UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

February 1, 1995

NOTE TO: David J. Vito
Senior Allegations Coordinator, RI

FROM: Jean Lee
Allegations Coordinator, NRR

SUBJECT: TRANSFER OF ALLEGATION CONCERNING SECURITY VIOLATIONS AT OYSTER CREEK (NRR-94-A-0074)

On January 23, 1995, I forwarded to you a copy of the subject allegation information for your preparation for the NRR Allegation Review Board meeting. The meeting was held on January 26, 1995. The Region I representatives who participated by telephone were Greg Smith, Dave Limroth and Ed King. It was determined at that meeting that Region I should have the lead for disposition of the allegation.

Per our telecon today, attached for your use is a copy of my records. The ARB meeting summary and the letter to the alleger informing him of the transfer to Region I are in the concurrence chain; a copy of each will be forwarded to you, when issued. A copy of a submittal by the alleger that he marked as "Safeguards Information" has been provided separately to Greg Smith.

For reference purposes, please inform me of your AMS No.

Attachments:
As stated

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ALLEGATION REVIEW BOARD
SUMMARY
Allegation Number NRR-94-A-0074
TAC No. M91096

1. The NRR Allegation Review Board met on January 26, 1995, at 3:00 pm.

2. Present at the meeting were:

RLSpessard*	SLewis	RI by phone:
SVarga*	BJones	EKing
LCunningham	BManili	DLimroth
PMcKee	JLee*	GSmith
AGallow		

3. Facilities/organizations involved: Oyster Creek

4. Allegation title: Security Violations

5. This allegation has been previously assigned to TSGR for resolution.

6. The ARB determined the allegation to be of low safety significance.

7. The ARB previously assigned this allegation a Priority Level of 3 after consideration of its safety significance.

8. OI has been provided a copy of the allegation.

9. RI reported that the licensee is conducting an investigation of information supplied to the licensee by the alleger. Based on the safety significance and the ongoing activities of the licensee, RI stated that no immediate NRC action is warranted; RI recommended issuance of a referral to the licensee. The ARB determined that RI should be the lead office for disposition of the allegation because the allegation is plant-specific and expressed no objection to the proposed referral. The OAC will inform the alleger of the transfer to RI.

10. Prepared by: Jean Lee — 2/1/95
Jean Lee, Office Allegations Coordinator — Date

11. Approved by: R L Spessard — 2/8/95
R. Lee Spessard, Chairman, ARB — Date

*ARB members

Distribution:
DD:NRR ADT:NRR D:OI CEROssi JGoldberg SVarga PMckee
LCunningham AGautam NRR OAC RIOAC

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PRIORITY ATTENTION REQUIRED MORNING REPORT - REGION I FEBRUARY 8, 1995

Licensee/Facility:

Gpu Nuclear Corp.
Oyster Creek 1
Forked Rver,New Jersey
Dockets: 50-219
BWR/GE-2

Notification:

MR Number: 1-95-0019
Date: 02/07/95

Subject: Briefing to NJ Senator's Staffs

Reportable Event Number: N/A

Discussion:

On February 7, 1995, the NRC regional staff briefed members of Senator Lautenberg and Senator Bradley's staff on the salient issues and the plants' status for Oyster Creek and Artifical Island (Salem and Hope Creek).

Regional Action:

This Is For Informational Purposes Only.

Contact: Jacque Durr (610)337-5224
John Roque (610)337-5146
John White (610)337-5114

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Allegation Receipt Report Page 1 of ___
(Use also for staff suspected wrongdoing)

Date/Time Received: * 3/9/95 4:00p.m Allegation No. RI-95-A-0044 (leave blank)

Employee Receiving Allegation or suspecting wrongdoing (first two initials and last name): T.A. Joustra

Name of Alleger: * Anonymous Home Address: *

Home Phone: * City/State/Zip: *

Alleger's Employer: * GPU Alleger's Position/Title: * Supervisor

Facility: Oyster Creek Docket No. or Materials License No.: 50-219

Was alleger informed of NRC identity protection policy? Yes ✓ No ___
If a licensee employee or contractor, did they raise the issue to their management? Yes ___ No ✓
Was confidentiality requested? Yes ___ No ✓
Was confidentiality initially granted? Yes ___ No ✓
Individual Granting Confidentiality: ___

Criteria for determining whether the issue is an allegation:

Is it a declaration, statement, or assertion of impropriety or inadequacy? (Yes) / No

Is the impropriety or inadequacy associated with NRC regulated activities? (Yes) / No

Is the validity of the issue unknown? (Yes) / No

If No to any of the above questions, the issue is not an allegation and should be handled by other appropriate methods (e.g. as a request for information or an OSHA referral).

Allegation Summary or staff suspected wrongdoing (brief description of concern(s)):

Continuous fire watch duty for A-B Battery Room (door lock failure) as of 3/7/95 was manned by security guards. Security guards not members of fire brigade and do not meet requirements for continuous fire watch

Number of concerns: 1

Type of Regulated Activity (a) ✓ Reactor (d) ___ Safeguards
(b) ___ Vendor (e) ___ Other: ___ (Specify)
(c) ___ Materials

Functional Area(s):
✓ (a) Operations ___ (e) Emergency Preparedness
___ (b) Construction ___ (f) Onsite Health and Safety
___ (c) Safeguards ___ (g) Offsite Health and Safety
___ (d) Transportation ___ (h) Other: ___

* These sections are not completed for instances of potential wrongdoing identified by NRC staff.

Distribution: SAC OI

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Detailed Description of Allegation or staff suspected wrongdoing:

A-B battery room door is being kept open due to mechanical lock failure. Procedure 120.2, Rev. 8, Step 4.2.1.2.4 requires continuous fire watch. Door is being manned by security guards who are not members of the fire brigade. Area is being periodically toured by operations personnel but observation is not continuous.

1-92-92

10:10AM from Jim Riccio 6/10/92

OYSTER CREEK CONCERNS

A. DEPTH OF INVESTIGATION

1. What was the IRTs charter, scope, number of members, and expertise level?

   A1: IRT's charter was to identify and address anomalies and discrepancies inherent to the tours conducted by the Operations personnel.

   A2: The scope of the investigation was not addressed but appeared limited in that other departments were not investigated, no licensed operators were investigated, training was not addressed, management culpability was not addressed, and human factors concerns were not addressed in any depth.

   A3: The basic team consisted of 4 security type personnel. Their expertise was not addressed. Limited help was also received from the Rad Waste Operations Manager and a technical analyst. Independence of the team was not apparent in that they daily briefed OC management of their findings.

   A4: The expertise level of the IRT members could not be determined from the report. However based on both phase one and two reports it appears they had little operational experience.

2. Adequacy of IRT investigation

   a. Was the investigation period long enough to adequately determine the depth of the problem?

      A1: The investigation period was from December 1, 1991, to February 29, 1992. The IRT investigated 12 days of turbine building rounds, 1 day of reactor building rounds, and 0 days of intake area rounds during this time period.

      C1: Why did the investigation only focus on the turbine building rounds?

      C2: Was a 13 day sample period large enough to assess the depth of the problem at OC?

   b. Did the IRT investigate other departments possible involvement?

      A1: Not addressed in the report.

   c. Was any data analysis done to help determine root cause?

      A1: Not addressed in the report

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d. What was the percentage of the operating staff investigated?

A1: Eighteen out of 25 (?) operators were interviewed. It was determined however that 24/25 operators did not complete both rounds of their tours. Five operators missed both inspections of an area per shift one or more times.

C1: Were any licensed operators investigated?
C2: Did all 24 operators who had not completed both of their rounds falsify their round sheets or leave them blank?

e. Did the NPOs falsify their round sheets or just fail to perform the inspection rounds and left the round sheets blank?

A1: The report indicated that it was a mixture of both.

C1: Where was management supervision regarding round sheets left blank?

B. MANAGEMENT CULPABILITY

1. How were management's expectations regarding inspection rounds relayed to NPOs?

A1: Not addressed in the report

2. Did the procedures governing inspection rounds adequately address integrity issues and provide guidance on how to perform inspection rounds?

A1: Not addressed in the report

3. Was there appropriate supervisory oversight of inspection rounds?

A1: Not addressed in the report

4. Prior to the INPO inspection, had anyone in management received information that this problem existed (i.e. QA audit results, general knowledge, etc)?

A1: Not addressed in the report

C. TRAINING DEPARTMENTS CULPABILITY

1. Did the NPO training program adequately address integrity issues?

A1: Not addressed in the report

2. Did the NPO training program regarding inspection rounds have clear cut measurable training objectives?

A1: Not addressed in the report

3. Did the Operations/Training departments have a program for identifying NPO performance deficiencies and responding in a timely manner?

A1: Not addressed in the report.

D. MANAGEMENTS RESPONSIVENESS FOR ASSURING SAFETY

1. What immediate actions did management take upon discovery of the problem?

A1: Director of OC directed investigation based on INPO concerns.

C1: Reports did not address whether management determined that the missed inspections represented a safety concern or not.

C2: Report did not address what other immediate actions management took when they learned of the problem. Did they talk to the NPOs, were memos sent to the staff, etc.?

2. What is managements long term plan for getting well?

A1: Not addressed in the report

C1: It appears as if there is a definite training problem, management oversight problem and procedural problems which were not addressed in the report.

3. What disciplinary actions were taken?

A1: The five NPOs who missed both inspections of an area during their shift were given 5 day suspensions and them met with upper management to discuss integrity type issues.

C1: For two of the operators involved it appeared that a serious training problem existed. Why wasn't this addressed by the licensee?

C2: Why weren't the other operators disciplined who had missed inspections on their rounds?

C3: Why wasn't their different levels of discipline administered based on the seriousness and number of the missed inspections?

E. QUESTIONS RELATED DIRECTLY TO PHASE TWO REPORT

1. page 2: "One anomaly was identified..."

   Q1: What was this **one** anomaly? What about the 5 operators identified on page 4?

2. page 4: "Most nuclear plant operators did not make two complete tours ..."

   Q1: Did these NPOs falsify their round sheets or leave them blank? (One is an integrity issue and the other is a management issue.)

3. page 4: "7) Several operators did not accurately record readings ..."

   Q1: Is this a falsification issue?
   Q2: Identify the NPOs by number?

4. page 12: "Corrective Responses" "Similar meetings occurred between the **previously** identified NPOs and ..."

   Q1: Which NPOs are these? Are they the remaining 19/24 NPOs who had missed the second inspections of their rounds or are they those NPOs who were identified in the phase 1 report?

5. page 15: Item 7) "Although interviews of NPOs...was not pursued..."

   Q1: Why wasn't an investigation of these other NPOs conducted?

CONFIDENTIAL

GPU Nuclear **Memorandum**

Subject: [redacted] Concerns EX 4

Date: December 2, 1994

From: R. Cook
Area Human Resources Manager

Location: Oyster Creek

To: M. Basil, Nuclear Security Agent
and
J. Knubel, Director Security & Corp. Planning

[redacted] EX 4

On November 28, 1994, [redacted] during his termination interview, stated he had several concerns regarding plant security procedure violations. I will just list the issues since it is my understanding that Marty will be talking to [redacted] in the near future.

[redacted]

EX 4+6

Continued . . .

N 0949 (06-93)

D/1

EY4+6

[redacted]

EY4 [redacted] did not think there was supervisory knowledge regarding these issues.

Please call me if you have any questions.

Russ Cook
Beeper # (908) 506-3816

TOTAL P.02

TOTAL P.03