many of the procedures and processes in response to an SBO event were used.

Your request has been referred to me pursuant to 10 CFR 2.206. We agree that several of the issues you raised needed to be resolved before unit restart. In response to the August 31, 1999, event the staff performed special inspection and evaluation efforts. These efforts included dispatching an Augmented Inspection Team (AIT), supplementing the resident inspector staff with regional specialist inspectors prior to and during restart, and an AIT follow-up inspection team which was also present prior to and after unit restart. The scope of the inspection and evaluation effort included event cause determination and corrective actions, review of Con Ed's Recovery Plan, control of the station load tap changer, and Con Ed's initial extent of condition review. The staff found that Con Ed's corrective actions and Recovery Plan were adequate for ensuring the underlying root causes were identified and resolved prior to restart. Therefore, the staff has concluded that although the issues you raised have merit, the confirmatory action letter and/or order preventing restart was not necessary to ensure the licensee adhered to requirements of their license and as stated in my acknowledgment letter the licensee had taken prudent actions to address the key concerns contained in your Petition.

The specific details of our evaluation are enclosed in the Final Director's Decision (Decision) which addresses the issues you raised in your Petition. The results of the agency's inspection efforts were published in inspection reports 05000247/99-08, 99-13 and 99-14. Based on the information developed during the inspections, the staff concluded that three violations of NRC requirements did occur. Further, by letter dated February 25, 2000, the staff issued a notice of violation and proposed imposition of civil penalty ($88,000). The agency will continue its onsite inspections to verify that the licensee's actions adequately ensure that operation of IP2 does not constitute an undue risk to public health and safety. Noting the recent February 15, 2000, event the staff is taking additional steps to compare these events to ensure any common concerns receive a heightened sensitivity by the licensee.

As you are aware, we have a number of efforts underway to improve the 2.206 process. As a result of a stakeholder survey we revised Management Directive 8.11 in July of 1999. This revision resulted in several improvements that give Petitioners greater access to our decision-making process. You were offered the opportunity to make a presentation to members of the Petition Review Board on September 22, 1999, to clarify points within your Petition. In addition, we have increased the amount of contact between the Petition manager and the Petitioner. We have accomplished this by having the Petition manager contact the Petitioner throughout the review process to provide a report on the status of the Petition. For example, you were contacted October 8, 1999, October 25, 1999, January 31, 2000, and April 6, 2000. The Petition manager also contacts the Petitioner before the issuance of the Director's Decision.

A copy of the Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR 2.206(c). As provided by this regulation, the Decision will constitute the final action of the Commission 25 days after the date of issuance of the Decision unless the Commission, on its own motion, institutes a review of the Decision within that time.

I have also enclosed a copy of the notice of "Issuance of Final Director's Decision Under 10 CFR 2.206" that has been filed with the Office of the Federal Register for publication.

We recognize your efforts to bring these issues to our attention and appreciate your interest in and concern for ensuring public health and safety and the continued operational safety of nuclear power reactors. Please feel free to contact Jefferey Harold, Project Manager, at 301-415-1421 (e-mail jfh@nrc.gov) to discuss these or any future concerns you have regarding Con Ed or IP2.

Sincerely,

/RA/

Samuel J. Collins, Director
Office of Nuclear Reactor Regulation

Docket No. 50-247

Enclosures:
1. Director's Decision 00-02
2. Federal Register Notice

United States of America Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation

Samuel J. Collins, Director

In the Matter of	)	Docket No. 50-247
	)	
Consolidated Edison Company of New York, Inc.	)	License No. DPR-26
	)	
(Indian Point Nuclear Generating Unit No. 2)	)	

I. Introduction

By letter dated September 15, 1999, Mr. David A. Lochbaum, on behalf of the Union of Concerned Scientists (Petitioner), pursuant to Section 2.206 of Title 10 of the **Code of Federal Regulations** (10 CFR 2.206), requested that the U.S. Nuclear Regulatory Commission (Commission or NRC) take action with regard to the Indian Point Nuclear Generating Unit No. 2, (IP2), owned and operated by the Consolidated Edison Company of New York, Inc. (Con Ed). The Petitioner requested that the NRC take enforcement action to modify or suspend the operating license for the IP2 to prevent the reactor from resuming operation until the five issues identified in the attachment to the Petition had been fully resolved. As an acceptable alternative in lieu of a suspension or modification of the license, the Petitioner requested that the NRC issue a confirmatory action letter or an order requiring these issues to be fully resolved before unit restart. The five issues that were raised in the Petition are (1) the apparent violation of station battery design and licensing bases, (2) the apparent failure to adequately correct circuit breaker problems, (3) the apparent unreliability of emergency diesel generators (EDGs), (4) the potentially unjustified license amendment for undervoltage and degraded voltage relay surveillance intervals, and (5) the apparent errors and nonconservatisms in individual plant examination (IPE). Along with the last issue, the Petitioner stated that the event on August 31, 1999, at IP2 revealed potential problems with the plant-specific risk assessment developed by the licensee and now used to establish priorities for maintenance and inspections. Additionally, the Petitioner requested that a public hearing on this Petition be conducted in the vicinity of the plant before its restart is authorized by the NRC. In a transcribed telephone conversation between the Petitioner and the members of the NRC's Petition Review Board on September 22, 1999, the Petitioner clarified two of the issues in the Petition. First, the Petitioner stated that because of an apparent failure to accomplish the commitment in the NRC's safety evaluation for the license amendment mentioned in the Petition, the Petitioner was concerned that past licensing commitments may not have been implemented. Second, the Petitioner questioned whether the amount of time the licensee took to perform certain actions during the event on August 31, 1999, was consistent with the times expected if a station blackout (SBO) had occurred since many of the procedures and processes in response to an SBO event were used.

II. Background

As a basis for the requests described above, the Petitioner stated that the issues, if valid, have clear and direct safety implications because they involve equipment explicitly required to function to mitigate accidents. With

regard to the IPE issue, the Petitioner states that, if valid, it has indirect safety implications because it involves information used by the plant's owner to schedule maintenance and inspections of equipment implicitly required to function to mitigate an accident. The Petitioner also stated that the specific problems revealed by the event on August 31, 1999, were caused by systematic process breakdowns, including inadequate procedures, inadequate training, and plant configuration errors, and that the licensee's plan does not contain sufficient activities that provide reasonable assurance that problems in other safety systems are identified and corrected.

The Commission informed the Petitioner in a letter dated October 8, 1999, that the request for the NRC to take enforcement action to modify or suspend the operating license for IP2 to prevent the reactor from resuming operation until the five issues identified in the attachment to the Petition had been fully resolved or, in lieu of a suspension or modification of the license, the NRC issue a confirmatory action letter or an order requiring these issues to be fully resolved before unit restart was not necessary. The staff found that Con Ed's corrective actions and Recovery Plan were adequate for ensuring the underlying root causes were identified and resolved prior to restart. Although some of the actions entailed long-term corrective actions, the staff found that the licensee's short-term actions addressed the issues that needed to be accomplished before restart.

III. Discussion

Issue 1: Apparent Violation of Station Battery Design and Licensing Bases

The Petitioner stated that the event on August 31, 1999, appears to violate the design and licensing bases for the station batteries because (1) the unit is licensed with an 8-hour SBO coping duration but it took 10½ hours to restore power to the 6A safety bus; (2) although licensee calculations determined that there is sufficient battery capacity for 1 hour, after which time the alternate AC (AAC) source (gas turbine) will be available to power the battery charger, the licensee failed to connect the AAC source to the 24-vdc battery before it fully discharged; (3) the licensee operated the 24-vdc battery for nearly 5 hours longer than the design duration of 2 hours specified in the updated final safety analysis report (UFSAR), Section 8.2.3.5, and did not prevent the excessive discharge; and (4) the loss of the dc feed disabled some engineered safeguards equipment.

In a transcribed telephone conversation between the Petitioner and the NRC's Petition Review Board on September 22, 1999, the Petitioner further clarified the issue. The Petitioner stated that the August 31 event showed that there were not even any procedures in place for recovering a 480-volt safety bus. The licensee, in performing the fault analysis to ensure that there was no problem on the bus, took what seemed to be an inordinate amount of time to megger the bus. Even after the megger results were found to be successful, or showed that there was no problem with the bus, it still took several hours before the bus was reenergized. The Petitioner, therefore, questioned whether that result is consistent with the amount of time it takes this licensee to perform certain actions in case of an SBO. Recognizing that the August 31 event was not an SBO, the Petitioner stated that many of the same procedures and processes would have been invoked if there had been an SBO.

The Petitioner stated that it is questionable whether the licensee could have met the 8-hour duration, given the procedures it had in place. So, the Petitioner stated that he has doubts about whether in case of a true SBO the licensee would be able to do all the things it needs to do within the time frames it has established, i.e., the one hour for starting the gas turbines and the eight hours for restoring power from some source.

Response:

As stated in the staff's letter of October 8, 1999, the conditions associated with an SBO were not present during the subject event. The Petitioner is accurate, the licensee operated Station Battery 24 beyond the two hour duration discussed in the UFSAR. Section 8.2.3.5 of the UFSAR states that each station battery is sized to carry its expected shutdown load without battery terminal voltage falling below 105 volts for a period of two hours following a plant trip and a loss of all AC power. Station Battery 24 supplied its shutdown load for more than 11

hours. For approximately seven and one-half hours of the 11 hours voltage was maintained above 105 volts. The battery was allowed to continue discharging until power was restored to Bus 6A from EDG 23. The minimum terminal voltage decreased to approximately 35 volts during the entire discharge period (Inspection Report 50-247/99-08). The licensee provided their corrective action for restoration of the battery to the NRC by letter dated September 24, 1999. To restore the battery to an operable condition the licensee (a) performed a thorough engineering review of the effects of the battery discharge, (b) developed and performed special procedures with the technical advice and support of the battery manufacturer and industry experts for recharging and testing the battery, and (c) replaced one of the 58 cells on the basis of the test. After establishing the proper recharge on the battery, the licensee declared the battery to be operable. The NRC conducted an inspection and agreed with the licensee that Station Battery 24 had been restored to the operable condition and was satisfactory to support safe plant restart and operation. (NRC Inspection Report 50-247/99013)

The staff does not characterize the August 31 event as an SBO event. Therefore, the licensee was not required nor did they use their SBO procedures. However, the staff does believe the absence of a procedure to recover from the loss of a single 480-volt safety bus did contribute to the inordinate recovery time associated with this event. In this regard, the licensee prepared new operational procedures for a loss of 480-volt buses, including providing for the supply of alternate power to vital loads on those buses, and operator training was conducted on the use of the procedures. The inspectors reviewed the licensee's action to implement temporary facility changes (TFCs) that are needed to support the Loss of a 480V Bus procedure. The TFCs provide a method for operators to defeat the under voltage relays for Buses 5A and 6A and provide alternate power supply to Battery Chargers 21, 22, 23, and 24. The inspectors reviewed the TFCs and the associated safety evaluations and independently verified that the methods described in the TFCs were technically adequate by review of the associated electrical schematics and plant drawings. The procedures and operator training were completed on October 13, 1999, to support reactor restart.

Issue 2: Apparent Failure to Adequately Correct Circuit Breaker Problems

In addition to the problem with the overcurrent trip setting on the EDG 23 output breaker that was identified because of the August 31 event, the Petitioner stated that the plant has experienced an inordinately high number of breaker problems in recent years. Furthermore, the Petitioner noted that the overcurrent protection setting was caused by personnel error, and a post-calibration test procedure, which is commonly used throughout the nuclear industry, was not performed. Thus, these breaker problems provided ample opportunity for the licensee to benchmark its practices against industry norms, yet those opportunities were wasted.

Response:

As stated in the staff's letter of October 8, 1999, the results of the root cause investigation for the EDG 23 output breaker revealed that the Amptector device was improperly set at too low of a value. To correct this the licensee developed new calibration procedures. The NRC staff reviewed the procedures and other activities to evaluate and correct the overcurrent trip of the 23 emergency diesel output breakers on August 31, 1999, and found them to be acceptable for safe restart and operation of the reactor plant. The staff also concluded that an appropriate sample of circuit breakers was selected for recalibration and the review was properly expanded when additional breaker setting problems were identified. The revised methodology used by Con Ed confirmed the setpoints for the Amptectors and ensured that susceptible breakers would not trip below the minimum value specified for the short-time overcurrent trip. (NRC Inspection Report 05000247/99013)

The issue of inadequate calibration of the EDG output breaker short time overcurrent trip setting, which caused the de-energization of the vital bus, resulted in a violation. This violation was one of three violations cited in the staff's February 25, 2000, letter to the licensee forwarding a notice of violation and proposed imposition of civil penalty ($88,000).

Issue 3: Apparent Unreliability of the EDGs

In support of this issue, the Petitioner stated that there have been at least four EDG failures, including at least one failure upon demand, in the past 13 months at IP2. Further, the Petitioner noted that the plant was licensed with an 8-hour SBO coping duration that was based, in part, on an EDG reliability of 95 percent and that the actual performance of the EDGs may now be less than 95 percent. In each of the examples provided in the Petition, the EDG experienced a problem after the engine started because of a breaker failure or, in one instance, a broken fuel oil line. Other than during the August 31 event, the problems were found during the performance of scheduled surveillance testing.

Response:

The staff shares the Petitioner's concerns with the reliability of the IP2 EDGs. However, we have reviewed the recent EDG performance and determined that neither the performance nor the condition of the EDGs degraded below margins to support safe plant operation.

The August 31 failure of the #23 emergency diesel generator output breaker caused the Maintenance Rule (MR) performance criteria for the 480 Vac switchgear system to be exceeded. Exceeding these criteria required the licensee to establish a corrective action plan and establish goals to return this equipment to an acceptable level of performance. We will continue to monitor the licensee's progress in implementing this plan. The intent of the MR is to highlight equipment performance deficiencies prior to these deficiencies having a significant adverse impact on plant safety.

The revised reactor oversight process includes a performance indicator (PI) for the EDGs. The method used to calculate the EDG PI combines both reliability and unavailability performance data by including the fault exposure time unavailabilty. The PI for the IP2 EDGs is in the increased regulatory response band. Therefore, the NRC will continue to focus inspection resources on the licensee's corrective actions for improving EDG performance.

While the staff acknowledges and shares the Petitioner's concern regarding EDG performance at IP2, the staff does not believe that the performance of the EDGs has degraded the margins of safety to a point where the plant is no longer safe. Both the MR and PI's are designed to identify degrading equipment performance prior to its having a significant adverse effect on plant safety. In this case, the staff believes the MR and PI have identified this performance problem prior to having a significant impact on safety. The basis for this conclusion is our review of recent EDG reliability and unavailability data as described below.

In an October 6, 1999, letter to the NRC, the licensee stated that the 2-year rolling average (as of October 1, 1999) reliability of the #21, #22, and #23 EDG, was 96.83% (1 failure to start in March 1998 and one breaker failure in July 1998), 100%, and 98.48% (output breaker failure in August 1999), respectively. The number of demands (tests and actual demands) that this reliability data was based on for the #21, #22, and #23 EDGs was 64, 56, and 66, respectively. As you stated in your September 15, 1999, letter to the NRC, the target reliability for EDGs as stated in Regulatory Guide 1.155, "Station Blackout" is 95% for the last 100 demands. The licensee's EDGs have recently performed better than the 95% target reliability; therefore, we do not believe that there currently exists a significant safety problem with the reliability of the IP2 emergency diesel generators.

We have also reviewed the EDG unavailability data from February 1999 to the present. The unavailability data indicates that the three EDGs have met the MR unavailability performance criteria since April 1999 (unavailability data does not include fault exposure time because reliability data is explicitly included in the MR performance criteria). Prior to this date the #23 EDG had exceeded its MR performance criteria. Therefore, the staff does not believe there is a significant safety problem with EDG unavailability.

In conclusion, both the maintenance rule equipment performance monitoring and PI data indicate that there is a need to improve EDG performance at IP2. The staff will continue to monitor Con Ed's actions to improve

performance. Based on our review of the EDG reliability and unavailability performance data, the staff believes that the EDG performance meets the licensing basis for SBO and is acceptable to support safe plant operation.

The specific concerns with the EDG output breakers are addressed in the response to Issue 2, Apparent Failure to Adequately Correct Circuit Breaker Problems.

Issue 4: Potentially Unjustified License Amendment for Undervoltage and Degraded Voltage Relay Surveillance Intervals

The Petitioner stated that it was possible that the problem that caused the auxiliary transformer tap changer configuration error (i.e., it was in manual rather than in automatic control) would have been identified and fixed during a surveillance test. If so, the reduction of the testing interval in the 1994 Technical Specification (TS) amendment that extended the surveillance interval from 18 to 24 months for the loss of power undervoltage and degraded voltage relays also reduced safety margins at the plant.

On the basis of the tap changer commitment issue, the Petitioner asked whether there are any other such commitments that were made by the licensee to the NRC that undermined plant safety margins because the commitments were not carried out.

Response:

The petitioners issues regarding indentification of the tap changer configuration error and the concern of other NRC commitments not being implemented were addressed in the staff's October 8, 1999, letter. The issues of failure to (1) translate the correct reset values for the eight undervoltage relays requirements into procedures when a modification was made to the 480 V vital bus degraded voltage relays in 1995, which caused the loss of offsite power to the vital busses, and (2) not correctly translate, into the design basis, the requirement for automatic operation of the station auxiliary transformer load tap changer resulted in a violation. These violations combined to form the basis for one of three violations cited in the staff's February 25, 2000, letter to the licensee forwarding a notice of violation and proposed imposition of civil penalty ($88,000).

Issue 5: Apparent Errors and Nonconservatisms in Individual Plant Examination (IPE)

In August 1992, the licensee submitted to the NRC an IPE for IP2. The Petition stated that the NRC's evaluation of this IPE, sent to the licensee on August 14, 1996, contains statements and conclusions that appear to be invalidated by the August 31 event. Specifically, the Petitioner listed items regarding (a) the availability of the gas turbines and (b) the failure probabilities of the motor-driven auxiliary feedwater (MDAFW) pumps and turbine-driven auxiliary feedwater (TDAFW) pump, 480-volt or 13.8-kilovolt circuit breakers, ac buses, EDGs, high-head safety injection (HHSI) pumps, and component cooling water (CCW) pumps. If the IPE results are nonconservative, the Petitioner stated that the NRC and the licensee may be improperly allocating resources to inspections. Likewise, the licensee may be improperly allocating resources to scheduled repairs.

Response:

The petitioner's concerns regarding the use of IPE data by both the NRC and the licensee was addressed in the staff's letter of October 8, 1999. In summary, the staff concluded that the IPE met the intent of Generic Letter 88-20 to identify "severe accident vulnerabilities," and the August 31 event did not appear to invalidate the IPE. Nevertheless, the calculated risk data for the event indicates, from a risk perspective, that it is important for the licensee's corrective actions from the event ensure a reliable source of power after a reactor trip. Further, the maintenance rule requires the licensee to monitor equipment performance. The rule also requires any changes in equipment performance be evaluated and the maintenance program be adjusted accordingly.

IV. Conclusion

For the reasons discussed above, the NRC staff concludes that although the issues the Petitioner raised have merit, the immediate action requested was not necessary to ensure the licensee adhered to requirements of their license. The NRC staff also concludes that a meeting with the public to discuss the issues raised in the Petition is not warranted. Therefore, the staff's efforts regarding this Petition are complete.

A copy of the Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR 2.206(c). As provided for by that regulation, the Decision will constitute the final action of the Commission 25 days after the date of issuance of the Decision unless the Commission, on its own motion, institutes a review of the Decision within that time.

For the Nuclear Regulatory Commission
/RA/

Samuel J. Collins, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland, this 13th day of April 2000.

7590-01-P

United States Nuclear Regulatory Commission
Consolidated Edison Company of New York, Inc.
Indian Point Nuclear Generating Unit No. 2
Docket No. 50-247

Issuance of Final Director's Decision under 10 CFR 2.206

By letter dated September 15, 1999, Mr. David A. Lochbaum, on behalf of the Union of Concerned Scientists (Petitioner), pursuant to Section 2.206 of Title 10 of the **Code of Federal Regulations** (10 CFR 2.206), requested that the U.S. Nuclear Regulatory Commission (Commission or NRC) take action with regard to the Indian Point Nuclear Generating Unit No. 2 (IP2), owned and operated by Consolidated Edison Company of New York, Inc. (Con Ed). The Petitioner requested that the NRC take enforcement action to modify or suspend the operating license for IP2, operated by Con Ed (the licensee), to prevent the reactor from resuming operation until the five issues identified in the attachment to the Petition have been fully resolved. As an acceptable alternative in lieu of a suspension or modification of the license, the Petitioner requested that the NRC issue a confirmatory action letter or an order requiring these issues to be fully resolved before unit restart. The five issues that were raised in the Petition are (1) the apparent violation of station battery design and licensing bases, (2) the apparent failure to adequately correct circuit breaker problems, (3) the apparent unreliability of emergency diesel generators, (4) the potentially unjustified license amendment for undervoltage and degraded voltage relay surveillance intervals, and (5) the apparent errors and nonconservatisms in individual plant examinations (IPEs). Along with the last issue, the Petitioner stated that the event on August 31, 1999, at IP2 revealed potential problems with the plant-specific risk assessment developed by the licensee and now used to establish priorities for maintenance and inspections. Additionally, the Petitioner requested that a public hearing

on this Petition be conducted in the vicinity of the plant before its restart is authorized by the NRC. In a transcribed telephone conversation between the Petitioner and the members of the NRC's Petition Review Board on September 22, 1999, the Petitioner clarified two of the issues in the Petition. First, the Petitioner stated that because of an apparent failure to accomplish the commitment in the NRC's safety evaluation for the license amendment mentioned in the Petition, the Petitioner was concerned that past licensing commitments may not have been implemented. Second, the Petitioner questioned whether the amount of time the licensee took to perform certain actions during the event on August 31, 1999, was consistent with the times expected if a station blackout (SBO) had occurred since many of the procedures and processes in response to an SBO event were used.

The Director of the Office of Nuclear Reactor Regulation has addressed the technical concerns provided by the Petitioner. However, the Petitioner's request for the staff to take enforcement action was not granted for the reasons that are explained in the "Final Director's Decision Pursuant to 10 CFR 2.206" (DD-00-02). The complete text of the Final Director's Decision is available for public inspection at the Commission's Public Document Room located in the Gelman Building, 2120 L Street, NW., Washington, DC., and will be accessible electronically from the agencywide documents access and management system (ADAMS) public library component on the NRC web site, http://www.nrc.gov (the electronic reading room).

A copy of the Decision will be filed with the Secretary of the Commission for the Commission's review in accordance with 10 CFR 2.206(c) of the Commission's regulations. As provided for by this regulation, the Decision will constitute the final action of the Commission 25 days after the date of issuance of the Decision unless the Commission, on its own motion, institutes a review of the Decision within that time.

Dated at Rockville, Maryland, this 13th day of April 2000.

For the Nuclear Regulatory Commission
/RA/

Samuel J. Collins, Director
Office of Nuclear Reactor Regulation

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