

NOTATION VOTE

RESPONSE SHEET

TO: Annette Vietti-Cook, Secretary
FROM: COMMISSIONER DICUS
SUBJECT: **SECY-00-0003 - REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 1999**

Approved x ^{w/comments} Disapproved _____ Abstain _____

Not Participating _____

COMMENTS:

See attached comments.

Patricia Joy Dicus
SIGNATURE

January 24, 2000
DATE

Entered on "AS" Yes x No _____

COMMENTS OF COMMISSIONER DICUS REGARDING SECY 00-0003

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.

A. 99-1 Fire Breaches 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.

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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.