GPU Nuclear

GPU Nuclear Corporation
One Upper Pond Road
Parsippany, New Jersey 07054
201-316-7000
TELEX 136-482
Writer's Direct Dial Number:
201-361-7797

September 22, 1987
1000-87-2119

Document Control Desk
United States Nuclear Regulatory Commission
Washington, DC 20555

Gentlemen:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Destruction of a Portion of Sequence of Alarms Tape

My letter to Dr. Murley of September 20, 1987, on the Technical Specification violation at Oyster Creek on September 11, 1987 stated that the related matter of deliberate destruction of a portion of the Sequence of Alarms Recorder data at the Oyster Creek plant on September 11, 1987 was being pursued separately.

At GPU Nuclear Corporation's request, Mr. Edwin H. Stier, on September 11, 1987, initiated a thorough and comprehensive independent investigation to ascertain the facts about the response to the violation and, particularly, the destruction of the records. The NRC Staff has been kept advised by Mr. Stier of the status of his investigation and the NRC Office of Investigations has been briefed on the evidence obtained.

Enclosed is a letter to me from Mr. Stier dated September 21, 1987 which presents his preliminary findings. While he indicates that certain details have not yet been determined, and some discrepancies and inconsistencies remain to be resolved, Mr. Stier states that "(t)he factual conclusions summarized below are based upon evidence that is sufficiently complete, consistent, and undisputed to enable us to make findings we have no reasonable basis for believing will change during the next phase of our investigation." Mr. Stier also states that, "The next phase of our investigation will be . . . an effort to resolve as many remaining factual issues as possible."

A conclusion reached by Mr. Stier in his letter is, "The evidence we have obtained to date also establishes that when management personnel above the level of 'B' shift learned of the conduct that had occurred on 'B' shift, they acted promptly to investigate and report the circumstances to their superiors and to the NRC."

The "B" shift crew was relieved of licensed duties on September 11, 1987 pending results of the investigation. If we desire to return any of them to licensed duties we will provide prior notification to the NRC.

A001

The destruction of records or coverup is a clear violation of established company policy. We have repeatedly expressed and reinforced to employees our policy regarding openness, honesty, and retention of records. Corporate Policy 1000-POL-2002.00 states, "It is company policy to cooperate with law enforcement and regulatory agencies and, therefore, employees are expected to be truthful and professional when interfacing with such agencies. Employees having such knowledge of actions or conditions not in accordance with corporate, legal, or regulatory requirements must provide this information to applicable management to enable the company to take necessary corrective action." These same principles have been the subject of memoranda from the Office of the President to all employees. Recently, this subject has been addressed in the Corporate Vision and Values Statement sent to all employees in June 1987, and Corporate Policy 1000-ADM-2130.01 on disciplinary guidelines, dated May 1986.

Nonetheless, in view of the September 11, 1987 event, we are taking steps to assure ourselves prior to restarting the plant that similar behavior will not be expected in the future. This will include:

- The Director, Oyster Creek and the Director, Planning & Nuclear Safety will meet with the staff and with each of the other five control room crews to ensure understanding of the Corporate Standards and the underlying principle that mistakes occur and need to be dealt with but "coverup" or data destruction is unacceptable.

- Using the September 11 event as a case study we will reemphasize the importance of candor, honesty, and preservation of records and that it is the personal and professional responsibility of each employee to promptly make known to his supervisor or higher level official any observed misconduct.

We believe that completion of our efforts in this area will provide assurance of proper conduct in the continued operation of Oyster Creek.

We would welcome discussion with the NRC Staff on this matter.

Sincerely,

P. R. Clark

P. R. Clark
President

/pfk
Enclosure

EMERY WORLDWIDE

cc: Distribution Attached
CARIRS

Dr. Thomas E. Murley, Director
Office of Nuclear Reactor Regulation
United States Nuclear Regulatory Commission
Washington, DC 20555

Mr. William T. Russell, Administrator
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

Mr. Alex Dromerick, Jr.
United States Nuclear Regulatory Commission
7920 Norfolk Avenue
Phillips Building, Mail Stop 314
Bethesda, Maryland 20014

Mr. Lee Bettenhausen
Chief, Projects Branch #1
United States Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

E. Blak[illegible], Esquire
Shaw, P[illegible]tman, Potts and Trowbridge
2300 N Street, NW
Washington, DC 20555

Mr. David H. Fyock
GPU Service Corporation
600 Maryland Avenue, SW
Suite 520
Washington, DC 20024

EDWIN H. STIER
PROFESSIONAL ASSOCIATION
LAW OFFICES

11 E. CLIFF STREET
SOMERVILLE, NEW JERSEY 08876

TELEPHONE
(201) 725-4111

September 21, 1987

Mr. Philip R. Clark
President
GPU Nuclear Corporation
One Upper Pond Road
Parsippany, N. J. 07054

Dear Mr. Clark:

You have requested that I advise you of the status of our investigation concerning the response by plant personnel to the safety limit violation that occurred at the Oyster Creek Nuclear Generating Station (Oyster Creek) on September 11, 1987, at the conclusion of the preliminary stage of the investigation. We have now reached a point where I can give you our preliminary findings.

At your direction, this investigation began on September 11, 1987, as an independent investigation under my exclusive control. You assured me that GPUN personnel would provide their complete cooperation. You further instructed me to keep Nuclear Regulatory Commission (NRC) representatives fully apprised of all of the evidence that we obtained.

On September 11, I assembled a team of three additional investigators and traveled to Oyster Creek where we received a preliminary briefing from plant management. On the next day we discussed plans for our investigation with NRC personnel, examined physical evidence that had been collected by GPUN employees, and began our preliminary interviews. During the investigation we added an engineer to our staff to assist in the analysis of technical data.

The preliminary stage of this investigation has included interviewing all of the critical witnesses, examining physical evidence and reviewing technical analyses. NRC staff members were advised on a daily basis of the progress of our investigation. In addition, we have fully briefed a member of the NRC Office of Investigations on the evidence we obtained.

This investigation has focused upon whether the safety limit violation was properly reported within the GPUN management chain and to the NRC. In addition, we are investigating whether anyone attempted to conceal or destroy evidence relating to the safety limit violation and whether GPUN personnel appropriatly responded to evidence that such concealment or destruction may have occurred.

Based on our preliminary investigation, we have determined when certain critical events occurred, and how GPUN personnel responded to those events. The basis for those findings is evidential consistency in both witness interviews and documentary evidence.

However, certain other details cannot as yet be determined because of conflicts in the recollections of witnesses or between witnesses and documentary evidence. The next phase of our investigation will be to examine the witnesses under oath before a court reporter and to confront them with discrepancies and inconsistencies in the evidence in an effort to resolve as many remaining factual issues as possible.

The factual conclusions summarized below are based upon evidence that is sufficiently complete, consistent, and undisputed to enable us to make findings we have no reasonable basis for believing will change during the next phase of our investigation.

Between approximately 2 and 2:30 a.m. on September 11, 1987, the operators on "B" shift completed a procedure designed to isolate a valve in the Reactor Building Closed Cooling Water System (RBCCW), which had started leaking in the course of a maintenance operation. During this process, one of the operators, while attempting to shut down recirculation pumps, triggered an alarm indicating a safety limit violation because less than two recirculation loops were fully open. Following the alarm, the operator opened two additional valves in order to correct the situation indicated by the alarm.

The isolation of the RBCCW valve was completed and the leak from that valve was eventually corrected by manually backseating the valve. Following the stopping of the leak, the operating crew followed procedures to restore the RBCCW system to service.

Some time between the time of the safety limit alarm and 4 a.m., a paper tape record produced by the Sequence of Alarms Recorder (SAR tape) was removed and an attempt was made to conceal or destroy it by a member or members of "B" shift. Some time prior to 4 a.m., the "B" shift Group Shift Supervisor (GSS) learned that the critical portion of the SAR tape was missing.

Between approximately 3 and 4:30 a.m. there were a series of telephone conversations among the GSS, his immediate supervisor, the Operations Control Manager (OCM), and the managers above the OCM in the Operations chain of command, the Plant Operations Director and the Deputy Director, Oyster Creek (Deputy Director). In the first of these conversations, estimated to have occurred at approximately 3:15 a.m., the GSS called the OCM at his home and informed him that there had been a leak in the RBCCW system as well as certain details concerning the leak, including that a maintenance worker had been splashed with water from the leak and that the Operations crew had shut down the recirculation pumps while isolating the leaking valve. During this first conversation, the GSS did not, however, inform the OCM that a safety limit alarm had occurred.

The OCM learned of the alarm when he called back to the GSS in order to obtain further information about the worker who had been splashed with water, and about the procedures the crew had followed when shutting down the recirculation pumps. When the GSS disclosed the alarm to the OCM during this conversation, the OCM immediately instructed the GSS to make the notifications required by company procedures for such events.

The GSS notified the NRC pursuant to this instruction at 4:05 a.m. The OCM then notified his superior, the Plant Operations Director, of the safety limit violation. The Plant Operations Director, in turn, reported the incident to the Deputy Director. The Plant Operations Director also telephoned the NRC resident inspector some time between approximately 4 and 4:30 a.m. and advised him of the safety limit violation.

In telephone conversations to and from each other's homes between 3:30 and 4:30 a.m., the Deputy Director, the Plant Operations Director, and the OCM discussed the incident and agreed to meet at the plant. They tentatively scheduled a meeting there for 6 a.m. and began telephoning persons to be invited to the meeting.

Between 4:30 and 5:00 a.m., GPUN management personnel began arriving at the plant. The Deputy Director, the OCM, and the assistant to the OCM went to the control room between 4:43 and 4:57 a.m. Between 5 and 6:00 a.m. these persons, along with others acting at their direction, were in the control room and elsewhere gathering information in preparation for the 6 a.m. meeting.

During the telephone conversations between the OCM and the GSS discussed above, the OCM had been informed that there was no SAR record of the time of the alarm. However, he was not given any information at that time that implied that the SAR tape had been tampered with.

Shortly before the 6 a.m. meeting, the Plant Operations Director and the OCM began to suspect the possibility that someone had tampered with the SAR record. Immediately following the 6 a.m. meeting, the Plant Operations Director called a meeting for the purpose of investigating that possibility.

Between 5:30 and 7:30 a.m., while examining the SAR tape, the OCM Assistant became concerned about the condition of the tape. He observed that the oldest alarm recorded on the portion of the tape in the SAR was at 0232 on September 11, 1987. The portion of the tape on the floor that was separated from the SAR had a record of the most recent alarm at 1848 on September 10, 1987. This indicated to him that a long period had elapsed for which no SAR record existed. The OCM Assistant immediately called this information to the attention of the Plant Operations Director and the OCM.

As a result of the OCM Assistant's information and other steps that were taken to investigate the condition of the SAR tape, the Plant Operations Director initiated a search of the trash located in and around the control room.

Between approximately 10 and 10:30 a.m. a portion of the SAR tape which contained a reference to the safety limit alarm was located in the trash. This was promptly reported by the Plant Operations Director to the NRC, and the Security Department was contacted to assist in conducting the investigation and to physically secure the evidence.

On September 11, before the end of the shift at 8 a.m., the Deputy Director suspended "B" shift from any further license activities pending further investigation.

The evidence we have obtained, as summarized above, indicates that a member or members of "B" shift removed relevant portions of the SAR tape, discarded at least some portions of that tape, and either destroyed or discarded other portions. In addition, a member or members of "B" shift may have intentionally or unreasonably delayed reporting the safety limit violation and the fact that a portion of the SAR tape relating to the safety limit violation had been removed. In the next phase of our investigation we will attempt to resolve these issues.

The evidence we have obtained to date also establishes that when management personnel above the level of "B" shift learned of the conduct that had occurred on "B" shift, they acted promptly to investigate and report the circumstances to their superiors and to the NRC.

Very truly yours,

Edwin H. Stier

EHS:cr