



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
631 PARK AVENUE
KING OF PRUSSIA, PENNSYLVANIA 19406

ENCLOSURE 8

April 10, 1987

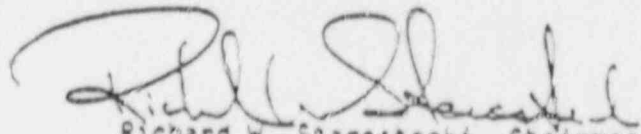
MEMORANDUM FOR: James M. Allan, Region I
J. Nelson Grace, Region II
A. Bert Davis, Region III
Robert D. Martin, Region IV
John B. Martin, Region V
James M. Taylor, DEDRO
Thomas E. Murley, NRR
Hugh L. Thompson, NMSS
James P. Murray, OGC
James G. Keppler, SPO

FROM: Richard W. Starostecki, Chairman, IRB

SUBJECT: PROPOSED IRB RECOMMENDATIONS

As a result of IRB activities over the past six months, in particular the two-day joint working meeting with the Regions on March 17 & 18, 1987, a number of issues and concerns relating to OI referrals have been discussed. The issues that have been most recurring were addressed by the IRB members and as a result we have prepared the attached "Proposed IRB Recommendations". Prior to preparation of a final set of recommendations to the EDO, I request your constructive review, comments and suggestions on the attached.

A response by April 27, 1987 would be appreciated.


Richard W. Starostecki, Chairman
Investigation Referral Board

Enclosure:
As stated

cc: B. Hayes, OI
J. Lieberman, IRB Member
J. Zerbe, IRB Member
K. Burnett, IRB Member
F. Miraglia, IRB Member
J. Gniezek, NRR
T. Rehm, EDO

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PROPOSED IRB RECOMMENDATIONS

1. OI and the staff should be encouraged to coordinate their activities at all levels. It is the view of the IRB that the activities of the IRB would have been expedited and enhanced by the participation of OI staff. Closer working relationships should be fostered such that the agency's objectives are attained with a clear understanding by OI and staff of their respective roles. Most matters identified as potential wrongdoing need to be followed or pursued far enough to adequately address potential safety concerns. The distinction between "wrongdoing" and "safety impact" will not always be clearly identified, nor in some cases can it. The regulatory needs of this agency are at times not considered sufficiently because of the perception that "this is ours" and "that is theirs". Consequently, the respective staffs must work together until the regulatory and wrongdoing issues are clearly established.
2. There are instances when staff inspections can benefit from the participation by OI staff. Such assistance from OI is generally needed on short notice and is not conducive to review by a board. There is a need to clearly distinguish between requests for OI investigations and OI assistance. OI assistance refers to those situations where there is a need for OI support to an inspection (e.g., conduct of an interview) to collect additional data or information so that a reasonable determination can be made as to wrongdoing and whether there is a regulatory need. OI assistance requests appear to be the type of OI effort that may not be

resource intensive and for which OI may be able to provide prompt support to the staff. Requests for OI assistance by Regional Administrators have not always been routinely honored by the OI field office. Based on Regional experiences the field offices do not distinguish between investigations and assistance support in that written referral requests have been sought before initiating any field work. OI guidance to their field offices on this issue is needed to assure a consistent response.

3. To foster closer coordination between OI and staff, OI staff should be encouraged to attend pertinent Regional enforcement conferences, allegation panel meetings, or management meetings. OI should not self-initiate inquiries or investigations without coordinating with the Regional Administrator or the Program Office to assure completion of the staff's deliberative process. That is, if the staff decides at an allegation panel meeting that a referral is warranted and an appropriate request is forwarded for the Regional Administrator's signature, OI should not initiate its effort pending receipt of a specific request. It is the clear definition of the regulatory need that evolves from the deliberative process; to assure that the appropriate regulatory need will be satisfied by the OI effort, close coordination between OI and the staff during initiation as well as during the conduct of the investigation should be encouraged.

4. OI and Regional staff should be encouraged to provide feedback more routinely. The development of additional technical information resulting from certain OI investigative efforts can impact the regulatory need and attendant regulatory action. Consequently, the presence of a technically knowledgeable individual on selected OI efforts would enhance the utility of the OI results and provide more meaningful feedback upon which changes could be considered in the priority, need for and direction of the investigation. Conversely, OI presence on certain staff inspections could provide additional perspective to the staff. To assure feedback is attained, OI field offices and Regional managers should hold at least quarterly briefings on status of activities in progress. These quarterly briefings should also result in a regional prioritization of cases.
5. The concept of an emergency OI referral should be retained. Guidance needs to be developed for the Regional Administrators as to the threshold of such requests and the need for coordination with the respective Program Office. Emergency referrals are infrequent (four in six months) and do not appear to impose an administrative burden on the staff. Their treatment reflects the urgency of the matter and its immediate potential impact on public health and safety. Program office emergency referrals could similarly be directly provided to OI. Subsequent notification of the EDO Office on all emergency referrals is necessary. Alternatively, emergency referrals could be reviewed by the Deputy EDO for Regional Operations. Emergency referrals to date have been coordinated with the IRB Chairman by telephone; this coordination should be continued with the

respective Program Office, and a copy of the final written request should be forwarded to the review board for information.

6. Retain the concept of a national priority listing that is periodically updated. Every six months, all outstanding OI cases should be reevaluated for their regulatory need and priority. A review board consisting of SES-level managers from the EDO Office, NMSS, NRR, Regions and OI should reassess from a national priority all cases such that a prioritized tabulation is provided to OI. The Deputy EDO for Regional Operations could be the Chairperson. A quarterly review of all outstanding cases by a board with a national overview would be very resource intensive. Quarterly reviews at the regional level with subsequent 6 month board reviews appears to be more useful.
7. The Commission's guidelines of January 10, 1986 for requesting and prioritizing investigation requests are adequate subject to consistent interpretation of safety concerns. The guidelines address safety concerns in the licensing process and this has been taken by the IRB to apply in the broad context of safety concerns in the regulatory process which does not discriminate between licensing and inspection. The term "licensing" has on occasion been read narrowly and applied primarily to NTOLs in the licensing process. The form used by the staff to request an investigation should be modified in certain respects. First, it should include in the prioritization request a reference to the applicable subparagraph of the guidelines which best matches the rationale for the

priority. This would enhance more consistent and uniform application of the guideline. The form should also be revised to include a short statement to solicit the safety significance of the issue. Third, the form should solicit a brief description of inspection activities and/or enforcement activities. In many IRB cases, the requests for referrals have been approved after additional information has been identified as being pertinent and the formal request revised to more clearly identify the problem warranting OI investigation.

8. The IRB process has fostered improved communication and coordination among the Regions and between the Regions and Headquarters. OGC and DEDROGR participation has been valuable in providing constructive suggestions and recommendations; the synergism of the IRB discussions has been most beneficial and the consensus decisions of the IRB have resulted in no cases being contested by any requesting Region or Office. Although the IRB process was at times very disruptive to individuals because of the time constraints (routine meetings usually required 2-3 hours), the level of involvement was desirable in light of the variety of issues. Due to extenuating circumstances, the Deputy Office Directors for NRR and NMSS were able to participate in only a few meetings. Consequently, NRR and NMSS participation was generally at the Division Director level. Accordingly, a board made up of SES-level managers could continue to provide the function of the IRB. The IRB focused its attention on the regulatory need and priority of each case. OI was invited to each meeting but never attended. Some OI field offices participated by

telephone on occasion. More active OI involvement in this process would have been beneficial because of their insights on what constitutes wrongdoing and their views of how far inspections can occur before they might interfere with a future investigation. Nonetheless, the IRB approach to reviewing each case was successful in that the regulatory need was more fully considered and prioritization was more uniformly and consistently assigned in accordance with the Commission's guidelines. As a result, there are two options that warrant consideration for the IRB:

Option A

The IRB function could be transferred to the Program Offices. The function of the IRB of reviewing the priority and the adequacy completeness of the specific request could be reassigned to the respective program offices. Prior to referral to OI, Regional reactor cases should be reviewed with NRR and materials cases with NMSS. Each Program Office could establish a SES-level board with OGC and/or DEDRO participation. For example, NRR could constitute a quorum with a 3 person board made up of a Division Director, OGC, and DEDRO representatives. Similar restrictions on timeliness, within two weeks of receipt, should be stated for considering requests. Program office referrals could be similarly referred to OI by the program office after board review. TVA and Comanche Peak issues should similarly be considered by a board; it is suggested that the Special Project Office have a participating member on the NRR board.

Option B

Retain the IRB as constituted with representation from NMSS, NRR, DEORO and QGC. The IRB Charter could be retained but representation from the offices should not be limited to Deputy Office Directors; members could be Division Directors, or higher.

COMMENTS PROVIDED ON PROPOSED IRB RECOMMENDATIONS

On April 10, 1987, 5 months after the inception of the IRB, proposed recommendations were developed by the IRB and provided to the Regional Administrators, Program Office Directors, the Director, Office of Special Projects (OSP), the Deputy Executive Director for Regional Operations and the Office of General Counsel for review and comment. These comments are attached.

The commenters were in general agreement and supportive of the recommendations, with some modifications. Disagreements however, were noted. The Director, OSP does not agree that IRB should continue. The Administrator, Region II does not believe that each individual referral should be reviewed in advance by an IRB. The proposed recommendations also identified the option of more direct program office review of each referral in lieu of the IRB. This option was generally not supported due to the need for more interactions by each region.

The general benefits stated by the commenters include:

1. The establishment of a national priority was reviewed as needed. As noted by Region II, if pending cases are reduced so that OI can complete investigations more quickly, there would be a better likelihood that appropriate regulatory action, such as enforcement, could be taken more timely. Concurrently, Region III also noted that a major percentage (80%) of the highest priority cases nationwide were in Region III.
2. There was agreement that the IRB process provided a consistent application of the Commission's threshold for requesting investigations.
3. The IRB improved the staff's appreciation for clearly stating the regulatory need for an investigation.
4. The IRB promoted improved communication and feedback among Headquarters, the Regions and OI.

Highlights from each commenter are provided.

Region I

The Administrator, Region I, supported the recommendations and indicated that they are appropriately aimed at encouraging better coordination between the staff and OI. The option of retaining a single board, weighing both reactor and material referrals from a national perspective, was preferred.

Region II

The Administrator, Region II, highlighted a number of benefits achieved by the IRB process but did not believe that the need for a review board, which reviews referrals in advance of formal submittal to OI, is warranted. It was stated that:

1. The IRB helped foster a better understanding of priorities from an agency-wide perspective;
2. The need for enhanced cooperation between OI and the regional staffs should be fostered;
3. Program offices should have more active participation in a passive oversight role;
4. Steps should be taken to review and reduce the backlog of pending OI cases so as to provide more timely support to the regions for those cases that have a high probability of resulting in enforcement action; and
5. A periodic review and updating of a national priority listing of pending cases should be continued.

Region III

The Administrator, Region III, made a number of comments. There is agreement with the concept of a review board to prioritize investigations and OI should attend board meetings. Selected comments include:

1. Close coordination between regional staff and OI is essential.
2. Guidance should be provided to OI field offices for providing assistance of a short term nature, as contrasted with an investigation. Use of OI to scope issues is beneficial;
3. OI should not be restricted from self-initiating investigative efforts;
4. The concept of emergency referrals should be retained. Guidance to the Regional Administrator for classifying emergencies should be provided; coordination with senior headquarters officials should occur on emergency referrals; and
5. Region III caseload after completion of the IRB process, including development of a national priority listing, included 80 percent of the highest priority cases nationwide; it was implied that reallocation of OI resources is warranted to deal with this.

Region IV

The Administrator, Region IV, proposed a revision to the modifications developed by the Commission relating to the definition of wrongdoing. Furthermore, he suggests a definition be developed for the terms "careless disregard" and "reckless indifference". Another issue addressed deals with the treatment of allegations. Region IV prefers more definitive guidance than currently exists as to who is responsible for establishing whether there is a reasonable basis for believing that an allegation does in fact involve wrongdoing. Finally, Region IV endorses the concept of maintaining and updating a national priority listing of pending cases.

(H) Why was the IRB "dis-established"?

ANSWER:

The IRB served its purpose of providing senior management oversight for the implementation of the Commission's guidance on the thresholds for requesting investigations and priorities of investigations. The IRB served a quality assurance function for the referral process. The IRB was established on a trial basis and, after an evaluation of its operations by the EDO, it was decided that it was no longer needed. The consideration of priorities on a national basis has been continued through periodic meetings of OI and staff officials in the Investigative Priority Review Group.

QUESTION 17: Although the IRB has been "dis-established," the NRC initiated the Investigation Priority Review Group.

(A) What is the charter of this body?

ANSWER:

The charter is attached.



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

SEP 15 1987

MEMORANDUM FOR: Those on Attached List

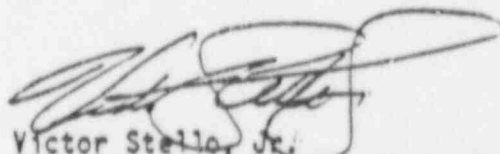
FROM: Victor Stello, Jr.
Executive Director for Operations

SUBJECT: SYSTEM FOR PERIODICALLY PRIORITIZING INVESTIGATIONS

The Investigation Priority Review Group (IPRG) is being established to consider the priorities for investigations of wrongdoing on a national basis. Matters of wrongdoing involve varying degrees of potential or actual safety significance. Therefore, NRC limited investigatory resources make a periodic agency wide review of investigation priorities necessary to assure that the investigatory resources are focused on the most important safety issues.

The composition and responsibilities of the IPRG are set out in the attached Investigation Priority Review Group Charter. Initial working arrangements for the IPRG are also attached to this Memorandum. The IPRG Chairman may revise these initial working arrangements as necessary. The Office of Investigations has been involved in developing the plans for the IPRG and the Director of OI supports this approach.

The Investigation Priority Review Group and the system for periodically reviewing and prioritizing requests for investigations will be effective September 30, 1987.



Victor Stello, Jr.
Executive Director for Operations

Enclosures: As stated

cc: B. Hayes, OI
S. Connelly, OIA
T. Rehm, EDO

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WORKING ARRANGEMENTS FOR THE INVESTIGATION PRIORITY REVIEW GROUP (IPRG)

The Director, OE, will provide staff support for the IPRG. This support will include (1) providing the reference and working materials necessary for the functioning of the Group, (2) preparing IPRG reports for the approval of the Group Chairman, and (3) performing such other IPRG functions as the Group Chairman may direct.

The IPRG will meet during the first month of each calendar quarter as scheduled by the Deputy EDO. At least 30 days before the scheduled quarterly meeting, OE will provide Regional Administrators and Office Directors a copy of the last national ranking made by the IPRG and a list of referrals made by the region or office since the last national ranking. The last national ranking developed by the IRB will be used for the initial Group meeting. The list of referrals will be grouped by the priorities designated in Manual Chapter 0517. Regional Administrators and Office Directors will review the OI referrals made by them on the list provided by OE and further rank the referrals using the following guidance. Within the High priority, rank according to Upper, Medium, and Lower. Within the Normal priority, rank according to Upper and Lower. No further ranking of cases within the Low priority is necessary. Outstanding OI case will also be reprioritized by the Regional Administrators and Office Directors who originally made the referral.

The Regional Administrators and Office Directors will also request from the appropriate OI Field Office Director, a status for OI investigations regarding (1) whether the case is a full investigation or an inquiry (Q case), (2) the percent of field investigative work completed for all outstanding OI cases, (3) a list of the OI cases closed, and (4) cases opened since last IPRG meeting with assigned priority. Regional Administrators and Office Directors will (1) annotate the national ranking lists provided by OE with the priority information regarding new referrals, (2) annotate the status of OI cases including the percent of field work completed, and (3) return the annotated lists to OE by the close of business, 10 days before the scheduled IPRG meeting.

Prior to the IPRG meeting, OE will prepare a "straw man" new national ranking list using the annotated lists from the Regional Administrators and Office Directors. In preparing the straw man list, OE will include the percent of the field investigative work completed, line out those cases that have been completed or administratively closed since the last national ranking, and include a brief "one line" description of the cases.

At the IPRG meeting, Group members will review the straw man national ranking list and develop a revised national ranking. After the IPRG meeting, OE will prepare a report of the Group meeting, including the new national ranking, and issue a report, after approval by the IPRG Chairman, to the organizations indicated in the IPRG Charter.

Attached List

J. M. Taylor, DEDO
H. L. Thompson, NMSS
T. E. Murley, NRR
E. S. Beckjord, RES
W. T. Russell, RI
J. N. Grace, RII
A. B. Davis, RIII
R. D. Martin, RIV
J. B. Martin, RV
J. G. Keppler, OSP
W. Parler, OGC
W. G. McDonald, ARM
H. Denton, GPA
E. L. Jordan, AEOD
J. Lieberman, OE
S. Schinkf, OGC

Charter for the Investigation Priority Review Group

I. PURPOSE

To review quarterly each open investigation:

1. The assigned priority (high, normal, low), and assure the priority is consistent with program and overall agency needs, and
2. The schedule when the results of the investigation are needed to support regulatory action.

II. Membership

Deputy Executive Director for Operations (Group Chairman)
Office Director, NMSS
Office Director, NRR
Director, OI
Assistant General Counsel for Enforcement, OGC (Advisory Member)
Director, OE (Advisory Member)

If Group members are unable to attend a meeting, they should appoint their deputies or acting office directors to substitute for them.

III. Meetings

Meetings will be conducted quarterly during the first month of each calendar quarter as scheduled by the Group Chairman. It is expected that the meeting will include Regional Administrators, Director, OSP, and OI Field Office Directors representation, via conference call.

IV. Staff Support

The Office of Enforcement will provide staff support for the Investigation Priority Review Group. This support will include (1) advising the Group regarding the application of the policies in Manual Chapter 0517, Appendix, Part III, (2) providing the reference and working materials necessary for the functioning of the Group, (3) preparing the Group quarterly report for the approval of the Group Chairman, and (4) performing such other IPRG functions as the Group Chairman may direct.

V. Report

A quarterly report will be provided to the EDO. The report will summarize the prioritization of open investigations, summarize the status of outstanding investigations, and identify any problems or potential problem areas. Copies of the report to the EDO will be provided to the Commissioners, the Directors, NRR, NMSS, OGC, OE, OI, OSP, and the five Regional Administrators.

QUESTION 17. (continued)

- 2 -

(B) Is the OI Director a participating member of the new body? If so, what are his responsibilities?

ANSWER:

Yes. The Director of OI has the same authority as any other member of the board.

QUESTION 18. In April 1987, the OI Director submitted SECY 87-93 to the Commission.

(A) For what specific reasons did the OI Director submit the SECY paper to the Commission?

(B) What events led to submitting the document to the Commission?

ANSWER

SECY-87-93 arose out of an OI concern that certain Staff and Commission actions taken from 1986 on had the effect of creating confusion regarding the scope of OI authority and responsibility. Two actions in particular - Commission approval of SECY-85-369 regarding the initiation, establishment of priorities, and the termination of investigations, and establishment of an Investigation Referral Board - appeared to the Director, OI to conflict with long standing OI policies and procedures, particularly in such areas as the authority of the Director, OI, to initiate investigations, or the obligation of NRC employees to report wrongdoing matters to OI. The need for clarification became evident to the Director, OI, in February 1987 when controversy over OI self-initiation of an investigation over the objections of some Staff officials led to at least one Commissioner severely criticizing the OI actions.

(C) What did the OI Director ask for in the SECY paper?

ANSWER

OI asked, (1) that the Commission reaffirm OI's authority and responsibilities, and (2) that the Commission direct OI and the Staff to develop joint guidance to ensure that all NRC employees are informed of the scope of OI authority and responsibility so that all matters of wrongdoing are brought to OI's attention. The paper was withdrawn without Commission action at OI's request.

In April 1987, the OI Director submitted SECY 87-93 to the Commission.

(D) What arrangements were reached as a result of the management meeting held to discuss the SECY paper?

ANSWER

The Director, OI, and his staff met with the Commission on July 29, 1987, to discuss SECY-87-93. During that meeting, the existing 27 OI Policy Statements previously approved by the Commission and the authority of OI to self-initiate investigations were discussed. Prior to that management meeting, but subsequent to the submission of SECY-87-93, the Investigation Referral Board was disestablished, and the Commission announced that neither Commission nor Office of General Counsel review of proposed OI referrals to the Department of Justice would be required. OI submitted SECY-87-93A, which formally withdrew SECY-87-93. OI's withdrawal of SECY-87-93 was based on its understanding that OI's concerns had been resolved.

QUESTION 19. What NRC document(s) define the procedures for conducting investigations under OI's jurisdiction?

(A) Define the thresholds for conducting OI investigations.

ANSWER

The thresholds for conducting OI investigations are found generally in Part III. B.1. of the Appendix to NRC Manual Chapter 0517. The threshold for a Staff investigative request is a reasonable basis for belief of wrongdoing and a Staff determination that an investigation is necessary for enforcement or other regulatory action. The Director, OI, may self-initiate an investigation based on reasonable belief of wrongdoing on a matter within NRC purview in accordance with OI Policy 4.

(B) Define the priorities for conducting OI investigations.

ANSWER

Investigative priorities are initially assigned by the requestor of an investigation in accordance with the guidance in NRC Manual Chapter 0517. OI normally accepts this assigned priority. Additionally, the Investigation Priority Review Group meets periodically to ensure that investigations have been properly prioritized from a national perspective. The Commission has formalized in NRC Manual Chapter 0517, Part III, guidance for establishment of priorities for, as well as initiation and termination of, investigations. A copy is attached.

PART III

GUIDANCE FOR INITIATION, ESTABLISHMENT OF PRIORITIES AND
TERMINATION OF INVESTIGATIONSA. General

On January 10, 1986, the Commission approved the guidelines proposed by the Staff and the Office of Investigations (OI) for initiation, establishment of priorities and termination of investigations. The Commission concluded that uniform guidelines should be used by both the Staff and OI in establishing priorities for investigations and that staff views on the need for a d priority of an investigation were an integral part of the investigation process. The following procedures are to be followed in implementing the guidelines.

B. Referral by the Staff of Matters for Investigation

1. Regional Administrator and Office Directors, the latter through the EDO, shall refer to the Office of Investigations for possible investigation all matters where: (a) there is a reasonable basis for belief of wrongdoing, as that term is defined elsewhere in this chapter; and (b) the staff determines an investigation is necessary for it to decide whether enforcement or other regulatory action is required. Matters for which there is not a reasonable basis to believe wrongdoing is involved or matters which may involve wrongdoing but for which an investigation would be unnecessary to determine the appropriate course of action should not be referred to OI for investigation. For example, where a licensee discovers that a low-level employee deliberately violated a requirement or falsified a document, disciplines the employee and takes appropriate corrective action which the Staff has reviewed, the Staff may conclude that further NRC action is unnecessary.
2. All referrals to OI shall be made using the "Request for Investigation" form (Exhibit 3). A priority of high, normal or low will be assigned to the requested investigation using the examples set forth below as guidance. Each request to OI arising from an allegation should be coordinated with the OAC. OGC or Regional Counsel should also be consulted to review the legal basis for the referral. Copies of the completed request forms shall be distributed as indicated on the form.
3. As indicated above, the staff will recommend a high, normal or low priority for each matter referred to OI. The following examples may serve as guidance in assigning priorities. It should be recognized that these examples are just that. Judgment must still be exercised in each case to assure that the appropriate priority is established.

a. High

- (1) Current manager, licensed operator or other employee involved in deliberate violation of requirements having high safety significance, e.g., continuing potential for unnecessary radiation exposure to employees or members of the public.
- (2) Suspected tampering with vital equipment at a power reactor.
- (3) Allegations of falsification of records available for NRC inspection or submittals to the NRC or deliberate withholding of information required to be reported to the NRC, where the situation involved presents an immediate and continuing health and safety concern, e.g.,
 - (a) falsification of records having high safety significance, such as falsifications which conceal a repeated failure to perform a required test;
 - (b) alleged withholding of significant design flaw or seismic criteria information for an operating facility; or
 - (c) level of individual involved in the alleged withholding of information or falsification is such that a serious question of the willingness of management to conduct safe operations is raised.
- (4) Allegations of falsification of records available for NRC inspection or deliberate violations of NRC requirements concerning an area of significant safety concern for licensing.
- (5) Allegations of wrongdoing where immediate investigation is necessary to ensure preservation and availability of evidence or which are in some other way time perishable.

b. Normal

- (1) Allegations of intimidation or harassment of QC inspectors or workers on safety-related equipment at a facility under construction.
- (2) Allegations of deliberate violations of NRC requirements where there is no indication the violation is recurring or causing immediate and direct health and safety impact on the general public or employees.
- (3) Allegations of falsification of records available for NRC inspection or deliberate violation of NRC requirements of a safety concern in the licensing process.

MANAGEMENT OF ALLEGATIONS

c. Low

- (1) Allegations of deliberate violations of NRC requirements, falsification of records or submittals to NRC, or harassment or intimidation of workers where the licensee is aware of the allegation and has already undertaken corrective action.
 - (2) Allegations of deliberate violation of NRC requirements at an operating facility where there is no near-term safety concern; e.g., the reactor is in long-term shutdown.
4. Program offices are responsible to the EDO for assuring that within their areas of responsibilities necessary investigations are conducted. If the program office believes that a priority for a matter should be different than that requested by the Region, the Region should be contacted immediately to resolve the matter.
 5. Once a matter has been accepted by OI for investigation, if the requestor of the investigation determines that the need for or priority of an investigation has changed, that information will be provided to the Director, OI, for his/her consideration.

C. Initiation of an Investigation by OI

1. Upon receipt of the "Request for Investigation" form, OI will evaluate the request and conduct consultations as necessary with the requesting office. OI will initiate an investigation if:
 - a. The staff has found that the alleged wrongdoing has had or could have an impact on the public health and safety, the common defense and security, protection of the environment, or antitrust laws provided that these matters are within NRC jurisdiction; and
 - b. The Director, OI, determines that there is a reasonable basis to believe that the matter involves wrongdoing; and
 - c. The Director, OI, determines that there is sufficient information available to support the allegation to warrant initiation of an investigation.
2. If upon review of the request, there is a reasonable belief that the alleged wrongdoing is solely a product of careless disregard or reckless indifference, OI will not normally conduct an investigation unless the requester indicates that the matter requires application of OI resources because there are major regulatory implications and the Director, OI, concurs with this judgment.
3. OI will seek Commission guidance prior to initiating an investigation relating to the character/integrity of an individual in those instances where the character or suitability aspects of the matter being

considered for investigation are unrelated to a violation of NRC regulatory requirements.

4. OI will notify the requester within 30 days of receipt of the request whether the matter has been accepted for investigation and, if so, the priority assigned to the matter and the estimated schedule for completion. If a matter is not accepted for investigation, OI will provide the requester with the basis for its decision. Copies of OI correspondence on scheduling and priorities will be sent to all those who received a copy of the original request as indicated on the request form.

D. Resolution of Differences Between Staff and OI

1. Following OI notification of its action on a request for investigation, if the Regional Administrator has concerns about the priority or schedule assigned to the matter or the declination of OI to investigate at all, he shall promptly notify the Director of the appropriate program office of his concern.
2. The Director of the responsible program office will review disputed matters referred by the Regional Administrator and the priorities and schedules assigned on matters referred to OI directly by the program office. If the Director determines that an investigation priority or schedule established by OI or the lack thereof does not meet regulatory needs, and the matter cannot be resolved with the Director, OI, he/she will promptly notify the EDO.
3. The EDO will attempt to resolve all differences over the need for and priority and schedules for investigations with the Director, OI, and if unsuccessful, seek Commission resolution.

E. Termination of Investigations

1. The decision by OI to terminate an investigation which has been initiated will normally be made outside the context of the investigative priority/threshold system. OI will normally continue an investigation to its conclusion if there is a reasonable basis for a belief that the matter being investigated involves a deliberate violation of NRC requirements. The decision to terminate an investigation will be a case-by-case assessment by the Director, OI, of such issues as whether the relevant facts necessary to resolve the matter under investigation have been gathered, whether allegations of events or conditions are so old that witnesses are unavailable or could no longer be expected to recall pertinent information, or whether continued investigation would be nonproductive or otherwise not serve the agency's interests.
2. As indicated in section B.5., above, if the requester of an investigation determines that the need for or priority of an investigation has changed, that information will be provided to the Director, OI, for his/her consideration.

MANAGEMENT OF ALLEGATIONS

NRC Appendix 0517
Part III, Exhibit 3

LIMITED DISTRIBUTION -- NOT FOR PUBLIC DISCLOSURE

Request No. _____

Region/Office-year-No.)

Allegation No. _____

TO:

FROM:

REQUEST FOR INVESTIGATION

Licensee/Vendor/Applicant

Docket No.

Facility or Site Location

Regional Administrator/Office

Date

A. Request

What is the matter that is being requested for investigation (be as specific as possible regarding the underlying incident).

LIMITED DISTRIBUTION -- NOT FOR PUBLIC DISCLOSURE W/O OI APPROVAL

LIMITED DISTRIBUTION -- NOT FOR PUBLIC DISCLOSURE

- 2 -

B. Purpose of Investigation

1. What is the basis for the belief that the violation of a regulatory requirement is more likely to have been intentional or to have resulted from careless disregard or reckless indifference than from error or oversight? (be as specific as possible).
2. What are the potential regulatory requirements that may have been violated?
3. If no violation is suspected, what is the specific regulatory concern?
4. Why is an investigation needed for regulatory action and what is the regulatory impact of this matter, if true?

C. Requester's Priority

1. Is the priority of the investigation high, normal, or low? _____
2. What is the estimated date when the results of the investigation are needed? _____
3. What is the basis for the date and the impact of not meeting this date? (For example, is there an immediate safety issue that must be addressed or are the results necessary to resolve any ongoing regulatory issue and if so, what actions are dependent on the outcome of the investigation?)

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D. Contact

1. Staff members:

2. Allegers identification with address and telephone number if not confidential. (Indicate if any confidential sources are involved and who may be contacted for the identifying details.)

F. Other Relevant Information

Signature

cc: OI */
EDO
NRR/NMSS/OSP as appropriate */
OGC
Regional Administrator **/
OE

*/ If generated by region.
**/ If generated by NRR/NMSS/OSP

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QUESTION 20. Who has the ultimate authority, within NRC, to open a full-scale investigation under OI's jurisdiction? Who has the primary responsibility to determine whether or not an OI investigation is needed?

ANSWER

Ultimate authority rests with the Commission. Although the EDO and Regional Administrators may request investigations, only the Commission may direct OI to open an investigation. Except where the Commission may direct initiation of an investigation, the Director, OI, determines whether or not to initiate an investigation. Authorized requestors have a responsibility to request OI investigations when the threshold criteria of NRC Manual Chapter 0517 are met. The authority of the Director, OI, to self-initiate investigations is addressed in our response to Question 16(A).

QUESTION 21. Has the Commission ever denied an OI request to initiate an investigation under its jurisdiction? If so, describe the specific incidences and why the request(s) were denied.

ANSWER

The Commission has never denied an OI request to initiate an investigation under its jurisdiction.

QUESTION 22. Please explain the relationship between wrongdoing and safety issues in the context of OI's responsibilities to investigate wrongdoing. In the Commission's view, does wrongdoing always have safety significance? Does OI share the Commission's view of the relationship between wrongdoing and safety issues?

ANSWER

NRC prescribes requirements to protect public health and safety. Normally, wrongdoing as it occurs under the purview of NRC involves a deliberate violation of NRC requirements. Wrongdoing or deliberate violations are of significance because they reach to the character, reliability, and integrity of the licensee individuals involved. The potential significance to safety is also gauged by the position and responsibilities of the person involved. For example, wrongdoing on the part of a nuclear plant manager is clearly more significant than wrongdoing by a firewatch.

The Commission cannot prejudge the safety significance of each case of wrongdoing. The safety significance of wrongdoing also varies depending upon the specific requirement violated. Each case is reviewed on its merits. For example, wrongdoing could span deliberately concealing incapacitated systems vital to reactor safety all the way to falsification of logs used to record the routine tours of fire watches.

OI offers the following observations regarding the interrelationship of wrongdoing and safety:

The nuclear industry is largely self-regulating. For the most part, our regulatory assumption is that most licensees will comply voluntarily with NRC requirements, and that their commitment to the protection of the public health and safety is as vigorous as that of the NRC. OI does not disagree with this assumption. But this is what makes character and integrity so important. The NRC must be able to rely on persons in the industry to comply with, not circumvent NRC requirements. Industry employees who engage in deliberate violations of NRC requirements represent a potential safety threat in terms of their unreliability.

It is difficult enough for NRC inspectors to detect non-compliance when it is not deliberate given NRC resource constraints. When such violations are done on purpose, and covered up, such non-compliance is highly unlikely to be discovered during routine inspections. Whatever character traits that may lead licensee employees to commit such violations render them untrustworthy for regulatory safety responsibilities.

Thus, it is OI's view that wrongdoing, as defined by the NRC, generally has safety significance.

QUESTION 24. In his October 8, 1987, testimony before the Subcommittee, Mr. Hayes noted OI's mission of providing thorough, objective, and timely reports to the staff to assist them in making regulatory decisions. What criteria is used to suspend an investigation based upon a regulatory need? Who makes this decision? Please give specific examples of OI investigations that have been suspended.

ANSWER

The Director, OI, may elect to suspend an investigation based on a lack of regulatory need, but this would be an unusual action for the following reason. Virtually all current OI investigations have been carefully reviewed by the Staff and OI prior to initiation. At the time of a staff request for investigation there is a consensus that a regulatory need for it exists. Example of factors that could lead to a decision that a regulatory need for investigation no longer exists would be evidence supporting a reasonable belief that wrongdoing did not, in fact, exist or that the basis of regulatory need no longer exists. Under those circumstances, the assigned investigator would, with the concurrence of his supervisor, discontinue the investigation and write a final report of completed investigation work that would be issued in accordance with standard procedures.

Although the original requestor of an investigation may assert that he or she no longer requires an investigation, the investigation may be discontinued only by the Director, OI, if there was a reasonable belief that there was no wrongdoing.

On the other hand, the Director, OI, may want to close a case due to a requestor's assignment of a lower priority to the investigation. For example, the requestor of an investigation initially assigned a high priority may, based on the belief that the investigative results no longer are necessary, request it be treated as a low priority case. Under those circumstances, the case could become a candidate for OI administrative closure if the priority of the case is such that the investigation will not commence within six months. The practical results of such a Staff action would be to cause the matter to be closed administratively. At that point the staff would be notified and could take further action on its own or request OI to reopen the case with a higher priority if circumstances warrant.

As of December 31, 1987, OI has closed 39 cases administratively.

QUESTION 25 Please provide to the Subcommittee the following data by fiscal year through 1987.

- (a) the number of positions requested by OI.
- (b) the number of positions requested for OI by the Commission.
- (c) the number of positions allocated to OI.
- (d) the number of positions allocated to OI by the Congress.

ANSWER

The Office of Investigations (OI) was established in mid 1982 and allocated a personnel ceiling of 38 full-time equivalent (FTE) staff. The FY 1983 personnel ceiling for OI was also 38 FTE. The table below shows the Commission's FY 1984-1988 budget requests to OMB, and the Congress and the Commission's allocation of positions for OI.

<u>Fiscal Year</u>	<u>Commission Rqst to OMB</u>	<u>President's Budget Rqst^a</u>	<u>Allocated Positions</u>
	<u>FTE</u>	<u>FTE</u>	
1982	-	-	38
1983	-	-	38
1984	42	38	38
1985	49	49	38 ^b
1986	38	44	44
1987	44	44	45

^a Congressional Authorization Act and Appropriations Act did not reduce the President's Budget request for the Office of Investigations.

^b The Office of Investigations personnel ceiling was held to 38 FTE's until FY 1986. (See attached 1/24/85 memo from C. Kummerer to J. Asselstine.)