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Mr. Peter W. Eselgroth
Chief Projects Branch 2 Division of Reactor Projects
United States Nuclear Regulatory Commission Region 1
475 Allendale Road
King of Prussia, PA 19406-1415

Dear Mr. Eselgroth:

This letter is in response to your letter dated October 5, 2001 regarding a discussion about NRC Office of Investigations (OI) Report No. 1-2000-026, dated March 7, 2001 and the referenced Office of Inspector General (OIG) report dated October 5, 2000 which describes the investigations into a suspicious substance believed to have been urine stored in a refrigerator in the Radiological and Environmental Services (RES) Department onsite. In that letter you noted that no connection was found between the stored urine and possible use of an adulterated urine sample. Based on this, you concluded that the Part 26 program had been adequately implemented and that no further action was warranted.

On its own, the handling of the circumstances surrounding the refrigerated urine appear to be poorly handled, but not significant. However, the ^{original} OIG report details at least two other instances involving the same individual, each of which should have, on their own merits resulted in "for cause" testing, in accordance with the provisions of Part 26. In each instance, no "for cause" testing was performed. In one instance, an individual vigorously attempted to have the behavior adequately addressed.

possibly not definitively

In addition, the individual in question was involved in a violation of Administrative Technical Specifications involving Locked High Radiation Area controls shortly before submission of the adulterated urine sample. No "for cause" testing was performed. In addition, there was no discussion regarding the previous performance history of the individual in question, even though other RES department personnel explicitly inquired about performance history as part of the investigation of that event. These events were discussed during the OI investigation. One of the individuals responding to these events was the manager in charge of the Security Department and the Medical Department, and should either have had prior knowledge regarding the requirements of the Fitness for Duty program, or at the very least had ready access to personnel in both those organizations that could have provided advice on the regulatory requirements.

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Therefore, during the OI investigation, there were at least 3 identified instances in addition to the refrigerated urine, where there was a complete lack of any actions in support of the provisions of Part 26 with respect to vigilance on the part of supervision and management for potential fitness for duty indicators (10CFR26.10.b and 10CFR26.27.b.1), and the requirements of Part 26 with respect to for cause testing following events (10CFR26.24.a.3).

The OI investigation also revealed that 4 levels of management, a Health Physics Supervisor, a Health Physics General Supervisor, the Radiological Environmental Services Manager and the General Manager of Support Services were all involved in the discussions that occurred at the time the urine was discovered in the refrigerator. Contrary to existing plant procedures, training, stated management expectations and the requirements of 10CFR50 Appendix A Section XVI "Corrective Action", no report was made by any of these individuals. 10CFR50 states "Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected."

Since 4 different levels of management personnel were involved, there were at least four opportunities to abide by the requirements of 10CFR50. In point of fact, this event was not identified until several months after the event, after the Locked High Radiation Area key event and after the submission of the adulterated urine sample. The event came to light only when other members of the plant were overheard talking about the event. Even then, the event was not formally identified by one of the original participants, but by a non-involved manager.

In summary, there were at least four opportunities for trained and knowledgeable personnel spanning the lowest to highest management ranks to identify this event as a 10CFR26 concern. Each of the four individuals failed to follow plant procedures or the requirements of 10CFR50 Appendix A to formally identify and document deviations. The failure to follow plant procedures constitutes a violation of Technical Specification.

Sincerely,