



NUREG-1830, Vol. 6

# **Annual Report**

**FY 2009**

Office of Investigations

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## **ABSTRACT**

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This report provides the Commission with an overview of Office of Investigations (OI) activities, mission and purpose, along with the anatomy of case inventory with highlights of significant cases completed by the Nuclear Regulatory Commissions (NRC) OI during fiscal year (FY) 2009 (reference SRM COMJC-89-8, dated June 30, 1989). This is the 21st OI Annual Report.

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# FISCAL YEAR 2009 HIGHLIGHTS

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In FY 2009, OI sustained a highly productive, service-oriented, results driven workforce, which continued its dedication to outreach and effective communication. OI staff continues to be driven to exceed the expectations of both internal and external stakeholders, while implementing continuous process improvements at all levels.

Significant achievements during FY 2009:

- 140 investigations closed by OI. 99% developed sufficient information to reach a conclusion of substantiated or unsubstantiated regarding wrongdoing. This exceeded OI's performance goal of 90%
- Of the 138 investigations closed with sufficient information to reach a conclusion (substantiated or unsubstantiated) regarding wrongdoing, 94% were closed in 10 months or less. This exceeded OI's performance goals of 80% for reactor investigations and 85% for materials investigations.
- Of the 65 Assists to Staff closed, 100% were completed within 90 days, which exceeded OI's performance goal of 80%.
- OI processed 76 actions resulting from FOIA requests during FY 2009.
- OI referred 100% of its substantiated investigations to the Department of Justice for prosecution consideration.
- OI participated in outreach efforts with external stakeholders by presenting Office of Investigations related information at conferences held by the National Association of Employee Concerns Professionals in Washington, DC and the American Nuclear Society in Amelia Island, GA.
- OI attended the NUPIC conference in support of the community kick-off for NRC Counterfeit Suspect Fraudulent Items.
- OI assisted the Environmental Protection Agency's (EPA) Criminal Investigative Division on sensitive law enforcement activities at a licensed facility.
- OI proactively engaged OEDO, OIS, and NRC staff to implement significant changes in handling procedures for investigation information (SUNSI) to allow NRC and OI staff to securely utilize SUNSI information at remote locations.
- OI developed a proactive approach to investigations by hosting a Federal Law Enforcement Training Center (FLETC) instructor who taught a Product Substitution Fraud course for OI personnel and NRC staff during OI's Counterpart Meeting in Cambridge, MD.
- Working with OEDO staff, OI developed more challenging performance measures for implementation in FY 2010 toward the goal of continuous process improvements as gleaned from OI's 2008 Lean Six Sigma project.
- OI effectively managed its FTE in accordance with the NRC Human Capital Management Plan.

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# INTRODUCTION AND OVERVIEW

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## MISSION AND AUTHORITY

As stated in the NRC's Strategic Plan for FY 2008-2013, the NRC's mission is to license and regulate the Nation's civilian use of byproduct, source, and special nuclear materials to ensure adequate protection of public health and safety, promote the common defense and security, and protect the environment. The NRC's vision is excellence in regulating the safe and secure use and management of radioactive materials for the public good. The mission and vision provide the framework for the agency's strategies and goals, which in turn guide the allocation of resources across the agency. OI aligns with the agency's regulatory programs and strategic values to provide for the safe use of radioactive materials and nuclear fuels for beneficial civilian purposes that are enabled by the agency's adherence to the principles of good regulation, independence, openness, efficiency, clarity and reliability, and additionally, by providing regulatory actions that are effective, realistic and timely.

The Commission has delegated to the Director of OI the authority to take the necessary steps to accomplish the OI mission, as described in Title 10 of the Code of Federal Regulations (CFR), Part 1, Section 1.36 (1998). See Section 161(c) of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2201 (c)); and Section 206 of the Energy Reorganization Act of 1974 (42 U.S.C. 5846). OI investigative jurisdiction extends to the investigation of alleged wrongdoing by licensees, certificate holders, permittees, or applicants, by contractors, subcontractors, and vendors of such entities, and/or by management, supervisory, and other employed personnel of such entities who may have committed violations of the Atomic Energy Act, the Energy Reorganization Act, and rules, orders, and license conditions issued by the Commission thereunder.

Additionally, during the course investigations, OI may uncover potentially safety-significant issues that are not related to wrongdoing. In these instances OI forwards this information to the technical staff in a timely manner for appropriate action. OI also provides investigative assistance directly to the NRC staff when requested. Generally, these "Assists to Staff" are matters of regulatory concern for which the staff has requested OI's investigative expertise, but which may not involve a specific indication of wrongdoing.

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# THE OFFICE OF INVESTIGATIONS

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The Director of OI reports directly to the Deputy Executive Director for Materials, Waste, Research, State, Tribal, and Compliance Programs (DEDMRT) and provides investigative support to Reactor and Materials programs.

OI is a centralized investigations unit which consists of four regionally based field offices headed by Field Office Directors (FODs) who report to OI Headquarters. In FY 2009, on average, there were 32 special agents (GG-1811 Federal Criminal Investigators) and 8 (including one part-time Stay-in-School Student Clerk) operational support staff nationwide. The average number of years of specialized Federal law enforcement experience for an OI special agent in FY 2009 was approximately 19 years.

The Office of Investigations develops and implements policies, procedures, and quality control standards for investigations of licensees, applicants, and their contractors or vendors. OI conducts thorough, quality, and timely investigations of wrongdoing by licensee's certificatees and their contractors, in accordance with the Council of the Inspectors General on Integrity and Efficiency (CIGIE) (formerly PCIE) Quality Standards for Investigations. OI makes referrals of substantiated criminal cases to the Department of Justice for prosecution consideration, plans, coordinates, directs, and executes its administrative affairs, including the development and maintenance of a management information system. OI maintains current awareness of inquiries and formal investigations. OI keeps Commission principals currently informed of matters under investigation as they affect public health and safety. OI conducts liaison with other agencies and organizations to ensure the timely exchange of information of mutual interest.

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## **FIELD OFFICE REVIEW VISITS**

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Field office review visits (FORVs) are annual self-assessments conducted of each field office to support the goal of continuous process improvement of OI's investigations program. OI FORVs assess three major focus areas: operations, management and administration.

Each FORV includes a meeting of field office staff to discuss current OI Headquarters initiatives and activities; policy/procedural focus; and special and/or regional items of interest. Also during the self-assessments, OI personnel are interviewed to obtain timely feedback regarding operational or other concerns and any issues of particular concern to the employee. Additionally, the FORV team meets with internal stakeholders, i.e., Regional/Deputy Regional Administrator, Regional Counsel, Enforcement Coordinator, Office Allegation Coordinator and other regional staff deemed appropriate. These meetings are designed to solicit stakeholder input regarding the effectiveness of OI's support and ways to improve the quality, effectiveness, and efficiency of OI's performance.

At the conclusion of the FORVs, exit briefings are conducted with the Field Office Directors and OI staff to discuss the findings and recommendations of the review team. Final OI Headquarters review of the teams' findings are conducted to identify best practices with a view towards continuous process improvement.

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# CASES

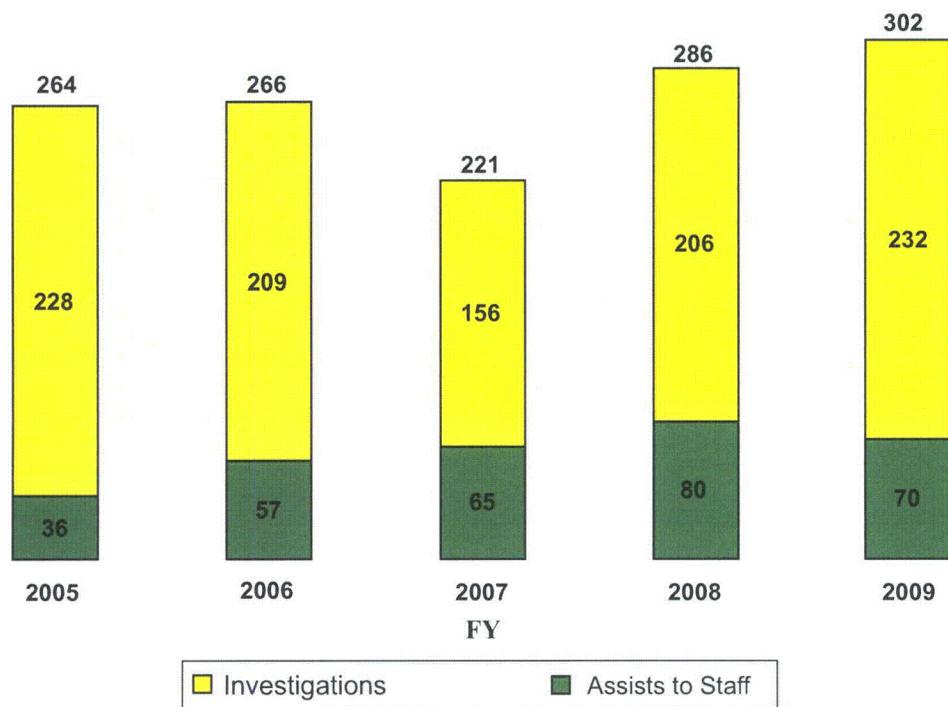
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## Case Inventory\*

Figure 1 shows the OI case inventory that reflects all Investigations and Assists to Staff conducted during the FYs indicated. Generally, Assists to Staff are matters of regulatory concern for which the staff has requested OI's investigative expertise, but which may not involve specific indications of wrongdoing. The total case inventory in FY 2009 was 302. The total includes 232 investigations, 93 of which were carried over from FY 2008. Also included are 70 Assists to Staff, 3 of which were carried over from FY 2008.

Figure 1

### Case Inventory



\* Cases carried over from previous year, plus cases opened in current year

The total number of cases in the OI inventory during FY 2009 was 302, a 6% increase from 286 in FY 2008.

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## CASES OPENED

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Table 1 shows the number of cases opened by category during FYs 2005 through 2009. In FY 2009 there was a 7% decrease in total cases opened from FY 2008. There was a 9% increase in the number of suspected Material False Statements and an 11% decrease of Violations of other NRC regulatory requirements. Discrimination investigations decreased by 6% and Assists to Staff decreased by 7%. OI opened 206 cases in FY 2009 in the categories listed below:

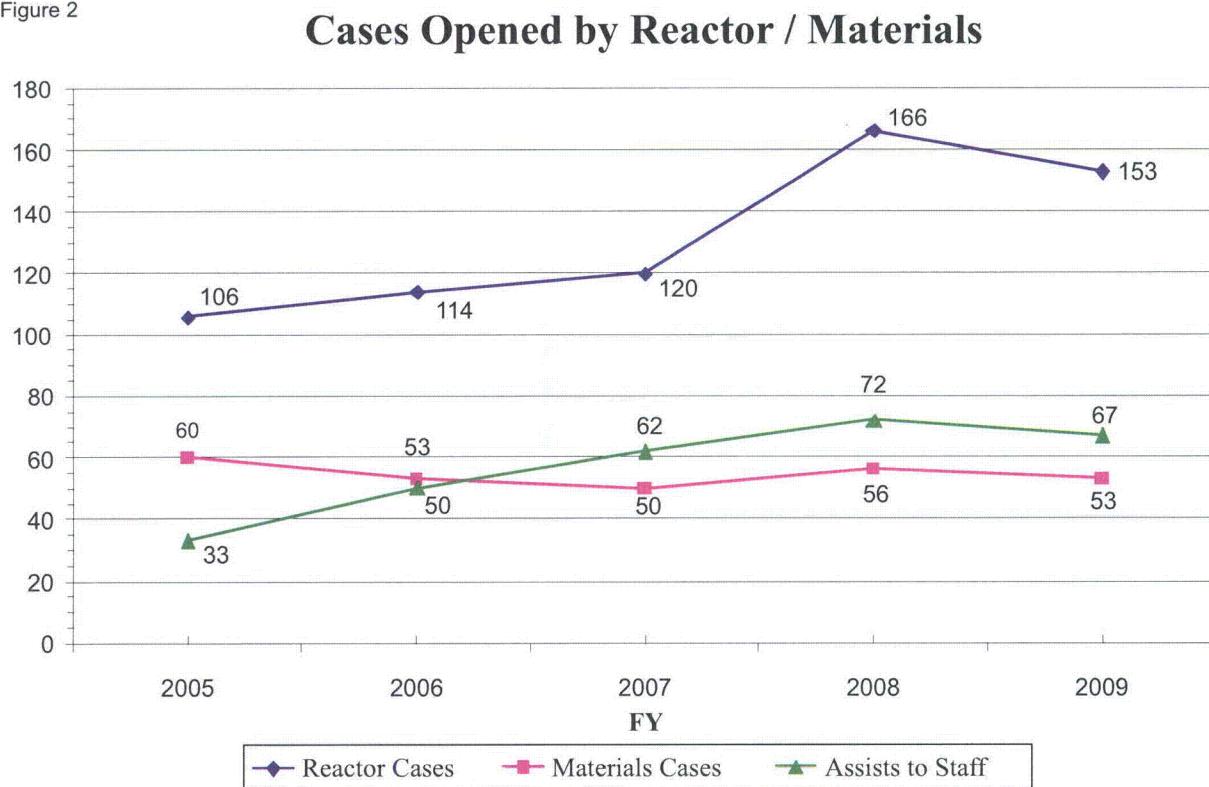
**Table 1. Cases Opened by Category**

Category	FY2005	FY2006	FY2007	FY2008	FY2009
Total	166	167	170	222	206
Materials False Statement	39	17	17	21	23
Violations of Other NRC Regulatory Requirements	54	48	66	97	86
Discrimination	40	52	25	32	30
Assists to Staff	33	50	62	72	67

Note: During FY 2009, NRC received 622 allegations of potential violations of its rules, regulations, or requirements. The 622 allegations represent a 3% decrease from the 639 received in FY 2008.

The graph in Figure 2 shows the distribution of cases opened during FYs 2005 through 2009 for the Reactor and Materials programs. From FY 2008 to FY 2009, the overall reactor-related cases decreased 8% with a 27% increase in reactor investigations and a 16% decrease in reactor-related Assists to Staff. Materials cases decreased overall by 5% with a 17% decrease in materials investigations and a 2% increase in materials-related Assists to Staff.

Figure 2



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# CASES CLOSED

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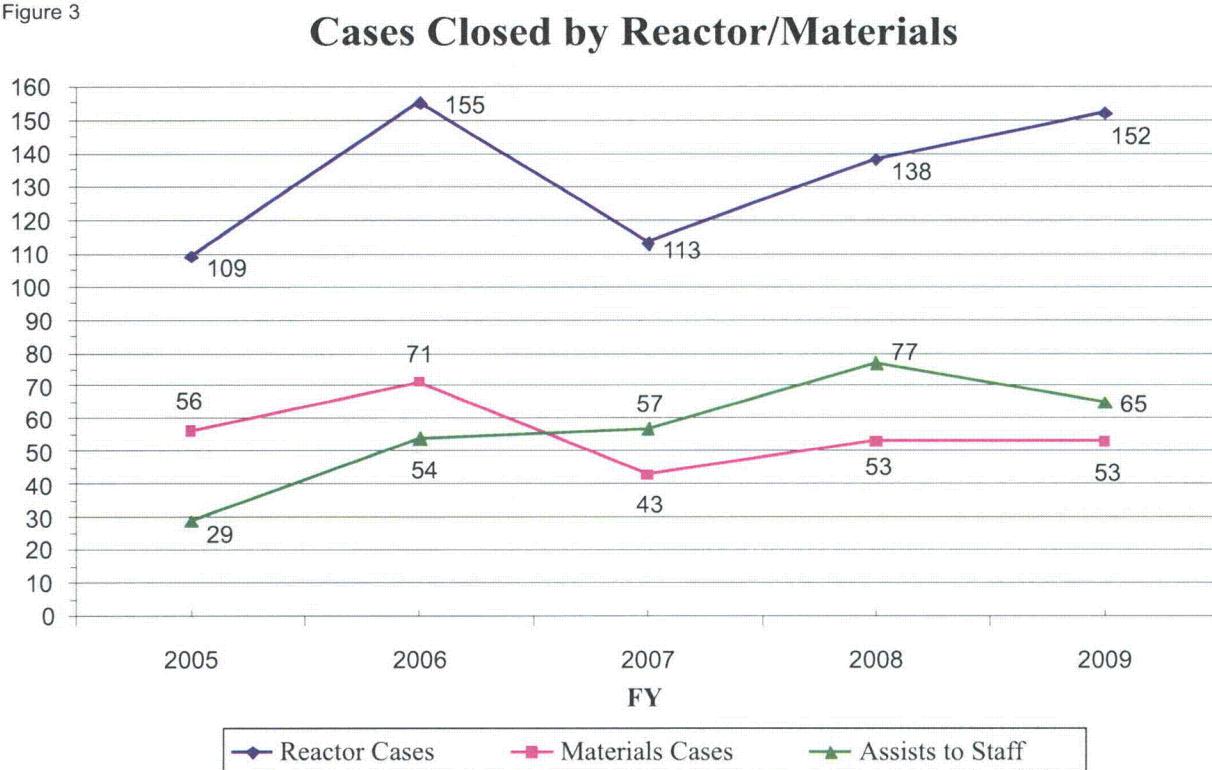
Table 2 shows the number of cases closed by category during FYs 2005 through 2009. The total cases closed during FY 2009 represent a 7% increase from the number closed in FY 2008. Material False Statement investigations comprised 9% of the closed cases in FY 2009, investigations involving Violations of Other of NRC Regulatory Requirements 17%, Discrimination investigations 8%, and Assists to Staff 16% of the total closed cases. OI closed 205 cases in FY 2009 in the categories listed below:

**Table 2. Cases Closed by Category**

Category	FY2005	FY2006	FY2007	FY2008	FY2009
Total	165	215	156	191	205
Materials False Statement	32	28	10	12	23
Violations of Other NRC Regulatory Requirements	52	67	59	77	90
Discrimination	52	66	30	25	27
Assists to Staff	29	54	57	77	65

The graph in Figure 3 shows the cases closed during FYs 2005 through 2009 for the Reactor and Materials programs. From FY 2008 to FY 2009, the overall reactor-related cases increased 10% accompanied by a 38% increase in reactor investigations and a 25% decrease in reactor-related Assists to Staff. Materials cases stayed the same overall, accompanied by a 8% decrease in materials investigations and a 19% increase in materials-related Assists to Staff during the same period.

Figure 3



Of the 205 cases closed in FY 2009:

- 54 investigations were closed after substantiating one or more of the allegations of wrongdoing.
- 84 investigations were closed after investigations revealed wrongdoing was not substantiated.
- 2 investigations were closed for administrative reasons.
- 65 of the total number of cases closed were Assists to Staff.

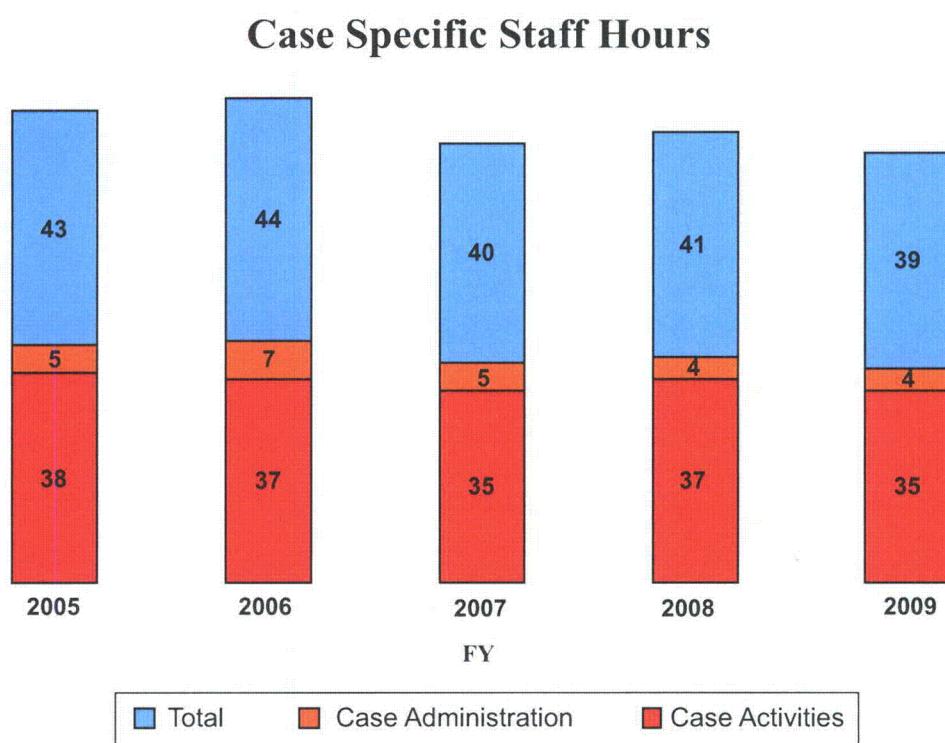
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# MANAGEMENT OF CASES

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The total case-specific staff hours in Figure 4 shows a decrease from FY 2008 to FY 2009 (from 41,000 to 39,000 investigative hours). Specifically, in FY 2009 case activities (planning, field work, and analyzing information) decreased while hours towards case administration (FOIA and other miscellaneous activities) remained the same.

Figure 4



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# **SIGNIFICANT INVESTIGATIONS**

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## **SOURCE PRODUCTION AND EQUIPMENT COMPANY**

This OI investigation determined that a Source Production and Equipment Company, Inc. (SPEC) contract employee, Radiation Safety Officer, Foss Therapy Services (FTS), deliberately violated NRC regulations regarding the transportation of NRC licensed materials without a license. The investigation determined that the FTS contract employee for SPEC did not comply with NRC Certificate of Compliance requirements by falsely certifying that a quality assurance inspection had been conducted on a transportation package.

On March 27, 2009, the FTS contract employee and his business partner, President/co-owner, were sentenced in U.S. District Court, Central District of California, to one year probation and a mandatory special assessment fee of \$100 for conspiring to make a materially false statement to the NRC, in violation of Title 18, United States Code, Section 371. All recommended fines and terms of imprisonment/probation for the individuals were waived by the District Court Judge in lieu of fines and assessments imposed upon the company. On the same date, the subject contracted company, FTS, was sentenced to 5 years probation and fined \$50,000 for its role in the violation. On July 14, 2008, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$9,600 was issued to SPEC for a deliberate Severity Level II violation of 10 CFR 71.3. Additionally, on September 8, 2008, the NRC issued a Confirmatory Order (Effective Immediately) upon the Foss Therapy Services employee prohibiting him from participating in any 10 CFR Part 71 licensed activities indefinitely.

## **MATTINGLY TESTING SERVICES**

This OI investigation substantiated that the President/Radiation Safety Officer for Mattingly Testing Services, Incorporated (MTS), willfully submitted incomplete and inaccurate information to the NRC and willfully violated regulatory requirements during the conduct of radiographic operations. Based upon evidence developed during the OI investigation and NRC inspection activities, eight apparent willful violations and one deliberate violation of the NRC requirements were identified related to the wrongdoing. As part of an NRC settlement with MTS through the Post-Investigation Alternative Dispute Resolution program, the NRC issued a Confirmatory Order to MTS; issued an individual Confirmatory Order prohibiting the President of MTS from engaging in NRC-licensed activities; and assessed a Civil Penalty in the amount of \$8,000. Furthermore, the Order stated that future violations of the Confirmatory Order may result in criminal prosecution and/or additional monetary civil penalties.

## **NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY**

This OI investigation, conducted with the assistance of the Department of Commerce Office of the Inspector General, substantiated that the Radiation Safety Officer (RSO) at the U.S. Department of Commerce's National Institute of Standards and Technology (NIST), Boulder, Colorado, willfully provided incomplete and inaccurate information to the NRC in previous licensing-related submissions dated December 15, 2004, and February 15, 2007. The incomplete and inaccurate information was discovered during NRC inspection activities following a plutonium spill at NIST on June 9, 2008. NIST has requested Post-Investigation Alternative Dispute Resolution.

## **PALO VERDE NUCLEAR GENERATING STATION**

This OI investigation substantiated that a Nuclear Security Officer (NSO) at Arizona Public Service Company's Palo Verde Nuclear Generating Station (Palo Verde) willfully failed to complete fire watch tours and falsified the required fire watch logs. Contrary to the NSO's log entries, he did not complete the fire watch but remained in the SAS. The NSO subsequently admitted to OI that he willfully failed to complete fire watch tours and falsified the fire watch logs. The NRC staff issued a non-cited Severity Level IV violation to the licensee. No civil penalty was assessed.

## **SOUTH TEXAS PROJECT**

This OI investigation was initiated to determine whether a former Security Officer at the South Texas Project Nuclear Operating Company's South Texas Project Electric Generating Station (STP) willfully failed to conduct vital area patrols and willfully provided false information regarding the conduct of the patrols. The investigation substantiated that the former security officer deliberately failed to conduct vital area patrols and deliberately falsely reported information regarding the completion of the patrols. A Notice of Violation was issued to STP, which included two Severity Level IV violations, and a closeout letter was issued to the individual.

## **PALISADES**

This OI investigation was initiated to determine whether the failure to provide complete and accurate information by officials from the Entergy Nuclear, Palisades Power Plant, to the NRC violated NRC's security requirements. The investigation substantiated that the senior security manager deliberately failed to provide complete and accurate information to the NRC by failing to recognize and correct inadequate security measures, and attempting to minimize the issue by implementing corrective measures under the guise of enhancements to their security. Several Condition Reports were opened and closed without the necessary action to correct the deficiency at the site. The NRC staff issued a Confirmatory Order to the licensee on November 10, 2009, as a result of successful Post-Investigation Alternative Dispute Resolution mediation.

## **VETERANS AFFAIRS MEDICAL CENTER, PHILADELPHIA, PA**

This investigation was initiated after a series of NRC inspections at the VA's National Health Physics Program, Philadelphia, PA, revealed that between 2001 and 2008, 97 medical events, as defined by NRC regulations, were not reported to the NRC as required. These 97 medical events occurred during 114 prostate brachytherapy procedures performed at the facility. The subsequent OI investigation did not substantiate that two radiation oncologists and two medical physicists willfully failed to report to the NRC the medical events as required by NRC regulations. However, the OI investigation did substantiate that two medical physicists willfully failed to provide complete and accurate information to NRC inspectors regarding the medical events.

## **VETERANS AFFAIRS LEXINGTON**

This OI investigation substantiated that a Radiation Safety Officer (RSO) at the VA Medical Center, Lexington, Kentucky: (1) deliberately failed to perform required annual reviews of the radiation safety program; (2) deliberately failed to hold required Radiation Safety Committee meetings from approximately September 2005 to September 2007; and (3) deliberately failed to provide required Hazmat training to Nuclear Medicine Technologists involved in the transportation of radioactive materials. During the OI investigation the RSO admitted to knowing the violated requirements. A Confirmatory Order was issued on July 28, 2009, as a result of a successful Post-Investigation Alternative Dispute Resolution mediation session.

## **CLINTON NUCLEAR POWER PLANT**

This OI investigation determined that a Radioactive-Waste Shipper employed by Exelon Nuclear, Clinton Nuclear Power Plant, willfully failed to provide complete and accurate information to the NRC by backdating a required NRC shipping form. The investigation determined that the waste site located in Barnwell, South Carolina, discovered its license limit had been exceeded due to an erroneous calculation related to a Clinton shipment. The waste site contacted the Radiation-Waste Shipper who concealed the mistake from his/her supervisor and decided to use a different method of calculation to obtain a lower limit to fall within the range of acceptable levels. Once the new and lower readings were obtained, the Radiation-Waste Shipper re-issued a new and backdated shipment form, indicating that the test and signature were done on an earlier date. The licensee was issued a Severity Level IV non-cited violation on July 28, 2009. The individual was issued an NRC closeout letter.

## **USEC PADUCAH GASEOUS DIFFUSION PLANT**

An OI investigation was initiated to determine whether a USEC Paducah Gaseous Diffusion Cascade Operator willfully skipped a procedural step in the "Cylinder Burping and Cold Pressure Checks" procedure, and subsequently took deliberate steps to conceal the error by disconnecting a damaged "pigtail." The OI investigation further developed wrongdoing by an operator trainee, and a second Cascade Operator who knew about the incident, but failed to

make the required reports. OI discovered that in addition to the operator trainee's failure to report the cause of the damage, the Cascade Operators also knew about the incident and failed to report it. OI determined that all three of the operators met shortly after the incident and conspired to conceal the information from USEC management. The licensee was issued a Confirmatory Order on August 18, 2009, as a result of a successful Post-Investigative Alternative Dispute Resolution mediation.

## **NUCLEAR FUEL SERVICES**

An OI investigation substantiated that a contract physician for Nuclear Fuel Services Inc. (NFS) deliberately failed to provide complete and accurate information to the NRC regarding two security officers' medical examinations. The contract physician signed and dated medical forms as complete for two security officers despite the fact no hearing tests were administered for the officers. During the interview with OI, the physician admitted signing the medical forms knowing that no hearing tests had been administered. The licensee and contract physician were issued separate Confirmatory Orders on November 23, 2009, as a result of successful Post-Investigation Alternate Dispute Resolution mediation.

## **SHAW AREVA MOX SERVICES**

OI substantiated that a Senior Structural Engineer (SSE) deliberately directed a subordinate Civil Structural Engineer (CSE) to sign his signature to Vendor Data Review Forms (travelers) without identifying the CSE as the signer. The OI investigation determined that the SSE knew this was a procedural violation. During an OI interview, the SSE admitted approximately 37 documents were signed by a subordinate, under his direction, in this manner. The SSE's deliberate action caused the licensee to be in violation of 10 CFR Section 70.9, "Completeness and Accuracy of information" and violated the applicable Engineering Directive procedure governing the delegation of signature authority at the Aiken, SC facility. The NRC staff issued a Confirmatory Order to the licensee on November 24, 2009, as a result of a successful Post-Investigation Alternative Dispute Resolution mediation.

## **FARLEY NUCLEAR PLANT**

OI substantiated that a Nuclear Security Officer (NSO) employed by Southern Company at the Farley Nuclear Plant (Farley) deliberately violated applicable Fitness-For-Duty procedures. The evidence in this case revealed the NSO deliberately brought alcohol (hidden in water bottles) into the Farley Protected Area, consumed the alcohol while on post, and subsequently lost consciousness. The licensee reported that the officer lost consciousness while the officer was moving from one post to the next. During his interview with OI, the NSO admitted to deliberately consuming alcohol prior to reporting for duty and deliberately bringing the additional quantity of alcohol into the Protected Area. On October 29, 2009, the NRC staff issued a Severity Level III Notice of Violation to the licensee and an Immediately Effective Order prohibiting the NSO's involvement in NRC licensed activities for a period of three years.

## **S & M TESTING LABORATORY – PUERTO RICO**

An OI investigation substantiated that the President/Radiation Safety Officer/Owner (President) of S&M Testing Laboratory (S&M) deliberately failed to amend S&M's NRC materials license for the storage of multiple gauges containing radioactive material and intentionally failed to provide the NRC the opportunity to inspect the gauges to ensure they were safe and not leaking radiation. NRC staff made numerous, unsuccessful attempts to contact the President. OI working with the FBI, located the President, at which time, the President agreed to meet and disclose the whereabouts of the nuclear gauges. The gauges were eventually transferred to another licensee by the NRC. OI substantiated that the President/Radiation Safety Officer (RSO)/Owner of S&M failed to amend the license for storage of licensed material and intentionally failed to provide the NRC opportunity to inspect the gauges. As a result of the investigation, S&M was issued a civil penalty in the amount of \$16,250 and the President/RSO/Owner was banned from licensed activities for a period of five years.

## **EASTERN TESTING AND INSPECTION**

An OI investigation revealed that the President/Radiation Safety Officer (President) and the Vice President of Eastern Testing and Inspection (ETI), falsely claimed to have undertaken preliminary discussions with a local law enforcement agency (LLEA), as required by NRC's Order (EA05-090). Specifically, the Order called for ETI to have a pre-arranged plan with LLEA for assistance in response to the theft of radioactive material, attempted theft, or sabotage. The NRC staff found no credible evidence that preliminary contacts had ever been made with LLEA and there was no plan with LLEA in place by May 13, 2006, the effective date of the Order. OI substantiated that the President and the Vice President submitted incomplete and inaccurate information to the NRC and deliberately violated the order. The President and the Vice President requested Post-Investigation Alternative Dispute Resolution with the NRC. On July 16, 2009, a settlement was reached and ETI's officials agreed to pay a civil penalty in the amount of \$4,500; the President agreed to not be involved in NRC-licensed activities for a period of six months; and the Vice President agreed to not be involved in NRC-licensed activities for one year.

## **CALVERT CLIFFS**

An OI investigation of a recently hired computer analyst at the Calvert Cliffs Nuclear Power Plant (Calvert Cliffs) determined that in May 2008, the analyst deliberately provided false criminal history information on a Personal History Questionnaire (PHQ), while seeking Unescorted Access Authorization (UAA) to the plant and its Protected Area. The analyst, hired to work in the licensee's security/UAA department, falsely claimed he had not been arrested or otherwise adversely involved with law enforcement. OI's investigation substantiated that the analyst was under federal investigation for theft and pending indictment at the time he submitted the PHQ. It was determined that the analyst also had a previous arrest for theft. OI prepared a sworn affidavit detailing the false entries made on the PHQ, which was

used by the U.S. Attorney's office during sentencing of the analyst in Federal District Court, Washington, DC on the theft charge. In part, as a result of OI's investigation and Affidavit, the analyst received an enhanced prison sentence of 18 months for the theft charge.

## **PEACH BOTTOM ATOMIC POWER STATION**

An OI investigation substantiated an allegation that a Maintenance Supervisor intentionally provided the licensee (Exelon) with incomplete and inaccurate information regarding his military service when he submitted a resume and application for employment to Peach Bottom and was granted Unescorted Access Authorization (UAA) to the Protected Area of the nuclear plant. The resume and application, dated February 2007 and April 2007, respectively, mischaracterized the supervisor's service record with the U.S. Navy, including, but not limited to, failing to report a "serious misconduct offense" that led to a Captain's Mast and Non-Judicial Punishment, which factored into his "other than Honorable" discharge from the Navy. The supervisor was eventually terminated by the licensee. Based on the results of the OI investigation, the Maintenance Supervisor attended a Pre-Decisional Enforcement Conference with the NRC where he continued to deny the allegations. Based on the evidence gathered by OI, the NRC issued an Order banning the former Supervisor from NRC-licensed activities for a period of three years. Exelon requested Post-Investigation Alternative Dispute Resolution and was issued a Confirmatory Order on December 1, 2009, detailing corrective actions taken, including the background investigation process for its employees and UAA.

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## **SIGNIFICANT ASSISTS TO STAFF**

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### **SUSQUEHANNA STEAM ELECTRIC STATION**

An OI Assist to Staff was conducted, upon request of NRC senior regional management, to evaluate the potential of adverse Safety Conscious Work Environment (SCWE)/Chilling Effect issues at the Susquehanna Steam Electric Station (SSES), due to the high number and recency of chilling effect and SCWE type concerns that were being received by NRC. OI and NRC technical staff jointly conducted a "smart sample" of interviews of station personnel. Results of the interviews were evaluated by OI and the staff which disclosed a common theme of a degrading trend in the area of SCWE. OI's efforts in this Assist played a prominent role in the Region's decision to issue a Chilling Effect Letter to the licensee in January 2009, requiring a written response.

### **SUSQUEHANNA STEAM ELECTRIC STATION**

OI completed an Assist to Staff at Susquehanna Steam Electric Station (SSES), which involved locating and interviewing a former Senior Reactor Operator (SRO) regarding his failure to cooperate with the NRC and meet the terms of a settlement agreement previously reached through the use of Post-Investigation Alternative Dispute Resolution (ADR), which was confirmed by an NRC Order. Specifically, an earlier ADR mediation session was held to discuss the deliberate violation by the former SRO for failing to report an arrest (Driving under the Influence) as required, which had been substantiated by OI. Through the use of Post-Investigation ADR, the former SRO consented to the issuance of a Severity Level III Notice of Violation and agreed to complete various actions by March 27, 2008. The former SRO failed to respond to the Confirmatory Order, did not notify the NRC as required by the Order, and did not complete the actions agreed upon. OI assisted the NRC staff in locating and interviewing the former SRO. The former SRO admitted that he did not complete the agreed upon actions in the Confirmatory Order and would not take responsibility for failing to report his previous arrest. As a result of the OI Assist, on April 1, 2009, the former SRO was issued an Order prohibiting his involvement in all NRC-licensed activities for a period of three years.

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