February 10, 2000

COMMISSION VOTING RECORD

DECISION ITEM: SECY-00-0003
TITLE: REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 1999

The Commission (with all Commissioners agreeing) approved the subject paper as recorded in the Staff Requirements Memorandum (SRM) of February 10, 2000.

This Record contains a summary of voting on this matter together with the individual vote sheets, views and comments of the Commission, and the SRM of February 10, 2000.

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Annette Vietti-Cook
Secretary of the Commission

Attachments:
1. Voting Summary
2. Commissioner Vote Sheets
3. Final SRM

cc: Chairman Meserve
Commissioner Dicus
Commissioner Diaz
Commissioner McGaffigan
Commissioner Merrifield
OGC
EDO
PDR
DCS

VOTING SUMMARY - SECY-00-0003

RECORDED VOTES

	APRVD	DISAPRVD	ABSTAIN	NOT PARTICIP	COMMENTS	DATE
CHRM. MESERVE	X				X	1/18/00
COMR. DICUS	X				X	1/24/00
COMR. DIAZ	X				X	1/20/00
COMR. McGAFFIGAN	X				X	1/21/00
COMR. MERRIFIELD	X				X	1/12/00

COMMENT RESOLUTION

In their vote sheets, all Commissioners approved the staff's recommendation and provided some additional comments. Subsequently, the comments of the Commission were incorporated into the guidance to staff as reflected in the SRM issued on February 10, 2000.

Commissioner Comments on SECY-00-0003

Chairman Meserve

I approve the proposed AO report to Congress for FY 1999 and the proposed letters to Congress forwarding the AO report, subject to the following revisions:

- 99-1 Fire at Portsmouth GDP

The staff should be more specific as to the consequences of the event. The report indicates that the radiological and chemical consequences on plant staff were "minor," but is unclear as to whether there were measurable consequences.

- 99-3 and AS 99-1 - Medical Events Involving Administration of I-131 to Pregnant Patient

  In both of these events, the staff should clarify in the section entitled "Cause or Causes" that the licensees' assumption that the patients were not pregnant was based on verbal statements made by the patient to the licensee staff.

Appendix C

- Fire at FitzPatrick

  The second paragraph, which discusses the location of the fire, should include a discussion of the distance and location of the hydrogen storage system from safety-related equipment and major plant structures at FitzPatrick. Without such a discussion, the linkage between the FitzPatrick fire and the staff's conclusion in Paragraph 6 that public health and safety was not threatened, is not clear.

  Indian Point Unit 2 Scram

  Portions of paragraphs 2, 4 and 5 are overly technical for a report to Congress. The text should be revised to make the event more understandable to the general public.

- Example 1 for NRC and Agreement State Licensees - Lost Radiography Camera

  The staff should discuss any subsequent actions, if any, taken by the state of Florida and add a statement regarding the safety implications associated with not recovering the camera.

Editorial Changes

- Page vii - Last paragraph: 1st sentence - replace "... events for Appendix C to this report." with "...Other Events of Interest.". Delete the last sentence and revise the 3rd sentence to read "... on events **that are not reportable as AOs but are reportable as "Other Events of Interest"** based on ..."

- Page viii - 2nd paragraph - Revise the last sentence to read "The NRC is seeking to make the regulatory system risk-informed ..."

- Page 8 - Last paragraph, replace "... such as..." with "...including ..."

- Page 27 - Insert "portable" before gauges in item (2) of last paragraph.

Commissioner Dicus

The report appears adequate from the standpoint that the documented Abnormal Occurrences (AOs) meet the Abnormal Occurrence Criteria and Guidelines for Other Events of Interest. However, in fuel-cycle facility AO 99-1, more clarifying information would be helpful when identifying information in the Nature and Probable Consequences and Actions Taken to Prevent Recurrence sections of the report. The following comments address these concerns and should be used for future process improvement purposes and not delay issuance of the subject report.

I.; **99-1** Fire Breeches Containment and Requires Shutdown of a Portion of the Cascade at the Portsmouth Gaseous Diffusion Plant in Piketon, Ohio

1. In the Nature and Probable Consequences section, first paragraph, fourth sentence, **"**Subsequent heat and pressure increases within the side purge cascade resulted in (1)..., (2) **the automatic shutdown of the side purge cascade**, (3)..., (4)..., and (5).**"** In the Actions Taken to Prevent Recurrence section, under Certificate Holder, last sentence, **"**The long-term corrective actions included the following:**"**, **"adding an alarm and automatic shutdowns on the side purge cascade compressors for compressor high-process gas temperature".** It appears that the automatic shutdown for the side purge cascade operated as designed and intended, therefore, I'm not sure why additional automatic shutdowns located on the compressors are necessary. Additionally, If the proposed automatic shutdowns are critical safety features, why are they considered a long-term corrective action item and what equivalent compensatory measures are being utilized until these controls are implemented.

NOTE - Additional information further describing the existing versus proposed safety features would help clarify why the suggested corrective action improves safety.

2. In the Actions Taken to Prevent Recurrence section, under Certificate Holder, (4) **development of a revised nuclear**

criticality safety basis for Cell 25-7-2. The AO did not at anytime reference criticality concerns as a result of this event, so I'm not sure why development of a revised nuclear criticality safety basis for Cell 25-7-2 is necessary. **This corrective action will draw people's attention**.

NOTE - Data and/or information supporting why a revised nuclear criticality safety basis is needed for Cell 25-7-2 would be very helpful. No where in the report was criticality mentioned or referenced as an issue.

3. In the Actions Taken to Prevent Recurrence section, under NRC. As a result of the December 9, 1998 Augmented Inspection and the March 9, 1999 follow-up inspection, the paragraph describes no problems with the adequacy of the Certificate Holders corrective actions. It then makes reference to procedural and reporting violations and goes on to identify that a $55,000 fine was assessed for failure to identify and declare an Alert. As identified in the Nature and Probable Consequences section, second paragraph, ***"The radiological and chemical consequences of the event on plant staff were minor and well within NRC requirements. The general public experienced no measurable radiological or chemical consequences from this event."*** The fine itself may not draw questions, however, I'm not certain as to why such a large fine was assessed. Additionally, it appears as if the classification of this incident may more appropriately be identified as an **Unusual Event** instead of an **Alert**, according to the definitions provided in NRC Response Technical Manual-96.

NOTE - Additional information as to the categorization (Alert) of this event and why a $55,000 fine was assessed would be helpful, especially, when plant staff experienced minor radiological and chemical consequences (within NRC requirements) and the general public experienced no measurable radiological or chemical consequences from the event.

Commissioner Diaz

I approve the report to Congress on abnormal occurrences for FY 1999 with the following modifications:

1. The nuclear power plant events included in Appendix C of the report should include the following as the first sentence of the description of each event: "This event did not meet the abnormal occurrence reporting criteria since it did not involve a major reduction in the degree of protection of public health or safety."

2. The NRC and Agreement State Materials Licensees section of Appendix C should be modified as follows:

    - Since the intent is to report events involving material entering the public domain, the first two paragraphs should be replaced with: "During FY 1999, NRC and Agreement States have received 188 reports of events that resulted in licensed materials entering the public domain in an uncontrolled manner: 74 events reported by NRC licensees and 114 events reported to Agreement States licensees. In some cases, the material caused radioactive contamination or radiation exposures."

    - The third sentence of the third paragraph should be replaced with: "Of these events, portable moisture density gauges were the most commonly reported events involving lost or stolen licensed devices."

    - To accurately reflect NRC's actions, the last sentence of the fourth paragraph should be replaced with: "The NRC and Agreement States have issued generic communications to inform licensees about these events and their consequences in order to prevent future incidents, in some cases have taken enforcement actions, and are in the process of making regulatory changes intended to increase licensees' accountability of material."

Commissioner Merrifield

I approve the report to Congress on abnormal occurrences for fiscal year 1999 with modifications as described in the following paragraphs. I have no objection to the actual number of events listed. However, the description of some of the events should be modified to better serve the audience for which the report is written. Otherwise, we may leave the wrong impression or touch a particularly sensitive point with the reader. Specific modifications are needed in the following events discussed in the report.

There are three events involving an unintended exposure to a fetus. All three events discuss possible medical effects on the fetus. However, only one event states that the pregnancy was terminated. The other two events are silent on what happened next. I understand from the staff that for the event in West Virginia, the staff can state that at the time of the investigation the patient had decided to continue the pregnancy. For the Wichita, Kansas case, the staff can state that the pregnancy went to full term. These facts should be added to the report. By this comment, I am not implying that the staff should now contact the licensee for additional follow-up information. We should simply state what we now know about the case. Also, in all three cases, the report essentially concludes that no NRC procedures were violated but all three hospitals are considering requiring a pregnancy test be performed within 24 hours before receiving specific radiopharmaceuticals. Taken as written, it would not be unreasonable for a reader to conclude that a pregnancy test should be mandatory, which was specifically not our intent in the recent votes on 10 CFR Part 35. I believe that we should be more specific in the report and say that because the licensee made a reasonable effort to obtain verbal or written confirmation from the patient that she was not pregnant before beginning the testing, no NRC (or Agreement State) requirements were violated. As far as requiring a pregnancy test to be performed within 24 hours before administering the therapy, the report should clearly indicate that is a voluntary decision on the part of the licensee.

The description for the lost source event in Florida ends in two sentences as follows: "After extensive searching for the missing source, DOE terminated its effort without recovering the camera. This event is closed for the purpose of this report." So we have an event of sufficient magnitude to call out a special team from DOE and then conclude that nothing further will be done. This can raise many questions. We should add several sentences to this section of the report which provides a larger perspective of activities taken to recover lost sources. The staff should develop the appropriate wording, but I would expect it to state something similar to the following. In lost sources, particularly those lost from potential criminal activity, it is not unusual that the source cannot be located. At some point a decision must be made that it is no longer practical to continue the search and the report is closed. However, there are other factors that may eventually lead to the recovery of the source. These factors include that the source is typically contained in a well marked container and the source itself has identification markers, many public landfills have radiation detectors, the scrap metal recycling industry has radiation detectors, and a report file (and possibly also a criminal investigation file) is maintained. There is a possibility that eventually the source may be found, identified, and properly disposed. However, we must admit that some sources are simply never found.