NRC FORM 464 Part I (6-1998)

U.S. NUCLEAR REGULATORY COMMISSION

RESPONSE TO FREEDOM OF INFORMATION ACT (FOIA) / PRIVACY ACT (PA) REQUEST

FOIA/PA	RESPONSE NUMBER
2000-0243	1

RESPONSE TYPE ☐ FINAL ☑ PARTIAL

REQUESTER: James P. Riccio

DATE: NOV 22 2000

PART I. -- INFORMATION RELEASED

☐ No additional agency records subject to the request have been located.

☐ Requested records are available through another public distribution program. See Comments section.

☐ APPENDICES _____ Agency records subject to the request that are identified in the listed appendices are already available for public inspection and copying at the NRC Public Document Room.

☑ APPENDICES A, B, C Agency records subject to the request that are identified in the listed appendices are being made available for public inspection and copying at the NRC Public Document Room.

☐ Enclosed is information on how you may obtain access to and the charges for copying records located at the NRC Public Document Room, 2120 L Street, NW, Washington, DC.

☑ APPENDICES A, B, C Agency records subject to the request are enclosed.

☐ Records subject to the request that contain information originated by or of interest to another Federal agency have been referred to that agency (see comments section) for a disclosure determination and direct response to you.

☑ We are continuing to process your request.

☐ See Comments.

PART I.A -- FEES

AMOUNT * $

* See comments for details

☐ You will be billed by NRC for the amount listed.

☐ You will receive a refund for the amount listed.

☐ None. Minimum fee threshold not met.

☑ Fees waived.

PART I.B -- INFORMATION NOT LOCATED OR WITHHELD FROM DISCLOSURE

☐ No agency records subject to the request have been located.

☑ Certain information in the requested records is being withheld from disclosure pursuant to the exemptions described in and for the reasons stated in Part II.

☑ This determination may be appealed within 30 days by writing to the FOIA/PA Officer, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001. Clearly state on the envelope and in the letter that it is a "FOIA/PA Appeal."

PART I.C COMMENTS (Use attached Comments continuation page if required)

SIGNATURE - FREEDOM OF INFORMATION ACT AND PRIVACY ACT OFFICER

Carol Ann Reed

NRC FORM 464 Part II (3-1998) | U.S. NUCLEAR REGULATORY COMMISSION

RESPONSE TO FREEDOM OF INFORMATION ACT (FOIA) / PRIVACY ACT (PA) REQUEST

FOIA/PA 2000-0243

DATE NOV 22 2000

PART II.A -- APPLICABLE EXEMPTIONS

APPENDICES B & C

Records subject to the request that are described in the enclosed Appendices are being withheld in their entirety or in part under the Exemption No.(s) of the PA and/or the FOIA as indicated below (5 U.S.C. 552a and/or 5 U.S.C. 552(b)).

- ☐ Exemption 1: The withheld information is properly classified pursuant to Executive Order 12958.
- ☐ Exemption 2: The withheld information relates solely to the internal personnel rules and procedures of NRC.
- ☐ Exemption 3: The withheld information is specifically exempted from public disclosure by statute indicated.
  - ☐ Sections 141-145 of the Atomic Energy Act, which prohibits the disclosure of Restricted Data or Formerly Restricted Data (42 U.S.C. 2161-2165).
  - ☐ Section 147 of the Atomic Energy Act, which prohibits the disclosure of Unclassified Safeguards Information (42 U.S.C. 2167).
  - ☐ 41 U.S.C., Section 253(b), subsection (m)(1), prohibits the disclosure of contractor proposals in the possession and control of an executive agency to any person under section 552 of Title 5, U.S.C. (the FOIA), except when incorporated into the contract between the agency and the submitter of the proposal.
- ☐ Exemption 4: The withheld information is a trade secret or commercial or financial information that is being withheld for the reason(s) indicated.
  - ☐ The information is considered to be confidential business (proprietary) information.
  - ☐ The information is considered to be proprietary because it concerns a licensee's or applicant's physical protection or material control and accounting program for special nuclear material pursuant to 10 CFR 2.790(d)(1).
  - ☐ The information was submitted by a foreign source and received in confidence pursuant to 10 CFR 2.790(d)(2).
- ☑ Exemption 5: The withheld information consists of interagency or intraagency records that are not available through discovery during litigation. Applicable privileges:
  - ☐ Deliberative process: Disclosure of predecisional information would tend to inhibit the open and frank exchange of ideas essential to the deliberative process. Where records are withheld in their entirety, the facts are inextricably intertwined with the predecisional information. There also are no reasonably segregable factual portions because the release of the facts would permit an indirect inquiry into the predecisional process of the agency.
  - ☐ Attorney work-product privilege. (Documents prepared by an attorney in contemplation of litigation)
  - ☑ Attorney-client privilege. (Confidential communications between an attorney and his/her client)
- ☑ Exemption 6: The withheld information is exempted from public disclosure because its disclosure would result in a clearly unwarranted invasion of personal privacy.
- ☑ Exemption 7: The withheld information consists of records compiled for law enforcement purposes and is being withheld for the reason(s) indicated.
  - ☐ (A) Disclosure could reasonably be expected to interfere with an enforcement proceeding (e.g., it would reveal the scope, direction, and focus of enforcement efforts, and thus could possibly allow recipients to take action to shield potential wrongdoing or a violation of NRC requirements from investigators).
  - ☑ (C) Disclosure would constitute an unwarranted invasion of personal privacy.
  - ☐ (D) The information consists of names of individuals and other information the disclosure of which could reasonably be expected to reveal identities of confidential sources.
  - ☐ (E) Disclosure would reveal techniques and procedures for law enforcement investigations or prosecutions, or guidelines that could reasonably be expected to risk circumvention of the law.
  - ☐ (F) Disclosure could reasonably be expected to endanger the life or physical safety of an individual.
- ☐ OTHER (Specify)

PART II.B -- DENYING OFFICIALS

Pursuant to 10 CFR 9.25(g), 9.25(h), and/or 9.65(b) of the U.S. Nuclear Regulatory Commission regulations, it has been determined that the information withheld is exempt from production or disclosure, and that its production or disclosure is contrary to the public interest. The person responsible for the denial are those officials identified below as denying officials and the FOIA/PA Officer for any denials that may be appealed to the Executive Director for Operations (EDO).

DENYING OFFICIAL	TITLE/OFFICE	RECORDS DENIED	APPELLATE OFFICIAL		
			EDO	SECY	IG
James E. Dyer	**Regional Administrator, RIII**	**Appendix B**	**XX**		
Guy P. Caputo	**Director, Office of Investigations**	**Appendix C**	**XX**		

Appeal must be made in writing within 30 days of receipt of this response. Appeals should be mailed to the FOIA/Privacy Act Officer, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, for action by the appropriate appellate official(s). You should clearly state on the envelope and letter that it is a "FOIA/PA Appeal."

Re: FOIA-00-0243

APPENDIX A
RECORDS BEING RELEASED IN THEIR ENTIRETY
(If copyrighted identify with *)

NO.	DATE	DESCRIPTION/(PAGE COUNT)
1.	01/05/98	ARB Minutes (4 pages)
2.	03/31/98	ARB Minutes (5 pages)
3.	06/09/98	ARB Minutes (1 page)
4.	05/17/99	ARB Minutes (9 pages)
5.	11/29/99	ARB Minutes (13 pages)
6.	01/11/00	ARB Minutes (6 pages)
7.	01/15/00	ARB Minutes (1 page)
8.	01/24/00	ARB Minutes (7 pages)

Re: FOIA-00-0243

APPENDIX B
RECORDS BEING WITHHELD IN PART

NO.	DATE	DESCRIPTION/(PAGE COUNT)/EXEMPTIONS
1.	09/09/98	ARB Minutes (5 pages) (**EX. 6 & 7C**)
2.	09/21/98	ARB Minutes (5 pages) (**EX. 6 & 7C**)
3.	10/13/98	ARB Minutes (27 pages) (**EX. 6 & 7C**)
4.	08/02/99	ARB Minutes (14 pages) (**EX. 6 & 7C**)
5.	10/04/99	ARB Minutes (4 pages) (**EX. 6 & 7C**)
6.	10/25/99	ARB Minutes (13 pages) (**EX. 6 & 7C**)
7.	12/20/99	ARB Minutes (15 pages) (**EX. 6 & 7C**)

Re: FOIA-2000–0243

APPENDIX C
RECORDS BEING WITHHELD IN PART

NO.	DATE	DESCRIPTION/(PAGE COUNT)/EXEMPTIONS
1.	06/25/98	Office of Investigations' Case No. 3-1998-014: Byron Nuclear Station - Alleged Deliberate Violation of a Radiations Protection Procedure by a Contract Senior health Physics Technician. (20 pages) **EX. 5, 6 & 7C**
2.	01/19/00	Office of Investigations' Case No. 3-1999-036: Byron Nuclear Generating Statio - Deliberate Violation of Compromising the Integrity of a Senior Ractor Operator Simulator Test. (15 pages) **EX. 6 & 7C**

SENSITIVE ALLEGATION MATERI

ALLEGATION ACTION PLAN AMS NO. RIII-97-A-0256

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS/PSB2

Allegation Review Board Membership:

Chairman - G. Grant / ~~C. Pederson~~

R. Paul - OI / ~~B Berson~~

M. Jordan, RPB3

J. Hopkins / ~~R. Doombos~~

G. Shear, PSB2

J. Grobe / ~~J. Jacobsen (DRS)~~

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE: There does not appear to be an immediate threat to public health & safety. Licensee appears to have taken prompt and aggressive corrective actions.

OI ACCEPTANCE: YES (NO) (Priority: **HIGH NORMAL LOW**)

Basis for priority:: OI will review licensee's investigation report and then determine next action.

COMMENTS:

A/1

(5)

GEGrant

Allegation Review Board Chairman

1-5-98

Date

SENSITIVE ALLEGATION MATERIAL

AMS No. RIII-97-A-0256

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1
A contract worker identified a senior contract radiation protection technician (RPT) who was asleep within the Unit 1 Containment Building. Station procedures prohibit activities such as loitering in radiologically posted areas.

Regulatory Basis:
Potential Deliberate Violation of TS 6.11 (Following Radiation Procedures).

I. Action Evaluation: The following method of resolution is recommended (circle):

(A) Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)

B. Priority RIII Follow up and Closure Memo to OAC

C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC

(D) Refer to OI

E. No Action - Outside NRC's Charter. Describe Basis in Closure Memo to OAC w/in ____ days.

F. No Action - Without Merit. Describe Basis in Closure Memo to OAC w/in ____ days.

(G) Other (specify) - Request copy of licensee's investigation report, 30 days

Responsible for Action - EICS

II. Special Considerations/Instructions:

- EICS request licensee's investigation report
- PSB 2 to review response
- Provide copy of licensee's response to OI.
- Follow up ARB after PSB 2 reviews licensee response.

SENSITIVE ALLEGATION MATERIAL

NEW ALLEGATION: RIII-97-A-0256

December 29, 1997

MEMORANDUM TO: G. Shear, Chief, PSB2, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC J. Hopkins 12-29-97

SUBJECT: **RECEIPT OF NEW ALLEGATION: RIII-97-A-0256 (Byron)**

On 12/23/97, RIII received a licensee identified allegation concerning a potential deliberate violation of radiation protection procedures. **An Allegation Review Board (ARB) for this/these issues has been tentatively scheduled for Monday 1/5/98.** Please review the following information to prepare for the ARB:

1) Review the Background Information attached to ensure all of the issues have been identified. Modify if needed. Contact the OAC before the ARB if modifications are needed.

2) **At the ARB be prepared to:**
Recommend a method to resolve each concern from the below examples.
Recommend a completion date.

REMINDER - THE PURPOSE OF THE ARB IS NOT TO DETERMINE WHO/WHAT/WHEN/WHERE/WHY OR HOW YOU WILL INSPECT, BUT WHEN THE INSPECTION WILL BE COMPLETED.

Below are examples of methods to resolve each concern:

A. Send to Licensee Requesting Response in _____ Days (At the ARB, be prepared to discuss the areas we expect the licensee to address.)
B. Priority RIII Follow up
C. Follow up During Routine Inspection Within _____ Days
D. Refer to OI
E. No Action - Outside NRC's Charter (At the ARB, be prepared to discuss the basis)
F. No Action - Without Merit (At the ARB, be prepared to discuss the basis)
G. Other (At the ARB, be prepared to discuss the specifics)

cc w/attachments:
ARB Copy
OI - RIII
RC - RIII
DRP Br Chief RPB3
DRS Division Director

cc w/ Summary of Concerns:
Deputy Regional Administrator

4

December 23, 1997

NOTE TO: Jay Hopkins, Senior Allegations Coordinator, EICS

FROM: Steven Orth, Senior Radiation Specialist, DRS

SUBJECT: POTENTIAL DELIBERATE VIOLATION OF RADIATION PROTECTION PROCEDURES AT BYRON STATION

On December 23, 1997, I was notified by the radiation protection manager (RPM) of an event that occurred at about 8:30 pm on December 20, 1997, at Byron Station. A contract worker identified a senior contract radiation protection technician (RPT) who was asleep within the Unit 1 Containment Building. Station procedures prohibit activities such as loitering in radiologically posted areas.

The RPT had started his shift (6 pm to 6 am) and was sent into containment at about 8:00 pm to perform routine oversight of work activities and surveys (i.e., containment rover). At about 8:30 pm, a contract worker found the RPT sleeping under the Unit 1 accumulator on the 426' elevation of Unit 1. The worker summoned two supervisors, who confirmed that the individual was truly asleep. The tank has a false bottom with an access manway. Apparently, the RPT crawled through the manway and fell asleep within the false tank bottom. The dose rates in the area were less than 1 millirem per hour.

The licensee immediately escorted the RPT offsite, and the contract organization terminated the RPT. The licensee initiated a problem identification form to document the occurrence.

Based on the initial details, it appears that the RPT may have crawled under the tank to find a inconspicuous area to fall asleep. Potentially, this may be a deliberate violation of plant radiation protection procedures by a senior contract RPT.

cc: G. Shear, DRS
M. Jordan, DRP

(3)

AMS RIII-97-A-0256

SENSITIVE ALLEGATION MATERIAL

APPROVED ARB ACTION PLAN

RIII-98-A-0256 (Byron)

March 31, 1998

MEMO TO: R. Paul, OI Field Director, RIII

FROM: J. Hopkins /R. Doornbos, RIII - OAC

SUBJECT: APPROVED ARB ACTION PLAN

Attached is your copy of the allegation action plan approved at the 3/30/98 ARB. Please take the assigned actions and when completed, please provide documentation of the results of those actions to EICS.

cc w/o attachments AMS File No. RIII-97-A-0256

SENSITIVE ALLEGATION MATERIAL

A/2

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FOLLOW UP ALLEGATION ACTION PLAN AMS NO. RIII-97-A-0256

****

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS / PSB2 - G. Shear

****

Allegation Review Board Membership:

Chairman - ~~G. Grant~~ M. Lapas

R. Paul - OI / B. Berson

G. Shear

J. Hopkins / R. Doornbos

M. Leach for J. Grobe

~~J. Grobe / (DRS)~~

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE: ~~No immediate significance because the individual no longer works for Comed - However - Has Significance~~ because the person may still work for the Contractor

OI ACCEPTANCE: (YES) NO (Priority: (HIGH) NORMAL LOW)

OI has Accepted Concern(s) No(s). 1

Signature of Accepting OI Official: R. C. Paul

Basis for OI Priority: Upper level RPT with potential for continued employment in the industry

COMMENTS:

Mark J Lapas
Allegation Review Board Chairman

3/30/98
Date

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SENSITIVE ALLEGATION MATERIAL

AMS No. RIII-97-A-0256

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No.1
Potential deliberate violation of RP Procedures - A contract worker identified a senior contract radiation protection technician (RPT) who was asleep within the Unit 1 Containment Building. Station procedures prohibit activities such as loitering in radiologically posted areas.

Regulatory Basis:
Potential deliberate violation of TS 6.11 (failure to follow procedures) BRP 5000 -7

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI
E. No Action - Outside NRC's Charter. Describe Basis in Closure Memo to OAC w/in ____ days.

F. No Action - Without Merit. Describe Basis in Closure Memo to OAC w/in ____ days.

G. Other (specify)

Responsible for Action - PSB2 to Review ~~Items~~ OI Report/Transcripts.

II. Special Considerations/Instructions:

SENSITIVE ALLEGATION MATERIAL

FOLLOW UP ARB: RIII-97-A-0256

March 19, 1998

MEMORANDUM TO: G. Shear, Chief, Plant Support Branch 2, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC

SUBJECT: **FOLLOW UP ARB: RIII-97-A-0256 (Byron)**

PSB2 has requested a follow-up ARB in order to refer the case to OI. **A Follow up ARB has been scheduled for March 30, 1998.** Please review the following information to prepare for the ARB:

1) Review the attached information. Contact the OAC before the ARB if needed.

2) **At the ARB be prepared to:**
Discuss the status of each concern (as applicable).
Recommend a method to resolve each concern discussed.
Recommend a completion date.

Below are examples of methods to resolve each concern:

A. Send to Licensee Requesting Response in _____ Days (At the ARB, be prepared to discuss the areas we expect the licensee to address.)
B. Priority RIII Follow up
C. Follow up During Routine Inspection Within _____ Days
D. Refer to OI
E. No Action - Outside NRC's Charter (At the ARB, be prepared to discuss the basis)
F. No Action - Without Merit (At the ARB, be prepared to discuss the basis)
G. Other (At the ARB, be prepared to discuss the specifics)

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director For Rx Cases
H.B. Clayton (Wrongdoing)

cc w/ Summary of Concerns:
Deputy Regional Administrator

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

March 13, 1998

MEMORANDUM TO : J. Hopkins, Senior Allegations Coordinator

FROM: Gary L. Shear, Chief, Plant Support Branch 2

SUBJECT: REVIEW OF LICENSEE INVESTIGATION REPORT NO. RIII-97-A-0256 (BYRON)

Reference: March 2, 1998 Memorandum; J. Hopkins to G. Shear

The referenced memorandum requested that my staff evaluate the results of the licensee's review of the subject allegation. The concern was referred to the Byron Station for follow up via NRC letter dated January 30, 1998. The licensee submitted the results of its review in letter dated February 27, 1998. This letter makes note of notification to the Region III radiation protection inspector, and states that the inspector reviewed the investigation and found the corrective actions acceptable. The only discussion held regarding this issue with anyone in Plant Support Branch 2 (PSB2) was the original notification. Immediate corrective actions were mentioned by the licensee during that conversation, however, no review of the investigation was performed until this documented review.

The licensee's investigation was performed by the ComEd Health Physics Support Department and did substantiate the concern. The review was an independant review that was of sufficient scope to address the concern. PSB2 agrees with the conclusion of the investigation. The investigation determined that the individual was found asleep under the B accumulator. It further states that the contract RPTs actions were 'covert' and that he intentionally found a place to 'hide'. The contract RPT was terminated by Numanco for sleeping on duty. No new concerns were identified in the licensee's review.

Based on our review of the licensee's investigation, we recommend that the concern be reboarded and referred to the Office of Investigations regarding the willful nature of the violation.

CONTACT: D. Nissen
(630)829-9744

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MEMO TO FILE: RIII-1997-A-0256 (Byron)

FROM: R. L. Doornbos, OAC

DATE: June 9, 1998

SUBJECT: 6 Month ARB

According to Management Directive 8.8, the OI monthly status briefing can be used for the 6 Month ARB, so long as only the OI investigation related concern is all that remains open. For the aforementioned file, the OI status briefing held today meets the requirements of MD 8.8 and serves to be the 6 Month ARB. The case status and priority were discussed and no changes were determined to be need at this time.

Those in attendance were:
J. Caldwell
R. Paul (OI)
C. Pederson (DNMS)
R. Gardner (for J. Grobe, DRS)
R. Doornbos, OAC

A/3

SENSITIVE ALLEGATION MATERIAL

FOLLOW UP ALLEGATION ACTION PLAN AMS NO. RIII-98-A-0146

****

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS/PSB

****

Allegation Review Board Membership:

Chairman - ~~G. Grant~~ J. Grobe

R. Paul - OI / ~~B. Berson~~

~~G. Shear~~ J. Foster for G. Shear

~~J. Hopkins /~~ R. Doornbos / B. Clayton

M. Jordan

~~J. Grobe / S. Reynolds (DRS)~~

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: _____

_____

OI ACCEPTANCE: ~~YES NO (Priority: HIGH NORMAL LOW)~~ OI Case 3-1998-038
OI had initially accepted the discrimination case (concern # 3) w/ a NORMAL Priority.

OI has Accepted Concern(s) No(s). ↗

Signature of Accepting OI Official: _____

Basis for OI Priority: _____

- ARB MINUTES PROVIDED TO _Dyer, OI, Shear Provided 5/19/99

COMMENTS:
Revised MD 8.8, Handbook Part I, C, 4 (pages 21 - 25) requires that an ARB be re-convened after the staff has reviewed the initial OI interview. This ARB will review the circumstances of the allegation in a broader context to determine if OI should defer its investigation and wait the results of the DOL investigation.

Concern 1 - Chilling Effect; Concern # 3 - Discrimination.

PLEASE CHECK ONE:

____ OI TO DEFER ITS INVESTIGATION AND WAIT THE RESULTS OF THE DOL INVESTIGATION.

✓ OI TO CONTINUE ITS INVESTIGATION WITH NORMAL PRIORITY.

John A. Grobe
Allegation Review Board Chairman

5/17/99
Date

A/4

5C

RIII-98-A-0146 (Byron) OI CASE NO. 3-1998-038

Revised MD 8.8, Handbook Part I, C, 4 (pages 21 - 25) requires that an ARB be re-convened after the staff has reviewed the initial OI interview. This ARB should review the circumstances in a broader context considering:

- the history of discrimination cases at the facility, **SEE TABLE**
- trends (if any) related to technical or discrimination allegations, **NO**
- trends (if any) in settlement of discrimination cases, **NO**
- trends (if any) to findings of discrimination cases by DOL, **SEE TABLE**
- trends (if any) related to NRC enforcement actions, **DISCUSS AT ARB**
  LICENSEE ASKED TO RESPOND TO ALLEGATIONS OF A CHILLED ENVIRONMENT. THE NRC RIII MANAGEMENT REVIEWED LICENSEE'S INITIAL WRITTEN RESPONSE AND CONCLUDED THAT MOST OF THE ALLEGATIONS OF A CHILLED ENVIRONMENT AT THE SITE COULD BE SUBSTANTIATED. PUBLIC MEETING SCHEDULED FOR 5/27/99 FOR LICENSEE TO RESPOND TO ADDITIONAL NRC QUESTIONS RELATED TO ITS INITIAL RESPONSE.

- if this case has generic or unique legal implications, **NONE APPARENT**
- if DOL is investigation (or adjudicating) the case, **AD DID NOT FIND MERIT. CI NOT APPEAL**
- if there are any generic or programmatic weaknesses identified by OI during the investigation. **NONE**
- if there were any new technical or regulatory issues raised by the CI during the interview, disposition them appropriately. **SEE 3/24/99 MEMO FROM DRS TO EICS (attached).**

Based on the results of the above issues and/or question, the ARB should determine the further disposition of the case as outlined below:

(i) For HIGH or NORMAL cases which DOL is pursuing an investigation, the ARB will request that OI defer its investigation and wait the results of the DOL investigation, UNLESS:

- in the previous 24 months, there has been a finding by NRC or DOL that the licensee discriminated against an employee, **NO**
- the alleged discriminatory act is particularly egregious, **NOT APPEAR TO BE PARTICULARLY EGREGIOUS.**
- the existence of related licensee performance issues indicating a deteriorating safety conscious work environment (e.g., the findings of other ongoing discrimination investigations, or relevant licensee problems in identifying and resolving safety concerns) lends credibility and/or potential significance to the discrimination allegation under investigation. **DISCUSS AT ARB**

(ii) For discrimination investigations that do not meet the criteria to be deferred, the ARB will request that OI perform a full investigation.

(iii) For instances where there are multiple open discrimination allegations involving a licensee with a history of adverse OI or DOL discrimination findings or other **relevant performance characteristics** which would indicate an environment not conducive to raising safety concerns, the ARB should consider additional actions to supplement investigations.

Other **relevant performance characteristics** include:

(1) a lack of effective evaluation, follow -up, or corrective actions for findings made by the licensee's QA or oversight organization or concerns raised to the ECP,
(2) licensee ineffectiveness in identifying safety issues,
(3) delays in or absence of feedback for concerns raised in the ECP, or
(4) breaches of confidentiality for concerns raised in the ECP.

These supplemental actions may include:

- a meeting with licensee management;
- a review of the licensee's ECP (Inspection Program 40501);
- a request or order that the licensee obtains an independent evaluation of its environment fro raising safety concerns;
- an order to establish independent third party oversight of the environment for raising concerns; or
- other actions as appropriate.

These actions should be coordinated with appropriate levels of NRC management. Note that the Commission has stated that they are to be consulted prior to ordering a licensee to conduct a survey or hire an independent third party to oversee the work environment.

For OI investigations that are deferred, the decision will be reviewed as each stage of the DOL process is completed. Following NRC review of the DOL Area Director's decision (and the DOL investigators' report) or the ALJ's decision, an ARB will review the previous ARB's decision to defer the OI investigation. The ARB should consider whether an OI investigation is necessary to provide information beyond that provided in the DOL process in order to reach a decision on whether to proceed with an enforcement action.

The rational for deferring the OI investigation will be documented in the ARB minutes. The Agency Allegation Advisor (AAA) will be notified of a deferral and a copy of the ARB minutes will be provided. The AAA will coordinate the review with OI and OE.

RIII-98-A-0146 (Byron) OI CASE NO. 3-1998-038

Byron Discrimination Allegations Since 5/97

Case #	Status	Substantiated	Filed w/DOL	AD	Appeal	Results	OI # PRIORITY
98-a-146	Open		Yes	No Merit	No		3-98-038 NORMAL
99-a-060	Closed	CI not want NRC to continue investigation. Not reveal ID.	No				Not accept case.

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1
You stated that you were screamed at for writing a problem identification form (PIF), with words such as "while you were writing your PIF, I had to have somebody else do your job" used by your supervisor. You felt a chilling effect for writing PIFs.

Regulatory Basis: Chilled Environment

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI. Recommended Priority: HIGH NORMAL LOW
Recommended Basis:
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
G. Other (specify) -

Responsible for Action - _____

II. Special Considerations/Instructions:

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 3
You believe that being given a day off (September 28, 1998) without pay was in retaliation for writing Problem Identification Form XXXX (see case file for number & title). You believe that not being allowed to begin an assignment at Braidwood on September 28 and therefore losing a weeks worth of overtime wages, was in retaliation for writing PIF XXXX.

Regulatory Basis: 10 CFR 50.7

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI. Recommended Priority: HIGH NORMAL LOW
Recommended Basis:
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
G. Other (specify) -

Responsible for Action - _____

II. Special Considerations/Instructions:

SENSITIVE ALLEGATION MATERIAL

FOLLOW UP ARB: RIII-98-A-0146

May 12, 1999

MEMORANDUM TO: G. Shear, Chief, PSB, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC J. Hopkins 5-12-99

SUBJECT: **FOLLOW UP ARB: RIII-98-A-0146 (Byron)**
OI Case No. 3-1998-038

Revised MD 8.8, Handbook Part I, C, 4 (pages 21 - 25) requires that an ARB be re-convened after the staff has reviewed the initial OI interview for discrimination (concern # 3). PSB documented its review of the initial OI interview in a memo date 3/24/99. A copy of the memo is attached. PSB recommended that the OI priority remain at NORMAL.

The 3/24/99 memo from PSB also recommends that the chilling effect issue (concern # 1) be included in the broader chilling effect letter to the licensee.

The DOL-OSHA Area Director (AD) did NOT find merit in the CI's discrimination case. The AD's decision was dated 12/30/98. The CI had 5 days to file an appeal w/ the DOL-ALJ. Based on my conversations with a clerk for the ALJ's office on 5/11/99, with the a staff member for the CI's attorney on 5/12/99, and a voice mail message from the DOL Whistle Blower specialists for DOL Region V, it does not appear that the CI appealed the AD's decision.

This ARB will review the circumstances of the allegation in a broader context to determine if OI should defer its investigation and wait the results of the DOL investigation. **A Follow up ARB has been scheduled for Monday, 5/17/99.** Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director
B. Clayton

SENSITIVE ALLEGATION MATERIAL

May 12, 1999

MEMO TO: G. Shear, Chief, Plant Support Branch, DRS

FROM: J. Hopkins, Senior Allegation Coordinator J. Hopkins 5-12-99

SUBJECT: CONVERSATION WITH CONCERNED INDIVIDUAL (CI)
AMS No. RIII-98-A-0146 (Byron); OI Case No. 3-1998-038

DOL-OSHA's Area Director's Decision

- The DOL-OSHA Area Director (AD) did NOT find merit in the CI's discrimination case. The AD's decision was dated 12/30/98. The CI had 5 days to file an appeal w/ the DOL-ALJ.

  On 5/12/99, the DOL-OSHA Whistle Blower specialists for DOL Region V, John Rizzo, left me a voice mail message that he was not aware that the CI had filed an appeal.

- I contacted the CI on 5/11/99 and asked if the CI had filed an appeal w/ the ALJ's office. The CI stated that I should contact the CI's attorney. The CI gave me verbal permission to speak to the attorney regarding the CI's discrimination case. (See serial # 1 in the case file for the attorney's name and telephone number.)

  Based on my conversation with a staff member for the CI's attorney on 5/12/99, the CI did not appeal the AD's decision.

- Based on my conversation with a clerk for the ALJ's office on 5/11/99, the CI did not appeal the AD's decision.

Other Information Developed During the Conversation:

- The CI stated that things had not gotten any better for him/her. The CI stated that things were still being done wrong by management. The CI agreed to provide specific examples in a letter to the NRC.

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FOLLOW UP ALLEGATION ACTION PLAN AMS NO RIII-99-A-0130

****

Licensee: Byron

Docket/License No: 50-454

Assigned Division/Branch: DRS/OLB

****

Allegation Review Board Membership:

Chairman - ~~G. Grant~~ J Grobe

R. Paul - OI /~~B. Berson~~ Mary Kay Fahrer

D. Hills

J. ~~Hopkins~~ Horlor /~~J. Adams / B. Clayton~~

M. Jordan

~~J. Grobe / S. Reynolds (DRS)~~

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: No immediate threat to public health and safety.

OI ACCEPTANCE: YES: **HIGH**

OI has Accepted Concern No. __#1__ on 9/13/99

Signature of Accepting OI Official: _____

Basis for OI Priority: _____

STATUS LETTER: PRINT IN FINAL _____ REVISE _____ N/A ✓

ACKNOWLEDGMENT LETTER: PRINT IN FINAL _____ REVISE _____ N/A ✓

REFERRAL LETTER: YES _____ NO ✓

- ARB MINUTES PROVIDED TO: Dyer / Hills / Jordan 11/30/99 BSH

COMMENTS:

Allegation Review Board Chairman

11/29/99
Date

A/5

SENSITIVE ALLEGATION MATERIAL

AMS No. RIII-99-A-0130

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1: A potential compromise of test material may have occurred on July 27, 1999, when the Shift Operation Supervisor (SOS) discussed relative information with one licensed crew prior to performing an evaluation scenario.

Regulatory Basis: 10 CFR 50.49

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI. Recommended Priority: HIGH NORMAL LOW
Recommended Basis:
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
****** **G. Other (specify) - Based upon the information reviewed, we recommend that Allegation RIII-99-A-0130 not be referred to OI because there is no violation of NRC requirements involved. However, because a verbal agreement between the NRC and the licensee had allegedly been circumvented, we recommend that the Region III Division of Reactor Safety management conduct a conference call with the licensee to discuss the occurrence. The results of that call would be referenced in the response to the concerned individuals.**

Responsible for Action - DRS to call and provide documentation of conversation to EICS. EICS to close.

II. Special Considerations/Instructions:

OL - Call the Licensee to implement ~~DOCC~~ Document call in a memo to EICS Due 12/13/99

~~DSE~~ Use of PIF 1999-02673 ~~will not~~ as the source of the concern will not compromise the identity of CP.

November 22, 1999

MEMORANDUM TO: H. Brent Clayton, Enforcement Investigations Officer

THRU: David E. Hills, Chief, Operations Branch
/s/ David E. Hills

FROM: Dell McNeil, Reactor Inspector
/s/ Dell McNeil

SUBJECT: ALLEGATION RIII-99-A-0130 (OI CASE NO. 3-99-036)
(AITS S00-2016)

99-A-0193

We have completed our reviews of Allegation RIII-99-A-130. As described below, we concluded that the original concern of Allegation RIII-99-A-0130 should not be referred to the Office of Investigations (OI) for investigation and should be handled by the inspection staff through discussion with the licensee. The new concerns identified during OI interviews should be opened with a new allegation number. One of the new concerns (discrimination complaint) should be referred to OI for investigation. Recommendations for the other new concerns are described below. An Allegation Review Board should be conducted for these concerns.

Original Concern for Allegation RIII-99-A-0130

Allegation RIII-99-A-0130 involved a potential willful violation of 10 CFR 55.49 regarding the alleged compromise of the integrity of a Byron evaluative training scenario administered to a license crew. This scenario was administered to all crews following failure of a significant number of crews on the simulator during the previous training cycle to complete actions in the time allowed by the FSAR for a steam generator tube rupture (SGTR). Per discussion with NRC management, licensee management had agreed that these evaluative scenarios would be performed with no prior content knowledge by the examined crews in order to provide greater confidence that the crews could respond appropriately in an actual event. The concerned individual had indicated to the NRC that, contrary to this verbal agreement, a Shift Operating Supervisor, who was knowledgeable of the agreement had intentionally trained the crew on this scenario just prior to the exam, and hence had compromised the integrity of the exam.

During an operator licensing counterpart call (including the Headquarters program office for operator licensing), the general consensus at that time was that 10 CFR 55.49, which requires that examination integrity not be compromised for exams and tests required by 10 CFR Part 55, was applicable to this situation. (While the evaluative scenario was not required directly by 10 CFR Part 55, 10 CFR 55.59(c) requires a requalification program approved by the NRC and the licensee's approved program references evaluative scenarios.) Based upon this information,

the Allegation Review Board of August 2, 1999, directed that the Region III Operations Branch develop and provide to the Regional Counsel a draft Notice of Violation (NOV) for review. If the Regional Counsel concurred that a viable NOV existed, then OI agreed to accept referral. The Operations Branch subsequently provided the draft NOV. In the interim, the Office of Investigations opted to interview the two concerned individuals, resulting in the new concerns discussed below. After review of the draft NOV, the Regional Counsel declined to provide an opinion, instead requesting that the 10 CFR 55.49 applicability question be directed again to the Headquarters program office for operator licensing. After further program office review, Mr. Dave Trimbel, Chief, Operator Licensing and Human Performance Section, during a telephone conference call on November 11, 1999, informed Mr. David Hills, Chief, Operations Branch, that the program office had concluded that a violation of 10 CFR 55.49 was not applicable to this situation. In addition, during a discussion between Mr. Jim Heller (Allegation Coordinator), Mr. David Hills (Operations Branch Chief), and Mr. Bruce Berson (Regional Counsel), the general consensus was that 10 CFR 50.5, "Deliberate Misconduct," and 10 CFR 50.9, "Completeness and Accuracy of Information," were also not applicable.

Recommendation: Based upon the above information, we recommend that Allegation RIII-99-A-0130 not be referred to OI because there is no violation of NRC requirements involved. However, because a verbal agreement between the NRC and the licensee had allegedly been circumvented, we recommend that the Region III Division of Reactor Safety management conduct a conference call with the licensee to discuss the occurrence. The results of that call would be referenced in the response to the concerned individuals.

New Concerns Identified During OI Interviews

During the OI interviews mentioned above, the concerned individuals communicated the following concerns as indicated by the referenced lines in the OI transcript:

Concern #1

Page 12, Lines 9-[illegible] - The station is providing false information to the NRC regarding SGTR response times in that one crew was intentionally trained on actions for the SGTR scenario just before its administration so that they would pass, thereby circumventing the purpose of providing confidence that required response times would be met during an actual event.

Regulatory Basis: 10 CFR 50.9(a) requires that information provided to the Commission by a licensee shall be complete and accurate in all material respects.

Recommendation: Training of this one crew on scenario content just prior to administration of the scenario, was not material to the NRC's evaluation of this issue. The NRC staff had observed the same evaluative scenario successfully administered to other crews and was aware of the alleged improper pre-conditioning of this one crew when evaluating the response of the licensee to this issue. The impact of this improper training was the elimination of one data point meant to build confidence in the crews' ability to properly respond to a real event. The remaining crews were sufficient to provide that confidence. This should be communicated in the response letter to the concerned individual. Regardless of how and when they were

trained, the subject crew did successfully complete the evaluative scenario and therefore demonstrated knowledge to properly respond.

Concern #2

Page 14, Lines 7-8 - The station failed to ensure requalification training examination security by allowing crews who have seen the examinations to interface with crews that will be examined using the same examination materials.

Regulatory Basis: Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether this practice violates those requirements.

Concern #3

Page 16, Lines 12-23; Page 17, Lines 2-13 - The training department and other evaluators passed one crew on an evaluated scenario during the last training cycle when the crew should have failed. They were reluctant to fail too many crews, and in this instance they had just failed the morning crew and so did not want to fail the afternoon crew.

Regulatory Basis: Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether this practice violates those requirements.

Concern #4

Page 22, Lines 4-20; Page 41, Lines 1-3 & 20-24 - A. The concerned individual had been labeled a whistle blower because he had come to the NRC before on a different matter and that this had a chilling effect. (The specific matter was not mentioned, nor who had labeled him a whistle blower.) B. The concerned individual had also researched and wrote a PIF involving a problem with gas decay tanking and his supervisor indicated that if he had time to write PIFs like that then the supervisor would find the concerned individual more to do. Therefore, the concerned individual would not write more PIFs like that anymore. C. Station personnel found out that the concerned individual's raise was less than others when the grade classification was changed for his job (see Concern #6) and that this action is telling everyone that if you write a PIF it's going to affect you salary or your promotion series.

Regulatory Basis: NRC Policy Statement on Safety Conscious Working Environment (Chilled Environment)

Recommendation: EICS to ask the concerned individual for permission to follow-up on this concern. (Follow-up would likely disclose the identity of the concerned individual.) If follow-up is allowed, then refer parts A & B to the licensee for evaluation. In the referral letter, ask the licensee to address these incidents in reference to the effectiveness of actions they indicated that they would take during the public meeting on chilling effect. Refer part C of this concern to the licensee for evaluation after OI completes its investigation of Concern #6.

Concern #5

Page 25, Lines 3-7 - One SRO (name in transcript) did not take the annual operating exam because the licensee allowed him to instead take credit for training evaluation scenarios.

Regulatory Basis: 10 CFR 55.59(a)(2) requires that a licensee (licensed operator) shall pass a comprehensive requalification written examination and an annual operating test. The alleged process does not appear to conform to a comprehensive test or examination. (Comprehensive means that the facility licensee evaluate all the respective parts together.)

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address whether and how they believe the practice meets 10 CFR 55.59(a)(2) for a comprehensive exam.

Concern #6

Page 32, Lines 2-15; Page 36, Lines 7-25; Page 37, Lines 1-13; Page 42, Lines 17-25; Page 43, Lines 1-7; Page 49, Lines 1-6 - Within a week after writing the PIF regarding the SGTR scenario preconditioning, the concerned individual received a letter in his file for missing a day of training several months before without pre-approval. The concerned individual admitted that he had missed the work because he mistakenly thought he had the day off, but that another operator had missed training that week and did not receive a letter. The concerned individual indicated that the letter was retribution for being a whistle blower. In addition, after writing the PIF, the facility licensee changed his position, along with other individuals, from a level 6 to a level 8, but raised his salary less than they raised others making the same change. In addition, after writing the PIF, the facility licensee did not pick him for the shift manager program, although others picked were newer than the concerned individual. In a previous incident about six years ago, the concerned individual and one other individual did not get shift premium for filling in (rotating in) for the work control position, although those before and after were paid, because the concerned individual and the other individual brought a safety concern to the supervisor. The safety concern involved control room operators coming in drunk. (No other details are given for this last safety concern, although the concerned individual indicated that he had raised it to the NRC at the time.) (Concerned individual gave permission to release his name in followup to this concern.)

Regulatory Basis: 10 CFR 50.7(a) requires that discrimination by a Commission licensee against an employee for engaging in certain protected activities is prohibited.

Recommendation: Refer to OI for investigation.

Concern #7

Page 45, Lines 17-25; Page 46, Lines 1-7 - Training has been significantly reduced (A. Systems training for "B" operators because they are trying to upgrade to EOs / B. Licensed operator requalification training so operators can fill in during outages).

Regulatory Basis: 10 CFR 55.120(b)(3) requires that the licensee have a training program for non-licensed operators that provides qualified personnel to operate and maintain the facility in a safe manner. Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC for licensed operators. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Part A is already covered by an existing allegation (RIII-99-A-0049). The licensee responded to this allegation on November 8, 1999, and that response is currently being evaluated by the Operations Branch. Therefore, part A should be closed in reference to the existing allegation. Refer part B to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether the reduced training violates those requirements.

SENSITIVE ALLEGATION MATERIAL

FOLLOW UP ARB: RIII-99-A-0130

November 24, 1999

MEMORANDUM TO: D. Hills, Chief, Operations Branch, DRS

FROM: J. Heller /J. Adams, RIII - OAC

SUBJECT: **FOLLOW UP ARB: RIII-99-A-0130 (Byron)**

A follow up ARB is needed to review the recommendation and the closure of this allegation.

A Follow up ARB has been scheduled for November 29, 1999. Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director For Rx Cases

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

November 22, 1999

MEMORANDUM TO: H. Brent Clayton, Enforcement Investigations Officer

THRU: David E. Hills, Chief, Operations Branch

FROM: Dell McNeil, Reactor Inspector

SUBJECT: ALLEGATION RIII-99-A-0130 (OI CASE NO. 3-99-036) (AITS S00-2016)

We have completed our reviews of Allegation RIII-99-A-130. As described below, we concluded that the original concern of Allegation RIII-99-A-0130 should not be referred to the Office of Investigations (OI) for investigation and should be handled by the inspection staff through discussion with the licensee. The new concerns identified during OI interviews should be opened with a new allegation number. One of the new concerns (discrimination complaint) should be referred to OI for investigation. Recommendations for the other new concerns are described below. An Allegation Review Board should be conducted for these concerns.

Original Concern for Allegation RIII-99-A-0130

Allegation RIII-99-A-0130 involved a potential willful violation of 10 CFR 55.49 regarding the alleged compromise of the integrity of a Byron evaluative training scenario administered to a license crew. This scenario was administered to all crews following failure of a significant number of crews on the simulator during the previous training cycle to complete actions in the time allowed by the FSAR for a steam generator tube rupture (SGTR). Per discussion with NRC management, licensee management had agreed that these evaluative scenarios would be performed with no prior content knowledge by the examined crews in order to provide greater confidence that the crews could respond appropriately in an actual event. The concerned individual had indicated to the NRC that, contrary to this verbal agreement, a Shift Operating Supervisor, who was knowledgeable of the agreement had intentionally trained the crew on this scenario just prior to the exam, and hence had compromised the integrity of the exam.

During an operator licensing counterpart call (including the Headquarters program office for operator licensing), the general consensus at that time was that 10 CFR 55.49, which requires that examination integrity not be compromised for exams and tests required by 10 CFR Part 55, was applicable to this situation. (While the evaluative scenario was not required directly by 10 CFR Part 55, 10 CFR 55.59(c) requires a requalification program approved by the NRC and the licensee's approved program references evaluative scenarios.) Based upon this information,

(18)

the Allegation Review Board of August 2, 1999, directed that the Region III Operations Branch develop and provide to the Regional Counsel a draft Notice of Violation (NOV) for review. If the Regional Counsel concurred that a viable NOV existed, then OI agreed to accept referral. The Operations Branch subsequently provided the draft NOV. In the interim, the Office of Investigations opted to interview the two concerned individuals, resulting in the new concerns discussed below. After review of the draft NOV, the Regional Counsel declined to provide an opinion, instead requesting that the 10 CFR 55.49 applicability question be directed again to the Headquarters program office for operator licensing. After further program office review, Mr. Dave Trimbel, Chief, Operator Licensing and Human Performance Section, during a telephone conference call on November 11, 1999, informed Mr. David Hills, Chief, Operations Branch, that the program office had concluded that a violation of 10 CFR 55.49 was not applicable to this situation. In addition, during a discussion between Mr. Jim Heller (Allegation Coordinator), Mr. David Hills (Operations Branch Chief), and Mr. Bruce Berson (Regional Counsel), the general consensus was that 10 CFR 50.5, "Deliberate Misconduct," and 10 CFR 50.9, "Completeness and Accuracy of Information," were also not applicable.

Recommendation: Based upon the above information, we recommend that Allegation RIII-99-A-0130 not be referred to OI because there is no violation of NRC requirements involved. However, because a verbal agreement between the NRC and the licensee had allegedly been circumvented, we recommend that the Region III Division of Reactor Safety management conduct a conference call with the licensee to discuss the occurrence. The results of that call would be referenced in the response to the concerned individuals.

New Concerns Identified During OI Interviews

During the OI interviews mentioned above, the concerned individuals communicated the following concerns as indicated by the referenced lines in the OI transcript:

Concern #1

Page 12, Lines 9-17 - The station is providing false information to the NRC regarding SGTR response times in that one crew was intentionally trained on actions for the SGTR scenario just before its administration so that they would pass, thereby circumventing the purpose of providing confidence that required response times would be met during an actual event.

Regulatory Basis: 10 CFR 50.9(a) requires that information provided to the Commission by a licensee shall be complete and accurate in all material respects.

Recommendation: Training of this one crew on scenario content just prior to administration of the scenario, was not material to the NRC's evaluation of this issue. The NRC staff had observed the same evaluative scenario successfully administered to other crews and was aware of the alleged improper pre-conditioning of this one crew when evaluating the response of the licensee to this issue. The impact of this improper training was the elimination of one data point meant to build confidence in the crews' ability to properly respond to a real event. The remaining crews were sufficient to provide that confidence. This should be communicated in the response letter to the concerned individual. Regardless of how and when they were

trained, the subject crew did successfully complete the evaluative scenario and therefore demonstrated knowledge to properly respond.

Concern #2

Page 14, Lines 7-8 - The station failed to ensure requalification training examination security by allowing crews who have seen the examinations to interface with crews that will be examined using the same examination materials.

Regulatory Basis: Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether this practice violates those requirements.

Concern #3

Page 16, Lines 12-23; Page 17, Lines 2-13 - The training department and other evaluators passed one crew on an evaluated scenario during the last training cycle when the crew should have failed. They were reluctant to fail too many crews, and in this instance they had just failed the morning crew and so did not want to fail the afternoon crew.

Regulatory Basis: Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether this practice violates those requirements.

Concern #4

Page 22, Lines 4-20; Page 41, Lines 1-3 & 20-24 - A. The concerned individual had been labeled a whistle blower because he had come to the NRC before on a different matter and that this had a chilling effect. (The specific matter was not mentioned, nor who had labeled him a whistle blower.) B. The concerned individual had also researched and wrote a PIF involving a problem with gas decay tanking and his supervisor indicated that if he had time to write PIFs like that then the supervisor would find the concerned individual more to do. Therefore, the concerned individual would not write more PIFs like that anymore. C. Station personnel found out that the concerned individual's raise was less than others when the grade classification was changed for his job (see Concern #6) and that this action is telling everyone that if you write a PIF it's going to affect you salary or your promotion series.

Regulatory Basis: NRC Policy Statement on Safety Conscious Working Environment (Chilled Environment)

Recommendation: EICS to ask the concerned individual for permission to follow-up on this concern. (Follow-up would likely disclose the identity of the concerned individual.) If follow-up is allowed, then refer parts A & B to the licensee for evaluation. In the referral letter, ask the licensee to address these incidents in reference to the effectiveness of actions they indicated that they would take during the public meeting on chilling effect. Refer part C of this concern to the licensee for evaluation after OI completes its investigation of Concern #6.

Concern #5

Page 25, Lines 3-7 - One SRO (name in transcript) did not take the annual operating exam because the licensee allowed him to instead take credit for training evaluation scenarios.

Regulatory Basis: 10 CFR 55.59(a)(2) requires that a licensee (licensed operator) shall pass a comprehensive requalification written examination and an annual operating test. The alleged process does not appear to conform to a comprehensive test or examination. (Comprehensive means that the facility licensee evaluate all the respective parts together.)

Recommendation: Refer to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address whether and how they believe the practice meets 10 CFR 55.59(a)(2) for a comprehensive exam.

Concern #6

Page 32, Lines 2-15; Page 36, Lines 7-25; Page 37, Lines 1-13; Page 42, Lines 17-25; Page 43, Lines 1-7; Page 49, Lines 1-6 - Within a week after writing the PIF regarding the SGTR scenario preconditioning, the concerned individual received a letter in his file for missing a day of training several months before without pre-approval. The concerned individual admitted that he had missed the work because he mistakenly thought he had the day off, but that another operator had missed training that week and did not receive a letter. The concerned individual indicated that the letter was retribution for being a whistle blower. In addition, after writing the PIF, the facility licensee changed his position, along with other individuals, from a level 6 to a level 8, but raised his salary less than they raised others making the same change. In addition, after writing the PIF, the facility licensee did not pick him for the shift manager program, although others picked were newer than the concerned individual. In a previous incident about six years ago, the concerned individual and one other individual did not get shift premium for filling in (rotating in) for the work control position, although those before and after were paid, because the concerned individual and the other individual brought a safety concern to the supervisor. The safety concern involved control room operators coming in drunk. (No other details are given for this last safety concern, although the concerned individual indicated that he had raised it to the NRC at the time.) (Concerned individual gave permission to release his name in followup to this concern.)

Regulatory Basis: 10 CFR 50.7(a) requires that discrimination by a Commission licensee against an employee for engaging in certain protected activities is prohibited.

Recommendation: Refer to OI for investigation.

Concern #7

Page 45, Lines 17-25; Page 46, Lines 1-7 - Training has been significantly reduced (A. Systems training for "B" operators because they are trying to upgrade to EOs / B. Licensed operator requalification training so operators can fill in during outages).

Regulatory Basis: 10 CFR 55.120(b)(2) requires that the licensee have a training program for non-licensed operators that provides qualified personnel to operate and maintain the facility in a safe manner. Possible violation of 10 CFR 55.59(c) which requires a requalification program approved by the NRC for licensed operators. This would be a regulatory basis only if the licensee failed to meet its approved requalification program.

Recommendation: Part A is already covered by an existing allegation (RIII-99-A-0049). The licensee responded to this allegation on November 8, 1999, and that response is currently being evaluated by the Operations Branch. Therefore, part A should be closed in reference to the existing allegation. Refer part B to the licensee for evaluation. Request that If the licensee substantiates the concern, that the licensee also address the requirements of their approved requalification program and whether the reduced training violates those requirements.

SENSITIVE ALLEGATION MATERIAL

6 MONTH ARB: RIII-99-A-0130

January 11, 2000

MEMORANDUM TO: David Hills, Chief, Operator Licensing Branch, DRS

FROM: J. Heller/ A. Kock, RIII - OAC

SUBJECT: **6 MONTH ARB: RIII-99-A-0130 (BYRON)**

Management Directive 8.8 requires that a Follow-up ARB be performed every 6 months in order to assure that Regional Management is aware of the reason for the concerns remaining open beyond the agency's expected closure date. This ARB is intended to meet that requirement. The current status is described in the attached information - if this information is incorrect, please provide the necessary corrections to EICS prior to the ARB.

A 6 Month ARB has been scheduled for January 24, 2000. Please review the following information to prepare for the ARB:

Review the attached information. Contact the OAC before the ARB if needed.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases-Jorden
DRS Division Director For Rx Cases-Grobe

Attendees:

J. Grobe
D. Hills, OLB
Ann Marie Stone, OLB
A. Kock/ J. Heller, EICS

A/6

(22)

S' 'SITIVE ALLEGATION MATERIAL

RIII-99-A-0130

6-MONTH ARB

ALLEGATION RECEIVED: July 29, 1999

Concern 1: A potential compromise of test material may have occurred on July 27, 1999, when the Shift Operation Supervisor (SOS) discussed relative information with one licensed crew prior to performing an evaluation scenario.

STATUS OF CONCERN 1: Technical review and resolution of the concern with the licensee has been accomplished, but the Office of Investigation Report has not yet been issued. A November 29, 1999 allegation review board directed the operator licensing branch to contact the licensee to discuss that a verbal agreement with the NRC had been allegedly circumvented. The Operator Licensing Branch contacted the licensee to resolve the issue on December 9, 1999. The Office of Investigations completed their evaluation of this matter with a recommendation to close the issue based on the lack of a regulatory basis. The report is expected to be issued in January 2000. Technical and legal review of this report is necessary to close the allegation.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

SENSITIVE ALLEGATION MATERIAL

ALLEGATION: RIII-99-A-0130 (BYRON)

MEMORANDUM TO: H. Brent Clayton, Enforcement/Investigations Officer

FROM: David E. Hills, Chief, Operations Branch David E Hills

SUBJECT: ALLEGATION RIII-99-A-0130 BYRON STEAM GENERATOR TUBE RUPTURE (SGTR) TRAINING PRE-CONDITIONING

In accordance with direction from the Allegation Review Board (ARB) on November 24, 1999, the NRC staff conducted a telephone conference call on December 9, 1999, with ComEd management to communicate our concern that a verbal agreement between ourselves and ComEd had been circumvented by a member of the licensee's staff. The ARB gave this direction because, after consultation with the NRR program office for operator licensing, we could not identify a clear regulatory basis on which to pursue an investigation by the NRC Office of Investigations into this matter. However, we were concerned that a verbal agreement with the NRC staff had not been met. Specifically, licensee management had agreed that they would administer the SGTR scenario to all operating crews to provide additional confidence that operator response time requirements described in the Final Safety Analysis Report could be met and that these crews would have no prior knowledge of the scenario content. An NRC inspector observed the scenario administration on two crews who successfully met the time requirements and who had no prior knowledge of the scenario content as documented in NRC Inspection Report 50-454/99013; 50-455/99013. However, with regard to a subsequent crew that was not observed by the NRC, that crew was briefed on the proper response to a SGTR event just prior to administration of this scenario, effectively invalidating that data point. There was no safety significance to the matter in that the crew that was preconditioned on the SGTR scenario constituted just one data point out of several.

Participants from the NRC staff on the telephone conference call were Mr. Steven Reynolds, Deputy Division Director, Division of Reactor Safety, Mr. David Hills, Chief, Operations Branch, Mr. M. Jordan, Chief, Projects Branch, and D. McNeil, Senior Examiner. Licensee management participants included Mr. R. Lopriore, Station Manager, and Mr. R. Krich, Vice President, Regulatory Services. During the call, Mr. Lopriore confirmed that the one crew had been briefed on SGTR response actions just prior to the scenario administration. In addition, to expressing concern that the agreement with the NRC staff had been circumvented, the NRC staff indicated concern that the licensee had not informed the NRC staff of the incident. Mr. Lopriore acknowledged the importance of ensuring agreements are met and proper communications with NRC management.

(21)

H. Clayton

In the absence of any violations of regulatory requirements, we consider NRC staff actions to be complete for this allegation. We note that related concerns are currently being addressed through Allegation No. RIII-99-A-0193.

cc: R. Paul, OI

SENSITIVE ALLEGATION MATERIAL

ALLEGATION: RIII-99-A-0130 (BYRON)

MEMORANDUM TO: H. Brent Clayton, Enforcement/Investigations Officer

FROM: David E. Hills, Chief, Operations Branch

SUBJECT: ALLEGATION RIII-99-A-0130 BYRON STEAM GENERATOR TUBE RUPTURE (SGTR) TRAINING PRE-CONDITIONING

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DOCUMENT NAME: G:DRS\ALLE0130.WPD

To receive a copy of this document, indicate in the box: "C" = Copy without attachment/enclosure "E" = Copy with attachment/enclosure "N" = No copy

OFFICE	RIII	E					
NAME	DHills:jp						
DATE	01/11 /00						

OFFICIAL RECORD COPY

In the absence of any violations of regulatory requirements, we consider NRC staff actions to be complete for this allegation. We note that related concerns are currently being addressed through Allegation No. RIII-99-A-0193.

cc: R. Paul, OI

To: See list of Allegation Files listed below

From: Jim Heller

Subject: Followup ARB

Management Directive 8.8 states that an ARB should be reconvened a 6 months and 4 months there after to review an allegation older than 6 months. An except to this requirement is if the allegation is an OI or DOL case that has no open technical issues.

The following file have no open technical issues. The open issues are either the subject of an OI investigation or a DOL proceeding. These files were discussed during the January 15, 2000, OI briefing. In attendance were Rich Paul, Jim Caldwell, Jim Dyer, Cindy Pederson, Marc Dapas, Steve Reynolds, Brent Clayton, and Myself.

The Files discussed were

8 =

RIII-1999-A-0125 (Quad Cities)
RIII-1999-A-0126 ~~(Quad Cities)~~ Braidwood
RIII-1999-A-0127 (Perry)
RIII-1999-A-0130 (Byron)
RIII-1999-A-0123 (Dresden)
RIII-1999-A-0133 (Point Beach)
RIII-1999-A-0126 (Braidwood)
RIII-1999-A-0135 (Quad Cities)

The group agreed that the OI briefing could substitute for the 6 month ARB

Attendees
J. Grobe

reported issued 01/15/100.
unobstantiated.

2/04/00 ARB to review report.

A/7

25

SENSITIVE ALLEGATION MATERIAL

GG-A-0030

ALLEGATION ACTION PLAN AMS NO. RIII-00-A-0007

Licensee: ~~Portsmouth~~ Byron

Docket/License No: ~~070-07002~~

Assigned Division/Branch: ~~DNMS/FCB~~ DRS/OLB

Allegation Review Board Membership: Chairman - G. ~~Grant~~ / M Dapas/ C. Pederson

R. Paul - OI / ~~B Berson~~ P. Hills ~~M. Phillips~~, FCB

~~J. Heller~~ / A. Kock / ~~B. Clayton~~ Ann Marie Stone, OLS

J. Grobe / ~~Reynolds~~ (DRS)

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE: No immediate threat to public health and safety.

OI ACCEPTANCE: YES NO (Priority: **HIGH NORMAL LOW**)

OI has Accepted Concern(s) No(s). N/A

Signature of Accepting OI Official:

Basis for OI Priority:

investigation completed 01/19/00. OLS in review by 02/04/00.

ACKNOWLEDGMENT LETTER: PRINT IN FINAL ____ REVISE ____ N/A X

REFERRAL LETTER: YES ____ NO X

ARB MINUTES PROVIDED TO: ~~Phillips~~/Dyer Hills 1/24/00

COMMENTS:
The CI **did** object to having identity released.

The CI **did not** object to having the concern(s) forwarded to the licensee.

Allegation Review Board Chairman

1/24/00
Date

A/8

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RIII-99-A-0130 6-MONTH ARB

ALLEGATION RECEIVED: July 29, 1999

Concern 1: A potential compromise of test material may have occurred on July 27, 1999, when the Shift Operation Supervisor (SOS) discussed relative information with one licensed crew prior to performing an evaluation scenario.

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SENSITIVE ALLEGATION MATERIAL

6 MONTH ARB: RIII-99-A-0130

January 11, 2000

MEMORANDUM TO: David Hills, Chief, Operator Licensing Branch, DRS

FROM: J. Heller/ A. Kock, RIII - OAC

SUBJECT: **6 MONTH ARB: RIII-99-A-0130 (BYRON)**

Management Directive 8.8 requires that a Follow-up ARB be performed every 6 months in order to assure that Regional Management is aware of the reason for the concerns remaining open beyond the agency's expected closure date. This ARB is intended to meet that requirement. The current status is described in the attached information - if this information is incorrect, please provide the necessary corrections to EICS prior to the ARB.

A 6 Month ARB has been scheduled for January 24, 2000. Please review the following information to prepare for the ARB:

Review the attached information. Contact the OAC before the ARB if needed.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases-Jorden
DRS Division Director For Rx Cases-Grobe

Attendees.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

SENSITIVE ALLEGATION MATERIAL

ALLEGATION: RIII-99-A-0130 (BYRON)

MEMORANDUM TO: H. Brent Clayton, Enforcement/Investigations Officer

FROM: David E. Hills, Chief, Operations Branch David E Hills

SUBJECT: ALLEGATION RIII-99-A-0130 BYRON STEAM GENERATOR TUBE RUPTURE (SGTR) TRAINING PRE-CONDITIONING

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(21)

H. Clayton

In the absence of any violations of regulatory requirements, we consider NRC staff actions to be complete for this allegation. We note that related concerns are currently being addressed through Allegation No. RIII-99-A-0193.

cc: R. Paul, OI

SENSITIVE ALLEGATION MATERIAL

ALLEGATION: RIII-99-A-0130 (BYRON)

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FROM: David E. Hills, Chief, Operations Branch

SUBJECT: ALLEGATION RIII-99-A-0130 BYRON STEAM GENERATOR TUBE RUPTURE (SGTR) TRAINING PRE-CONDITIONING

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OFFICE	RIII	E					
NAME	DHills:jp	per					
DATE	01/11 /00						

OFFICIAL RECORD COPY

In the absence of any violations of regulatory requirements, we consider NRC staff actions to be complete for this allegation. We note that related concerns are currently being addressed through Allegation No. RIII-99-A-0193.

cc: R. Paul, OI

6 MONTH ARB AMS NO. RIII-98-A-0146

****

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS/PSB2

****

Allegation Review Board Membership: Chairman - ~~G. Grant~~ J. Grobe

R. Paul - OI / B. Berson G. Shear

J. Hopkins ~~/ B. Clayton~~ / R. Doornbos

~~J. Grobe~~ / ~~S. Reynolds~~ (DRS)

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE:

OI ACCEPTANCE: YES NO (Priority: **HIGH** **NORMAL** **LOW**)

Basis for priority:

STATUS LETTER: YES X ~~NO XX~~ (Ack. Letter Sent 9/30/98 w/ concerns 1 - 3)
(Status Letter Sent 11/2/98 w/ concerns 1 -8)

Close concerns 6 + 7

- ARB MINUTES PROVIDED TO PSB2

COMMENTS:
Management Directive 8.8 requires that a Follow-up ARB be performed every 6 months in order to assure that Regional Management is aware of the reason for the concerns remaining open beyond the agency's expected closure date. This ARB is intended to meet that requirement. The current status is described in the attached information - if this information is incorrect, please provide the necessary corrections to EICS prior to the ARB.

John G. Grobe
Allegation Review Board Chairman

2/24/99
Date

A/9

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Allegation File RIII-98-A-0146 ALLEGATION RECEIVED: September 2, 1998

Concern 1:
You stated that you were screamed at for writing a problem identification form (PIF), with words such as "while you were writing your PIF, I had to have somebody else do your job" used by your supervisor. You felt a chilling effect for writing PIFs.

STATUS OF CONCERN: OPEN - Included as part of OI interview with CI. PSB2 to review transcript and determine next action.

Concern 2:
A couple of outages ago, a named individual was working nights at the plant and was spending the days in jail for driving under the influence (DUI).

STATUS OF CONCERN: CLOSED in 9/2/98 letter to CI.

Concern 3:
You believe that being given a day off (September 28, 1998) without pay was in retaliation for writing Problem Identification Form XXXX (see case file for number & title). You believe that not being allowed to begin an assignment at Braidwood on September 28 and therefore losing a weeks worth of overtime wages, was in retaliation for writing PIF XXXX.

STATUS OF CONCERN: OPEN - OI Case No. 3-1998-038.

Concern 4:
WRONGDOING: Potential, deliberate violation of station procedure Braidwood Administrative Procedure (BAP) BAP 720-3 (rev. 20), by a member of Radiation Protection (RP) management.

STATUS OF CONCERN: OPEN - OI Case No. 3-1998-038.

Concern 5:
In response to an NRC finding, XXXX had instructed the CI to post a cask as a Radiation Area. However, as the CI was attempting to satisfy this issue, XXXX told her to stop.

STATUS OF CONCERN: CLOSED in 9/2/98 letter to CI.

Concern 6:
You believe that the PIF written to address a Shepard calibrator did not adequately described the event.

STATUS OF CONCERN: OPEN - PSB2's review of the licensee's response completed. CI not informed of results. Informing CI is only remaining action. Next status letter due to CI in May 1999.

Concern 7:
You observed that the lock to the Shepard calibrator door was removed and laying atop the calibrator with no RP technicians in attendance. However, the source was not exposed and was properly secured. You stated that you relocked the door and reported this to RP supervision.

STATUS OF CONCERN OPEN - PSB2's review of the licensee's response completed. CI not informed of results. Informing CI is only remaining action. Next status letter due to CI in May 1999.

Allegation File RIII-98-A-0146

Concern 8:
On September 29, 1998, you entered the RP calibration room and observed the RP source cabinet doors to be bulging open, but still locked. You stated that you could put your hands through the bottom of the cabinet, remove a radioactive source (i.e., Rt 10 source), and receive a potentially significant exposure. You reported this to RP supervision.

STATUS OF CONCERN: CLOSED in 9/2/98 letter to CI.

SENSITIVE ALLEGATION MATERIAL

6 MONTH ARB: RIII-98-A-0146

February 18, 1999

MEMORANDUM TO: G. Shear, Chief, PSB2, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC J. Hopkins 2-18-98

SUBJECT: **6 MONTH ARB: RIII-98-A-0146 (BYRON)**

Management Directive 8.8 requires that a Follow-up ARB be performed every 6 months in order to assure that Regional Management is aware of the reason for the concerns remaining open beyond the agency's expected closure date. This ARB is intended to meet that requirement. The current status is described in the attached information - if this information is incorrect, please provide the necessary corrections to EICS prior to the ARB.

A 6 Month ARB has been scheduled for February 22, 1999. Please review the following information to prepare for the ARB:

Review the attached information. Contact the OAC before the ARB if needed.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director For Rx Cases

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

January 21, 1999

MEMORANDUM TO: J. Hopkins, Senior Allegation Coordinator

FROM: G. Shear, Chief, Plant Support Branch 2

SUBJECT: REVIEW OF U.S. DEPARTMENT OF LABOR INVESTIGATION RESULTS FOR BYRON ALLEGATION NO. RIII-98-0146 (AITS S99-2002)

As requested in your January 6, 1998, memorandum, the Plant Support Branch 2 (PSB2) staff reviewed the U. S. Department of Labor (USDOL) decision concerning an employment discrimination complaint at the Byron Nuclear Generating Station. The subject concern regarded a complaint of harassment and intimidation (H&I) by a Byron radiation protection technician for raising safety issues to licensee management. In addition to the USDOL investigation, this concern is being reviewed by the RIII Office of Investigations staff.

Our review of the USDOL decision, identified no enforceable items. The USDOL concluded that the licensee's actions toward the technician did not constitute H&I. Based on the facts as presented in the subject document, the PSB2 staff agrees with the USDOL decision.

However, one new technical issue was identified during the PSB2 staff review. As stated in the investigation summary, on August 31, 1998, the technician allowed laborers to continue working in a high radiation area after the workers' electronic dosimeters alarmed due to high dose rate. After investigating this incident, the licensee assigned the technician a one day suspension without pay. The technician denied having worked through the alarm and disagreed with the suspension. This incident and the disciplinary action were described (serial nos. 13 and 17) in the file for Byron concern no. RIII-98-A-0146. However, the PSB2 staff did not identify any documented NRC resolution of this issue. **Consequently, the PSB2 staff recommends that this issue be entered as a new concern and referred to the licensee.**

cc: J. Grobe
M. Jordan
K. Lambert
AMS File No. RIII-98-A-0146

New case file opened;
RIII-99-A-0010.
J Hopkins

Contact: K. Lambert (DRS)
630-829-9853

40

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

SENSITIVE ALLEGATION MATERIAL

January 6, 1999

MEMO TO: G. Shear, Chief, Plant Support Branch 2, DRS

FROM: J. Hopkins, Senior Allegation Coordinator

SUBJECT: REVIEW DOL AD DECISION FOR ALLEGATION NO. RIII-98-A-0146 (Byron)

EICS has received the DOL AD Decision (attached).

Action

- Please review the attached document to identify any new safety concerns and/or enforceable items and provide EICS with a memo with the results of your review. **The results of your review are due to OAC3 in a memo by February 6, 1999.** This memo should stated the concerns and/or enforceable items and the regulatory basis for the concern and/or enforceable item. The memo should be provided in both hard copy and electronic form (e-mail address for the memo is OAC3).

- If there are any new concerns, please make a recommendation if the concerns should be added to the existing AMS file, or if a new allegation file should be opened and a new ARB should be held.

Attachment: As stated

cc w/o attachment:
J. Grobe, Director, DRS
AMS File No. RIII-98-A-0146

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

December 30, 1998

MEMORANDUM TO: H. Brent Clayton, Enforcement/Allegations Officer

FROM: Gary L. Shear, Chief, Plant Support Branch 2 Wayne J. Slawinski for

SUBJECT: REVIEW OF LICENSEE RESPONSE AND RECOMMENDED CLOSURE OF CONCERNS NOS. 6 AND 7 OF ALLEGATION NO. RIII-98-A-0146 (BYRON) (AITS S98-2176)

Reference: Memorandum from J. Hopkins to G. Shear, dated December 4, 1998.

The referenced memorandum requested that my staff review the licensee's response to the subject concerns, which was submitted by the Byron Generating Station as an attachment to a letter dated December 1, 1998.

The Plant Support Branch 2 (PSB2) staff reviewed the response and concluded that the licensee's evaluation was independently conducted by the Commonwealth Edison Company Corporate Health Physics Support Staff and was of sufficient depth and scope to address the concerns. The response was supplemented by additional information obtained by my staff in a telephone conversation with Byron Station radiation protection (RP) management. During the PSB2 staff's review, no unresolved technical issues or new safety concerns were identified. However, two examples of a minor violation were identified, which were associated with the concerns. Details regarding the licensee's evaluation of the concerns and the PSB2 staff's review are provided below:

Concern 6: The CI was concerned that the PIF written to document a September 30, 1998, incident where the Shepard Calibrator was left unattended with the source exposed did not adequately describe the event.

The CI's concern was that Byron problem identification form (PIF) No. B1998-04254 did not adequately describe a September 30, 1998, event where the J. L. Shepherd Calibrator (calibrator) was found unattended and unlocked. As written, the PIF documented the event as follows:

CONTACT: Ken Lambert, DRS
(630) 829-9853

Natalie - FYI - Read
What is this
document. It doesn't
appear to be dated
and it starts on
p. 2 ? Part of
ARB package - there is
no p.1 in file -

On September 30, 1998, a health physicist (HP) w
a source characterization using the calibrator. Dur
HP was contacted regarding a safety issue concer
Auxiliary Building exit. The HP left the calibration f
the calibrator unlocked and unattended, which viol
5825-7, "J. L. Shepherd, Model 89, Gamma Calibr
NIST Traceability." (Step D.2 requires that the cali
unattended by a trained individual knowledgeable
specific to the unit.) An RP technician (the CI) disc
instrument to the calibration facility. The RP techn
shielded position, locked the calibrator, and notifie

The licensee's written response described the event and i
procedures. However, the licensee did not identify any inc
documented on the PIF and the event details. Similar to the above description, the licensee's response indicated that on September 30, 1998, an HP was performing a source characterization on the calibrator and received a telephone call concerning a problem with the whole body contamination monitors, which were located at the radiologically posted area (RPA) access point. Since the HP was responsible for those monitors, he left the calibration facility to attend to this issue. In his absence, the calibrator was left with the source exposed and with the calibrator unlocked and unattended in violation of Step D.2 of procedure BRP 5825-7. While returning to the calibration facility the HP was informed by an RP supervisor that an RP technician had discovered the calibrator unlocked and unattended, had secured the calibrator, and had removed the keys. The HP then returned to the calibration facility and retrieved the keys from the RP technician. Based on a comparison between the above description of events and the PIF, the licensee concluded that the PIF accurately described the above event.

The licensee's response documented the following steps taken to correct the procedure violation:

1. The instrumentation HP was counseled by the lead technical HP on attention to detail and on the S.T.A.R. (Stop, Think, Act, Review) system.

2. While certain individuals outside the RP staff had access to the calibration facility (a locked facility), only RP personnel were authorized to use the calibrator. Consequently, the licensee planned to review the adequacy of key control for the calibration facility and intended to have the assessment and corrective actions completed by February 1, 1999.

Based on the licensee's evaluation, a violation of NRC requirements (i.e., a violation of the RP procedure) was identified. However, the PSB2 staff has reviewed the violation and determined that the violation is consistent with the definition of a minor violation, as stated in the NRC's Enforcement Policy (NUREG 1600, Revision 1), and that the licensee's corrective actions appeared adequate. Specifically, the calibrator was equipped with interlocks that would automatically return the source to a safe position (i.e., shielded position) if the calibrator door was opened. A review of the monthly survey checklists indicated that the calibrator was tested on September 3, 1998, and October 5, 1998, and that the interlocks (which satisfy the

requirements of 10 CFR Part 20) functioned properly. 10 CFR 20.1601 requires control of access to high radiation areas by either a control device that, upon entry into the area, causes the level of radiation to be reduced below that of a high radiation area; a control device that energizes a visible or audible alarm; or entryways that are locked except when access is required. The calibrator interlocks function as the control device that would cause the level of radiation to be reduced. Therefore, the PSB2 staff concluded that Step D.2 of the licensee's procedure provided an administrative control which exceeded the NRC's requirements. Since the calibrator was in a locked room with limited access and the interlocks were functional, the procedural violation for leaving the calibrator unattended while in operation is of minor safety concern and is considered a minor violation in accordance with the NRC's Enforcement Policy. Consequently, the violation will not be documented in an NRC inspection report.

In summary, the PSB2 staff agrees with the licensee's conclusion that the concern was not substantiated. Specifically, the description of the event contained in PIF No. B1998-04254 and the licensee's description were in agreement. In addition, both the PIF and the licensee's evaluation identified a violation of Byron procedure BRP 5825-7, for the failure to have an individual in attendance when the calibrator was unlocked. This violation is characterized as a minor violation, consistent with the NRC Enforcement Manual. Therefore, the PSB2 staff recommends no further action on Concern No. 6 of Allegation No. RIII-98-A-0146 and recommends that the concern be closed.

Concern 7: The CI identified on September 29, 1998, that the lock to the Shepherd calibrator (calibrator) door was removed and laying atop the calibrator with no radiation protection technicians in attendance. However, the source was not exposed and was properly secured. The CI locked the door and reported this issue to RP supervision.

On September 29, 1998, the CI identified the concern that the calibrator door was not locked and no one was in attendance, although the source was not exposed and was properly secured. The CI locked the calibrator's door and reported the incident to RP supervision; however, a PIF was not written. The licensee's written response (describing the event) was in agreement with the CI's description and substantiated Concern No. 7. The licensee also concluded that a violation of procedure BRP 5825-7, step D.2 occurred for leaving the calibrator unlocked and unattended. This violation was similar to the violation identified in Concern 6, with the exception that the source was not exposed and was secured.

As described in Concern No. 6, the calibrator was in a locked calibration facility, which had limited access. In addition, the licensee had taken corrective actions to address the immediate problem and to prevent recurrence and had planned additional corrective actions (described above). Since the source was not exposed, the source was properly secured, and the interlocks were functional, the failure to lock the calibrator door is of minor safety concern and is considered another example of a minor violation in accordance with the NRC's Enforcement Policy.

In summary, the PSB2 staff agrees with the licensee's conclusion, i.e., the concern that the calibrator door was unlocked with no one in attendance was substantiated. While the failure to have the calibrator attended when unlocked is violation of station procedure, the PSB2 staff determined that the violation is another example of a minor violation, which will not be documented in an NRC inspection report. Therefore, the PSB2 staff recommends no further action on Concern No. 7 of Allegation No. RIII-98-A-0146 and recommends that the concern be closed.

cc: J. Grobe, DRS
Allegation File AMS No. RIII-98-0146(Byron)

~~SENSITIVE ALLEGATION MATERIAL~~

ALLEGATION ACTION PLAN AMS NO. RIII-98-A-0146

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS / PSB2

Allegation Review Board Membership:

Chairman - ~~G. Grant~~ J. Grobe

R. Paul - OI / ~~B Berson~~

~~G. Shear~~ S. Orth, PSB2

J. Hopkins / ~~R. Doernbos / B. Clayton~~

G. Grant

J. Grobe / S. Reynolds (DRS)

M. Jordan

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: No threat to public health and safety.

OI ACCEPTANCE: YES NO (Priority: **HIGH NORMAL LOW**)

OI has Accepted Concern(s) No(s). _____

Signature of Accepting OI Official: _____

Basis for OI Priority: _____

ACKNOWLEDGMENT LETTER: PRINT IN FINAL ____ REVISE X N/A ____

REFERRAL LETTER: YES ____ NO X

ARB MINUTES PROVIDED TO PSB2 9-11-98

COMMENTS:

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6+7C
FOIA- 2000-0245

John Q. Hopkins
Allegation Review Board Chairman

9-9-98
Date

5

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1

You stated that you were screamed at for writing a problem identification form (PIF), with words such as "while you were writing your PIF, I had to have somebody else do your job" used by the CI's supervisor. The individual felt a chilling effect concerning the writing of PIFs.

Regulatory Basis:

I. Action Evaluation: The following method of resolution is recommended (circle):

(A.) Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)

B. Priority RIII Follow up and Closure Memo to OAC

C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC

D. Refer to OI. Recommended Priority: HIGH NORMAL LOW
Recommended Basis:

E. Outside NRC's Jurisdiction. Describe Basis Below.

F. Too General for Follow-up. Describe Basis Below.

(G.) Other (specify) - See Below

Responsible for Action - ~~ELCS Send LTR / PSDZ Review Response~~ JLL

II. Special Considerations/Instructions:

~~Send as an additional example of a dutted environment~~

~~PSDZ to review for Licensee Response~~ JLL

- OAC to call CI and explain that in order to follow-up, the CI's identity would likely be revealed. Request CI's permission to reveal identity
- ~~ack/closure~~ Send letter.
- If CI agrees to reveal ID, refer to licensee.
  If CI does not agree, send ack/closure Letter.

~~SENSITIVE ALLEGATION MATERIAL~~

NEW ALLEGATION: RIII-98-A-0146

September 4, 1998

MEMORANDUM TO: G. Shear, Chief, Plant Support Branch 2, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC

SUBJECT: **RECEIPT OF NEW ALLEGATION: RIII-98-A-0146 (Byron)**

RIII received an allegation concerning a possible chilled environment at Byron.

On September 4, Gary Shear, PSB2 Branch Chief, reviewed the concerns with OAC and agrees:

- all of the concerns were identified,
- all of the concerns were correctly characterized,
- the regulatory basis for each concern was correctly identified,
- with the proposed action to resolve each concern, and
- with the proposed completion date.

An Allegation Review Board (ARB) has been scheduled for September 9, 1998. Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director For Rx Cases

4

September 3, 1998

MEMORANDUM TO: Jay Hopkins, OAC

THRU: M. Jordan, DRP Branch 3

FROM: Nick Hilton, Byron RI

SUBJECT: RECEIPT OF ALLEGATION

Late in the afternoon on September 2, 1998, I received a call from a concerned individual. The concern was:

- the person was allegedly screamed at for writing a problem identification form (PIF), with words such as "while you were writing your PIF, I had to have somebody else do your job" used by the CI's supervisor. The individual felt a chilling effect concerning the writing of PIFs.

The individual was concerned because of a [redacted] Ex. 6 In this case, the PIF described a problem the individual identified and felt required a PIF to document the issue.

Knowledgeable persons: [redacted] (RP Foreman), [redacted] (RPM), [redacted] Ex. 6 (Nuclear Oversight) and Dave Wozniac (Acting Station Manager).

The original concern was an ALARA issue for removing a ladder from a locked high rad area that the CI felt did not really require immediate removal since the only way to get to the ladder was from within the locked high rad area. This issue is documented in PIF B1998-03853, "Unnecessary Dose Removing a Ladder in a DLHRA." The licensee issued the PIF and the supervisory review was acceptable; specifically, a member of RP management noted that "post review of the job showed that alternate solutions may have existed, such as. . . ." This issue was originally considered a second concern; however, since the issue is documented in the licensee's corrective action system and appears to have received an appropriate initial review, recommend not entering as a second concern.

The individual preferred that their name NOT be released, but the issue could be turned over to the licensee if appropriate.

From: Nick D Hilton
To: JAH4
Date: 9/3/98 3:47pm
Subject: Chilling effect Concern

Per our conversation yesterday, here is the write-up. Note that I reference the original concern about man-rem, but since the CI wrote a PIF, and it got a reasonable review, I don't think we need to make that a separate concern. I believe I included enough info to create the second issue should current thought be otherwise! I also have the PIF and can fax it to you for the package if you want.

Questions? You know where to find me!

Nick

CC: MJJ

~~SENSITIVE ALLEGATION MATERIAL~~

FOLLOW UP ALLEGATION ACTION PLAN AMS NO. RIII-98-A-0146

****

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS / PSB1 Concern # 2

****

Allegation Review Board Membership: Chairman - G. Grant

R. Paul - OI / ~~B. Berson~~ J. Creed, PSB1

J. Hopkins / R. ~~Doornbos~~ / ~~B. Clayton~~ ~~M. Jordan, RPB3~~ R. Lanksbury

~~J. Grobe~~ / S. Reynolds (DRS)

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE: There does not appear to be a threat to the security of the plant or any danger to public health and safety.

OI ACCEPTANCE: YES (NO) (Priority: **HIGH NORMAL LOW**)

OI has Accepted Concern(s) No(s).

Signature of Accepting OI Official:

Basis for OI Priority:

- ARB MINUTES PROVIDED TO PSB1 9/22/98

COMMENTS:

New concern (#2) identified during 9/16/98 conversation with CI.

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6+7C
FOIA- 2000-0243

G E Grant
Allegation Review Board Chairman

9/21/98
Date

B/2
9

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 2
A couple of outages ago, a named individual [redacted] was working nights at the plant and was spending the days in jail for driving ~~while~~ under the influence (DUI).

Regulatory Basis: 10 CFR Part 73

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI. Recommended Priority: HIGH NORMAL LOW
Recommended Basis:
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
**** G. **Other (specify) - See Below**

Responsible for Action - **See Below**

II. Special Considerations/Instructions:

PSB1 to contact the licensee to determine if the named individual reported the DUI arrest. Due date is Wednesday 9/23/98. Provide memo to OAC.

If yes, no additional inspection required. OAC to inform CI that the named individual had reported the arrest to management as required by NRC regulations. OAC to provide information in letter to CI. Letter due no later than 10/2/98.

If no, PSB1 to request that licencee conduct a review of the issue and provide a response. OAC to send letter, PSB1 to review response.

~~SENSITIVE ALLEGATION MATERIAL~~

FOLLOW UP ARB: RIII-98-A-0146

September 17, 1998

MEMORANDUM TO: J. Creed, Chief, PSB1 Branch, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC J. Hopkins 9-17-98

SUBJECT: **FOLLOW UP ARB: RIII-98-A-0146 (Byron)**

During a 9/16/98 phone conversation with the Concerned Individual (CI), a new concern was identified. The concern was that a named [redacted] supervisor was working nights at the plant and was spending the days severing time in jail for a DUI arrest. The CI indicated that this occurred a couple of outages ago. No exact date for the outage was provided. Ex. 7C

Because licensee employees are required to report arrests to management, there is a potential that the RP supervisor did not report the arrest to management.

A Follow up ARB has been scheduled for Monday 9/21/98. Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief for RPB3
DRS Division Director

8

~~SENSITIVE ALLEGATION MATERIAL~~

September 17, 1998

MEMO TO: J. Creed, Chief, PSB1

FROM: J. Hopkins, Senior Allegation Coordinator J. Hopkins 9-17-98

SUBJECT: NEW CONCERN (# 2) IDENTIFIED DURING 9/16/98 CONVERSATION WITH CONCERNED INDIVIDUAL (CI) AMS No. RIII-98-A-0146 (Byron)

During a 9/16/98 phone conversation with the Concerned Individual (CI), a new concern was identified. The concern was that a named [redacted] supervisor was working nights at the plant and was spending the days severing time in jail for a DUI arrest. The CI indicated that this occurred a couple of outages ago. No exact date for the outage was provided.

Ex 6
7C

An ARB has been scheduled for Monday, 9/21/98 to determen the follow-up action.

cc:
AMS No. RIII-98-A-0146 (Byron)

7

~~SENSITIVE ALLEGATION MATERIAL~~

September 16, 1998

MEMO TO: AMS File No. RIII-98-A-0146 (Byron)

FROM: J. Hopkins, Senior Allegation Coordinator J. Hopkins 9-16-98

SUBJECT: 9/16/98 CONVERSATION WITH CONCERNED INDIVIDUAL (CI). NRC IS UNABLE TO FOLLOW-UP ON CONCERN BECAUSE LICENSEE COULD CONCLUDE THAT THE CI WAS THE SOURCE OF THE INFORMATION TO THE NRC.

On 9/9/98, the ARB directed that OAC explain to the CI that in order for the NRC to follow-up or to refer the concern to the licensee, the licensee could likely determine that the CI was the source of the information to the NRC.

On 9/16/98, at about 6:00 p.m., the OAC called the CI. Below is my summary of the call:

- I explained to the CI that because the issues of [redacted] Ex 6 7C

- The CI reiterated that he/she did not want his/her identity revealed to the licensee and understood that the NRC would not be conducting any follow-up activities on his/her issue. I informed the CI that we would be sending a letter documenting the conversation and the understanding that because we believed that the concern was so closely associated to the CI and the CI objected to having his/her identity released to the licensee, the NRC would be unable to follow-up on the concern.

- The CI stated that he/she had been interviewed by a lawyer from New York who was doing a review of a "chilled environment" at the site. The CI stated the he/she had informed the lawyer of the issues of [redacted] Ex 6 7C

  I informed the CI that the NRC had received allegations of a chilled environment at Byron and that we had requested that licensee conduct a review of the issue. I informed the CI that even though the NRC was not going to follow-up on the CI's specific concern, the general concern of a chilled environment for writing PIFs was being reviewed by the NRC. The CI seemed satisfied that the general issue was being reviewed.

cc:
G. Shear
M. Jordan
B. Clayton

(6)

~~SENSITIVE ALLEGATION MATERIAL~~

FOLLOW UP ALLEGATION ACTION PLAN AMS NO. RIII-98-A-0146

Licensee: Byron

Docket/License No: 50-454/455

Assigned Division/Branch: DRS / PSB2

Allegation Review Board Membership:

Chairman - G. Grant

R. Paul - OI / ~~B. Berson~~ J. McGarry, OGC (or his designee)

G Shear

J. Hopkins / ~~R. Doornbos~~ / ~~B. Clayton~~

M. Jordan

~~J. Grobe~~ / S. Reynolds (DRS)

GENERIC CONCERNS: If Yes Explain:

DISCUSSION OF SAFETY SIGNIFICANCE: No immediate threat to public health and safety

OI ACCEPTANCE: (YES) NO (Priority: HIGH (NORMAL) LOW)

OI has Accepted Concern(s) No(s). 3 & 4

Signature of Accepting OI Official: R. C. Paul

Basis for OI Priority: Concern #3 - Not rec'd High (not above 1st line); Concern #4 - without consideration of intent - a level ~~III~~ IV NOV,

ARB MINUTES PROVIDED TO OI & PSB2

COMMENTS:

Revisit concern 1 - CI authorized release of CI's identity

Discuss new concerns

Concern 3 - discrimination

Concern 4 - wrongdoing

Concern 5 - RP Posting of Area

Concern 6 - NRC Bl998-04254

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6 & 7C FOIA- 2000-0243

and Issues Identified

. Send CI Ack letter for new concerns which were identified in review of ~~CI~~ ~~or~~ material CI provided to RIII.

BJB

PSB2 to concurs on Ack Letter

Allegation Review Board Chairman

10-13-98
Date

26

SENSITIVE ALLEGATION MATERIAL

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1
You stated that you were screamed at for writing a problem identification form (PIF), with words such as "while you were writing your PIF, I had to have somebody else do your job" used by your supervisor. You felt a chilling effect for writing PIFs.

Regulatory Basis:

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
D. Refer to OI. Recommended Priority: NORMAL until after the OI interview
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
(G.) Other (specify) - See Below

Responsible for Action - See Below

II. Special Considerations/Instructions:

- OI will ask CE about "chilling effect" and details of being "screamed at."
- PSB2 to review OI transcript and determine next action.

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-98-A-0146

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 3
You believe that being given a day off [redacted] without pay was in retaliation for writing Problem Identification Form [redacted]. You believe that not being allowed to begin an assignment at [redacted] and therefore losing a weeks worth of overtime wages, was also in retaliation for writing [redacted]

EX6
7C

Regulatory Basis:
10 CFR 50.7 - employee protection

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC.
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC.
***** ***D. Refer to OI. Recommended Priority: NORMAL until after the OI interview***
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
G. Other (specify) -

Responsible for Action - PSB2 to review OI materials

II. Special Considerations/Instructions:

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-98-A-0146

Withhold Page in Its Entirety Ex 6

[redacted]

WITHHOLD ENTIRE PAGE EX. 6 & 7C

Concern #4

Potential, deliberate violation of station procedure BAP 720-3 (rev. 20), by a member of RP management. (Has been entered as concern 4 and allegation file)

While performing a radiological survey of an NRC survey instrument (believed to be a RAMGAM) and a teletector, the CI identified about 30,000 dpm/100 cm^2 of surface contamination. When [redacted] brought this to the attention of a supervisor [redacted] was told to "bury it and don't tell anyone." Another technician, doing a followup survey, found no contamination. The CI believes that this was a "cover-up" by licensee management, that the material was released with contamination, and that it resulted in a personnel contamination event (documented in PIF no. B1998-01565). Ex. 4

ARB Recommended Action:

See ARB Minutes (10/13/98)

Other Issues

~~1.~~ 2.

Concern #5

In response to an NRC finding, [redacted] had instructed the CI to post a cask as a Radiation Area. However, as the CI was attempting to satisfy this issue, [redacted] told [redacted] to stop. **A violation for this issue (50-454/455-98010-01) was identified by D. Nissen during the subject inspection. As the CI raised no new issues, we recommend no further action be taken.** 5-28-98 Ex.

ARB Recommended Action:

- No additional action needed -
- Inform CI in Ltr Ack letter that NRC was aware of issue & provide copy of IR 50-454/455-98010-01 (Byron) dated 5-28-98.

~~2.~~ 3.

Issue # 1

During the CI's counseling session, the licensee counselor [redacted] stated to the CI "If people are building personnel cases for litigation, I want to know. Is this clear ?" Additionally, several written comments made by another meeting attendee [redacted] state that [redacted] was visibly angry, spoke in a threatening manner to the CI and that the interview appeared to be an attempt to intimidate the CI. **The statement and written comments could support the CI's concern of discrimination for raising safety issues and should be discussed at the ARB addressing that concern.** Ex. 4

ARB Recommended Action:

- This is additional information for OI for discrimination case. Not include in letter to CI.

Other Issues

~~3~~ ~~4~~.

Issue #2

On September 29, 1998, the CI entered the RP Calibration Room and observed that the lock to the Shepard calibrator door was removed and laying atop the calibrator with no RPTs in attendance. However, the source was not exposed and was properly secured. The CI stated that [redacted] relocked the door and reported this to RP supervision [redacted]. **This is not a safety issue as the source was properly secured. No action is recommended.** Ex. 6

ARB Recommended Action:

- No additional ~~information~~ action needed.
- Inform CI in Ack letter that since source was secure, Not safety issue

~~4~~. ~~5~~.

Issue #3

On September 29, 1998, the CI entered the RP calibration room and observed the RP source cabinet doors to be bulging open, but still locked. The CI stated that [redacted] could put [redacted] hands through the bottom of the cabinet, remove a radioactive (i.e., Rt 10 source) source, and receive a potentially, significant exposure. [redacted] reported this to RP supervision [redacted]. **This apparent minor safety issue was identified and being addressed by the licensee. No action is recommended.** Ex. 6

ARB Recommended Action:

- No additional action
- Inform CI in Ack letter

~~5~~. ~~6~~.

~~Issue #4~~

Concern #6

On September 30, 1998, the CI entered the RP Calibration Room and observed the Shepard calibrator to be on, unsecured and unattended. Specifically, the keys were in the calibrator, the source was raised to the 400 Ci position, a meter was inside the calibration chamber and no RPTs were in attendance. The CI secured the calibrator, performed a radiological survey and reported the event to RP supervision [redacted] and the [redacted]. The CI stated that [redacted] admitted the problem was a procedural violation and agreed to write a PIF (No. B1998-04254). However, the CI subsequently informed us that she did not feel that this PIF adequately described the event. **This potentially significant safety issue was identified and being addressed by the licensee. No action is recommended.** Ex. 6

ARB Recommended Action:

- Refer to licensee. 30 day response
- PSB2 to review licensee response

Other Issues

~~6.~~ 7.

Issue #4

On October 2, 1998, the Byron Resident Inspector (N. Hilton) was approached by [redacted] regarding the CI's work performance and the discrimination issue. [redacted] was unaware that the CI had already approached the NRC. N. Hilton described the specific topics discussed in a Memorandum to J. Hopkins immediately after the conversation. The Memorandum does not identify additional technical concerns, but does provide some clarifying information. **This Memorandum should be discussed at the ARB addressing the discrimination concern.**

EA.6
7C

ARB Recommended Action:

- No action - Additional Information to provide to CI.
- Not include in letter to CI.

~~7. 8.~~

Issue #5

In selected RP logbook entries from 1996-1997, the CI highlighted entries she had made which had received negative comments from other licensee staff. The CI felt that these comments may have been made by management personnel. **These logbook entries could support the CI's discrimination claim and should be discussed at the ARB addressing that concern.** The entries also documented routine findings by licensee RP staff, some of which may constitute minor items of noncompliance. However, as they were identified by the licensee, appeared to be appropriately addressed, and were incidental to the CI's stated concerns, they were not identified as technical findings needing NRC followup.

ARB Recommended Action:

- No action - Additional Information to provide to CI.
- Not include in letter to CI.

~~SENSITIVE ALLEGATION MATERIAL~~

FOLLOW UP ARB: RIII-98-A-0146

October 8, 1998

MEMORANDUM TO: G. Shear, Chief, Plant Support Branch 2, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC

SUBJECT: **FOLLOW UP ARB: RIII-98-A-0146 (Byron)**

The CI has provided multiple documents for the NRC's review. PSB2 has completed its review and recommended that the newly identified issues be addressed at a follow-up ARB.

The follow-up ARB has been scheduled for October 13, 1998. Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases
DRS Division Director For Rx Cases
H. B. Clayton (Wrongdoing)

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

October 7, 1998

MEMORANDUM TO: J. Hopkins, Senior Allegation Coordinator

FROM: G. Shear, Chief, Plant Support Branch 2 (PSB2)

SUBJECT: REVIEW OF DOCUMENTS PROVIDED BY CONCERNED INDIVIDUAL (CI) FOR BYRON ALLEGATION NO. RIII-98-A-0146

Reference: September 29, 1998, Memorandum to G. Shear from J. Hopkins
Documents faxed from CI to J. Hopkins on September 30 and October 5, 1998

This will document the PSB2 staff review of the subject documents received by the Region III EICS staff between September 28 and October 5, 1998. Specifically, the PSB2 staff was asked to determine if there were additional technical concerns.

Our review identified the following additional concerns:

NOTE: Unless stated, no date was provided regarding when these events occurred.

1. While performing a radiological survey of an NRC survey instrument (believed to be a RAMGAM) and a teletector, the CI identified about 30,000 dpm/100 cm^2 of surface contamination. When she brought this to the attention of a supervisor [redacted] she was told to "bury it and don't tell anyone." Another technician, doing a followup survey, found no contamination. The CI believes that this was a "cover-up" by licensee management, that the material was released with contamination, and that it resulted in a personnel contamination event (documented in PIF no. B1998-01565). **This is a potential, deliberate violation of station procedure BAP 720-3 (rev. 20), by a member of RP management, that should be discussed at an ARB. A copy of the procedure is attached to this Memorandum.** EX

2. In response to an NRC finding, [redacted] had instructed the CI to post a cask as a Radiation Area. However, as the CI was attempting to satisfy this issue [redacted] told her to stop. **A violation for this issue (50-454/455-98010-01) was identified by D. Nissen during the subject inspection. As the CI raised no new issues, we recommend no further action be taken.** EX.1

3. During the CI's counseling session, the licensee counselor [redacted] stated to the CI "If people are building personnel cases for litigation, I want to know. Is this clear ?" Additionally, several written comments made by another meeting attendee [redacted] state that [redacted] was visibly angry, spoke in a threatening manner to the CI and that the interview appeared to be an attempt to intimidate the CI. **The statement and written comments could support the CI's concern of discrimination for raising safety issues and should be discussed at the ARB addressing that concern.** EX.6

CONTACT: N. Shah, DRS
630-829-9821

4. On September 29, 1998, the CI entered the RP Calibration Room and observed that the lock to the Shepard calibrator door was removed and laying atop the calibrator with no RPTs in attendance. However, the source was not exposed and was properly secured. The CI stated that she relocked the door and reported this to RP supervision [redacted]. **This is not a safety issue as the source was properly secured. No action is recommended.** EX.4

5. On September 29, 1998, the CI entered the RP calibration room and observed the RP source cabinet doors to be bulging open, but still locked. The CI stated that she could put her hands through the bottom of the cabinet, remove a radioactive (i.e., Rt 10 source) source, and receive a potentially, significant exposure. She reported this to RP supervision [redacted]. **This apparent minor safety issue was identified and being addressed by the licensee. No action is recommended.** EX.4

6. On September 30, 1998, the CI entered the RP Calibration Room and observed the Shepard calibrator to be on, unsecured and unattended. Specifically, the keys were in the calibrator, the source was raised to the 400 Ci position, a meter was inside the calibration chamber and no RPTs were in attendance. The CI secured the calibrator, performed a radiological survey and reported the event to RP supervision ([redacted] and the [redacted]. The CI stated that [redacted] admitted the problem was a procedural violation and agreed to write a PIF (No. B1998-04254). However, the CI subsequently informed us that she did not feel that this PIF adequately described the event. **This potentially significant safety issue was identified and being addressed by the licensee. No action is recommended.** EX.4

7. On October 2, 1998, the Byron Resident Inspector (N. Hilton) was approached by [redacted] regarding the CI's work performance and the discrimination issue. [redacted] was unaware that the CI had already approached the NRC. N. Hilton described the specific topics discussed in a Memorandum to J. Hopkins immediately after the conversation. The Memorandum does not identify additional technical concerns, but does provide some clarifying information. **This Memorandum should be discussed at the ARB addressing the discrimination concern.** EX.6

8. In selected RP logbook entries from 1996-1997, the CI highlighted entries she had made which had received negative comments from other licensee staff. The CI felt that these comments may have been made by management personnel. **These logbook entries could support the CI's discrimination claim and should be discussed at the ARB addressing that concern.** The entries also documented routine findings by licensee RP staff, some of which may constitute minor items of noncompliance. However, as they were identified by the licensee, appeared to be appropriately addressed, and were incidental to the CI's stated concerns, they were not identified as technical findings needing NRC followup.

On October 5, 1998, the CI entered a complaint with the U. S. Equal Employment Opportunity Commission (EEOC) alleging the discrimination issue and several of the above stated concerns. A copy of the EEOC complaint was provided to J. Hopkins by the CI. No new technical issues were described in the EEOC complaint.

In conclusion, the PSB2 staff review identified eight additional issues. Our assessment of the significance of each issue and the associated recommended actions are stated above. Please contact me (xt 9876) if you have additional questions or concerns.

Attachment: as stated

cc w/att: J. Grobe
M. Jordan
R. Paul, OI
K. Lambert
D. Nissen

BAP 720-3
Revision 20

CONTROL OF MATERIALS FOR CONDITIONAL OR UNCONDITIONAL RELEASE FROM RADIOLOGICALLY POSTED AREAS

A. STATEMENT OF APPLICABILITY:

The purpose of this procedure is to provide guidelines for the conditional or unconditional release and control the movement of tools, personnel belongings, volumetrics and other materials from Radiologically Posted Areas (RPAs). The procedure also addresses administrative guidelines for delivering samples to Chemistry for Isotopic Analysis.

B. REFERENCES:

1. BRP 6020-3, "Contamination Surveys".
2. NSRP Policy in the use of tool monitors and sensitivity limits, dated Jan. 4, 1993.
3. NO Directive NOD-RP.11, "Radioactive Material Control".
4. IE Circular 81-07, "Control of Radioactively Contaminated Material".
5. HPSD Guidelines for the use of tool monitors, dated Oct. 20, 1994.
6. IE Notice 85-46, "Removable Surface Contamination Limits".
7. Commitment:
   a. #454-251-88-0918
8. BRP 5825-17, "Control, Storage, Inventory, Leak Testing and Disposal of Radioactive Sources".
9. BRP 5610-9, "Transfer of Rad. Samples to a Non-Licensed Laboratory".

C. PREREQUISITES:

1. Small articles monitors (SAM), tool monitors, large area monitors, or equivalent shall be calibrated to detect 5000 dpm gross with 90% confidence when used for unconditional release.

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OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▶ 13

To NICK SHAH	From NICK HILTON
Dept./Agency DRS / IRTL	Phone # BYRON R10
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

2. Instruments used for unconditional release must have a detection sensitivity of 5000 dpm/100 cm^2 total contamination (fixed and smearable) and 1000 dpm/100 cm^2 removable beta/gamma contamination. If alpha contamination is likely, survey instrumentation must be capable of detecting 100 dpm/100 cm^2 fixed and 20 dpm/100 cm^2 removable alpha contamination.

3. Only qualified Radiation Protection (RP) personnel and those approved by the RP Manager shall be authorized to perform unconditional release of articles except those articles exempt by RP.

   Contracted Technicians normally will not be used to conduct unconditional release surveys of material from the RPA. Should the Station need to utilize Contracted Technicians for unconditional release surveys, the Station will ensure adequate training is conducted. Training should be documented by completion of a student sign-off and must include a review of the proper method and documentation for material release.

4. All items having the potential to be contaminated shall be unconditionally released or meet conditional release requirements.

5. When completing tags, specific descriptions are required to properly identify the materials. General descriptions such as; "tools" or "miscellaneous equipment", should not be used. All blanks should be completed identifying who is responsible for the item.

6. Visitors that will be entering the protected area should perform a whole body frisk to identify potential alarm concerns prior to entering an RPA or exiting the security gatehouse portal monitors (i.e., incoming contamination, nuclear medicine, etc.).

D. PRECAUTIONS:

1. If an item being surveyed for release fails to meet the unconditional release criteria, the item must be resurveyed with the same type of instrument in order to be released. For instance, if an item alarms the small articles monitor, it must subsequently pass a small articles monitor to be released, excluding confirmed natural radioactivity. However, if the tool alarms the SAM and byproduct material is identified during an investigational qualitative isotopic analysis, the item may be resurveyed using a SAM after decon since tools do not have a quantitative geometry.

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2. Only items, containers, and substances associated with specific and well-characterized geometries shall be released using gamma-spectrometry (i.e., liquids). If no quantifiable geometry exists, isotopic analysis will be used for qualitative analysis only. The SAM or portable survey instruments shall be used to supplement qualitative analysis.

3. Ensure all surfaces are surveyed and there is no internal contamination. Special attention should be given to items being released with protective coatings (i.e., grease film, paint, tape, etc.) since they may conceal contamination.

4. The Chemistry Tracking Log and Isotopic Request Form should be completed when anyone other than Chemistry delivers samples to the Counting Room. It is permissible to complete the Log and not submit an Isotopic Request Form for routine radiation monitor samples (e.g. 1/2PR011, 1/2PR028, and 1/2PR029.) The requestor must complete the log by assigning one tracking number per radiation monitor (e.g. 1PR028 gas, particulate, iodine and tritium only require one tracking number) The RPT is responsible for applying a SAVE sticker to 1/2PR028 and 1/2PR029 particulate filters. The iodine, gas, and tritium samples are not required to be saved.

5. If multiple samples are delivered to the Counting Room originating from different sample points, then multiple Tracking Log entries and Isotopic Request Forms are to be completed. For instance, four oil samples are delivered which originated from different sample points, four Tracking Log entries and four Isotopic Request Forms are required. However, if samples are from the same sample point, then only one request form and one log entry is required.

E. LIMITATIONS AND ACTIONS:

1. To determine the detection capability of a portable survey instrument, Attachment C relates detection capability to background. The detection capability was calculated using $4.66\sigma_{bkgd}$ at the midpoint of each range. This value was then added to the midpoint to determine the maximum count rate that can be considered indistinguishable from background (i.e., no activity statistically different from background).

2. A microRmeter (or microREM meter) may be used to augment unconditional release surveys. Any increase in reading above background levels should be treated as contamination.

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3. In some cases one method of monitoring of contamination may indicate activity where another method may not (i.e., SAM vs GM). This is usually due to the difference in surface area assessed. The SAM surveys the volume of material (sometimes several thousand square centimeters) where frisking applies detection only over the area of the probe (15.5 cm^2). For cases when one method indicates activity and another does not, the item will be treated as radioactive material.

4. A SAM should be used whenever practical as the primary means of performing unconditional releases. Items surveyed in the SAM do not need to be smear surveyed (Reference 5). A SAM is not practical for items that might be subject to considerable self-shielding which includes articles containing large quantities of liquid, lead, and paper or plastic >1 inch thick. These items shall be monitored using traditional portable radiation detection instruments. Attachment B lists items restricted from the SAM.

5. The Health Physics Supervisor's approval is required to set up a temporary RPA for more than one shift. Outside radiologically posted buildings/containers should be locked with an RP lock when practical. Material/personnel access in/out temporary RPAs requires approval of the Duty RPLS.

6. Cesium-137 is expected to occur in local soils and process charcoal exposed to outside air, with a magnitude of 1.5E-7 +/- 0.3E-7 $\mu Ci/g$ due to sources other than reactor operation. Soil and process charcoal may be unconditionally released when only Cesium 137 is identified by quantifiable analysis with activity below 1.8E-7 $\mu Ci/g$. Cosmogenically produced isotopes may be unconditionally released.

7. Tools/Equipment will be labelled per BRP 5010-1. These items will be surveyed in accordance with BRP 6020-3.

8. Sample media (filters and charcoal type cartridges) from process monitors and other air sampling equipment can only be unconditionally released if no byproduct material was found during the isotopic/prescreen process. If counts are detected during prescreening, the activity will be assumed to be byproduct material until proven otherwise through quantitative analysis. If no byproduct activity was found on the isotopic, these items may be exempt from further unconditional release survey requirements.

9. Any item that is found to be contaminated during an Unconditional Release survey should be immediately labeled or painted to alert subsequent Control Point RPTs of the survey results.

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10. Liquids containing water must also be analyzed for tritium to the environmental water LLD to be Unconditionally Released.

11. Per a telephone conference with Region III NRC and HPSD on 1/14/97, the NRC indicated that it is permissible to survey small quantities of liquid, including grease and oil, for Unconditional Release in the small articles monitor when residual matter remains, otherwise release per section F.3.f. Therefore, the use of the small articles monitor for surveying small quantities (e.g. a few ml's) of volumetric material as described above is permitted upon approval of Health Physics Supervision.

12. Any necessity for permanent change should be brought to the attention of the Radiation Protection Director. Temporary procedure changes may be made in accordance with existing station procedures.

F. MAIN BODY:

1. **Definitions:**

a. Unconditional release: article/material has no detectable licensed radioactive material above background.

b. Conditional release: article/material is contaminated, or suspected to be contaminated, and is logged and controlled to prevent unauthorized use or removal and is returned to a permanent RPA within 1 shift unless appropriate controls are established.

c. Representative: an adequate amount that serves as a characteristic example of the entire volume/batch.

2. **Control of material entering an RPA:**

a. Tools, equipment, and materials for entry into RPA:

1). A list of items approved for release survey is included in Attachment A. Only items on this list or other items that have been approved by RP Supervision prior to entering the RPA will be surveyed for release. Material entering the RPA should be minimized to reduce the potential of contamination and resulting waste.

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2). If not on Attachment A, before entry, attach a completed "Temporary RPA Use" tag to any tool, equipment, or material if removal from the RPA will be desired. This information should be logged by Radiation Protection on BAP 720-3T3. The tag will:

a). Establish the need to remove the material with the approval of Radiation Protection Supervision before admittance to the RPA.

b). List information including the item description, reason to remove it from the RPA, work supervisor, phone extension, and department. Radiation Protection Supervision will approve and date the tag, and provide as comments, any precautions needed to ensure the item will not become contaminated.

b. Equipment carts will not routinely be allowed to enter or leave an RPA. Equipment needed in RPA's may be transferred to carts already stored in the RPA at the RPA step off pads.

c. If equipment entering the RPA will need to be unconditionally released to be returned to an owner (i.e., owner does not have a license to receive rad material), an entry survey may be performed to establish and document initial on-site conditions. The entry survey will allow detection of licensable material that may be detected by ComEd's more sensitive instruments.

1). The initial survey method should follow the guidance in this procedure. If no activity is detected on the entry survey, then byproduct material detected on the exit survey will be known to be ComEd's responsibility.

a). When activity is detected by either the SAM or portable instrumentation, then document the dpm reading on the temporary use tag or equivalent.

b). If the activity is verified as naturally occurring, the item may be released if the exit release survey activity is within 25% of the entry survey.

c). Items suspected to have natural radioactivity may be sent to Chemistry for qualitative isotopic evaluation.

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2). Notify RP Supervision of any entry surveys that verify byproduct material is present to ensure ComEd will not be held accountable for contaminating equipment that arrived above our detection threshold.

3. **Material release from RPAs:**

a. Administrative controls applicable to all unconditional releases:

1). Workers leaving equipment at the 401' Control Point should complete the Survey Request Sticker and affix to item(s) needing survey. The sticker will ensure the proper owner is notified when the survey is complete.

2). Radiation Protection should document unconditional releases on BAP 720-3T1. Unconditional Release tags are not necessary if the owner immediately removes the item from the RPA, or the RPT places the item on the storage shelf outside the RPA.

3). Materials should be removed from the RPA immediately after unconditional release survey, but removal may be delayed up to 3 days, with Radiation Protection Supervision approval, if safeguards against contamination are ensured.

4). Unconditional release surveys should be performed in a radiation background of less than 100 cpm but shall be less than or equal to 200 cpm as measured by a GM (HP-210 or equivalent), 10 μR/hr (if a micro-R meter is also used) with low background fluctuation, and shall be maintained as low as practical. All material release surveys from the Auxiliary Building, Fuel Handling Building, and Containments will be performed at the 401' Auxiliary Building exit unless otherwise specified by RP Supervision.

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5). To accommodate the unconditional release of vehicles entering an RPA, before the vehicle enters the RPA, complete a smear survey of the area the vehicle is to travel over to ensure there is no smearable contamination. Vehicles which enter an RPA for temporary use (e.g., fork lift), and have no risk of fixed contamination due to the duration in the area and nature of activity, do not require a direct frisk to exit the RPA as long as a thorough smear survey is conducted on the vehicle and meets unconditional release requirements.

6). Options for articles that do not meet unconditional release criteria (contamination is indicated) are:

a). Decontamination and resurvey following procedural guidance (step D.1).

b). Retention for future use in RPA.

c). Decay for short-lived radionuclides.

d). Storage as radioactive material.

e). Shipment as radioactive material.

f). Send to Rad Waste for processing.

b. **Determine Specific Survey Requirements Based on the Category of Item to be Released:**

Items to be considered for unconditional release must be categorized to ensure proper survey techniques. Categorize the material for unconditional release survey into one of the five following choices:

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1). Volumetric sample (liquid, oil, paint, or a readily dispersible solid such as dirt, charcoal, resin, asbestos, etc.):

a). Do you have the volume required to meet the environmental LLD listed in Attachment E to perform a quantitative analysis? Quantifiable geometries are located in the Counting Room LLD book or can be obtained from the Counting Room Chemist. If the minimum volume is not met, go to section F.3.f.

b). Go to section F.3.c.

2). Equipment (tools, pumps, tubing, bottles etc.) and small items:

a). Go to section F.3.d.

3). Personnel and personal belongings:

a). Go to section F.3.e.

4). Qualitative isotopic analysis:

a). Volumetric samples that don't meet geometry requirements such as appropriate volume, or

b). Samples that do not have an approved geometry and are believed to contain naturally occurring isotopes,

c). Go to section F.3.f.

5). Large surface area items:

a). Items that are restricted from SAM, or

b). Items that do not fit in the SAM, or

c). Large amount of material such as trash, hoses, etc.

d). Go to section F.3.g.

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AUG 8 . 1998

c. **Volumetric Release Survey Criteria:**

1). If the sample is a liquid, then it shall be counted to the environmental water LLD. If the sample is a readily dispersible solid, then it shall be counted to the environmental sediment LLD.

2). Deliver a representative aliquot of the volumetric material to Chemistry.

3). All samples being delivered to the Chemistry counting room sample delivery area will be logged on BCP 400-T161, "Counting Room Sample Tracking Log", which will assign a unique tracking number to each sample and establish a Chain of Custody for the sample. Chemistry will then sign the log to acknowledge receipt of the sample and also document the spectrum number when the isotopic is complete.

4). The isotopic analysis requestor (RP personnel, Chemistry personnel, or trained designated alternate) will also complete BCP 400-T133, "Isotopic Analysis Request Form" as applicable. The request form will identify the sample, the purpose of the analysis, and document if the sample needs to be saved. If the sample is to be saved, the form directs the requestor to put a "SAVE" sticker on the sample and ensures the tracking number is on the sticker.

5). A duplicate set of save stickers may be used to clearly label the source of samples and ensure traceability to samples. For instance, Chemistry samples a drum of oil. Sticker 97-001 is placed on the drum and the sample obtained from the drum is also labeled with a save sticker numbered 97-001.

6). If carbon copy forms of BCP 400-T133 are used, both stay with the sample when delivered to Chemistry.

7). Once a sample has been delivered to Chemistry, the RP requestor will attempt to notify either the counting room Chem Tech, or ext. 2242. In addition, the counting room Chem Tech will routinely check the table and log book for new samples.

8). Chemistry will enter the sample tracking number on the isotopic in the Remarks Field or in the Tracking Number Field.

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9). Once analyzed, Chemistry will store all samples associated with surveillances as currently established.

10). Radiation Protection Supervision and/or Chemistry Supervision will review the isotopic report for completeness and accuracy. Radiation Protection will determine if the items will receive unconditional release if:

a). The analysis did not detect any licensable activity above background, and

b). All unidentified peaks have been resolved, or

c). The activity identified was naturally occurring.

11). Samples analyzed for unconditional release will be delivered to the 401' RP Control Point by Chemistry with the original isotopic request form attached. The isotopic will be put in the Duty HP bin with a copy of the request form if available. The Duty HP will notify the 401' RP Control Point of the results. The RPT will document the results on the request form and notify the owner.

12). Liquid samples delivered to the RP Control Point, need the sample container to be smeared to ensure the sample container has no external contamination prior to release.

13). RP will store flammable samples in a flammable cabinet until the owner retrieves them. Samples taken by Chemistry will be the responsibility of Chemistry for disposal, etc.

14). Other departments who may frequently request unconditional release, for example Fuel Handler's oil samples, may be trained on this procedure and then submit their own requests.

15). Refer to Attachment F to follow the sample custody process.

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16). Refer to Chemistry Department Aids to follow the sample analysis process. This process allows Chemistry to screen samples being requested for Unconditional Release before committing the necessary count time to meet Environmental Water LLD. If the sample meets the quick screen, it will be viable to attempt to release. If the sample shows activity on the screening, no further counting is necessary and the sample will be shipped in accordance with BRP 5610-9.

d. **Equipment Release Criteria**

1. Unconditional release surveys of equipment will be performed using the following instruments in order of priority:

   a). SAM or equivalent (see Attachment B for restricted articles).

   b). Portable monitors (GM, μR meter, gas flow proportional counter) when use of a SAM or equivalent is unacceptable. See Attachment D for examples of direct and indirect survey techniques for commonly released items.

2. If the SAM alarms, the contents may be broken down into smaller components to identify the item causing the alarm.

   a). If none of the individual components alarm the SAM, the item must still be treated as radioactive material until it clears the SAM in the original configuration (e.g., as a whole.)

3. If an item is too large to fit in the SAM, it can be broken down into smaller components that may be surveyed as individual parts in the SAM. If all individual parts clear the SAM, the item does not need to be reassembled and surveyed as a whole.

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4. Materials, tools, or equipment with enclosed or concealed areas (hoses, bourdon tubes in gauges, fan motors, etc.) that have potential for internal contamination will be released if no detectable contamination is found when surveyed as follows:

   a). If an item does not fit in the SAM or is not approved to be surveyed in the SAM:

      1). Smear (indirect survey) and frisk (direct survey) external surface with a GM or equivalent to detect external beta, and

      2). Perform a direct reading with μR meter, or equivalent to detect any internal gamma, and

      3). Use swab, pipe cleaner, or appropriate sample media to indirectly survey internal components to extent possible, or

      4). Break down into smaller components that do fit into SAM. In addition, steps 3.d.4.a).1),2), and 3) must be performed if self shielding or enclosed surfaces are still a concern, or

      5). Do not unconditionally release the item.

   b). If item does fit in SAM:

      1). Disassembly may be required at the direction of Radiation Protection Supervision.

      2). Items that have the potential for internal contamination but cannot be properly surveyed due to self-shielding or obstructed surfaces may only be conditionally released unless approved by RP Supervision.

5. Materials in sealed or fully encapsulated containers or in pressurized containers such as batteries, aerosols and gas cylinders do not require internal surveys.

6. Small tools carried in belts or pouches are to be surveyed prior to exit from an RPA.

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AUG 3 _ 1998

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

October 8, 1998

MEMORANDUM TO: J. Hopkins, Senior Allegation Coordinator

FROM: G. Shear, Chief, Plant Support Branch 2 (PSB2)

SUBJECT: REVIEW OF DOCUMENTS PROVIDED BY CONCERNED INDIVIDUAL (CI) FOR BYRON ALLEGATION NO. RIII-98-A-0146

Reference: Documents faxed to EICS staff on October 6, 1998 - serial 23
Record of Discussion between CI and J. Hopkins on October 6, 1998 - serial 22

This will document the PSB2 staff review of the above referenced documents. Specifically, the PSB2 staff was asked to determine if there were additional technical concerns.

Our review identified no new technical issues. Specifically:

1. The CI's concern regarding the potential exposure from the Shepard Calibrator was being addressed by the licensee (i.e., [redacted] and was not considered a significant, safety issue (i.e., required an individual to deliberately bypass controls); and

EX.(
7C

2. The CI's concern regarding overtime was previously identified to the EICS staff, is not regulated by the NRC and was communicated to the U.S. Department of Labor.

In conclusion, the PSB2 staff review identified no new technical issues. Our assessment of the significance of each issue and the associated recommended actions are stated above. Please contact me (xt 9876) if you have additional questions or concerns.

cc: J. Grobe
M. Jordan
K. Lambert
D. Nissen

Monday, October 05, 1998

To: [redacted]
Dept: [redacted]

~~THIS DOCUMENT IDENTIFIES AN ALLEGER~~

Thank You for completing a **PIF** for the problem you identified:

Title: **found digi calibrator (beaky) on and souce in the up position**

PIF No.: [redacted]

NTS No.: [redacted]

Ex 6
7C

Significance Level: **CAQ**

Report Type: **RCR**

Investigating Dept: **CA**

Screening Date: [redacted]

Event Screening Committee Comments:

WHY IS THIS A REPEAT EVENT?!! FIX THIS!! WHY DO OTHERS HAVE UNCONTROLLED KEYS TO AREA? HOW ARE WE CONTROLLING SOURCES IN GENERAL?

If you need further information, please contact the IRP Coordinator or the Event Screening Committee.
A copy of the PIF investigation will be sent to you after it has been completed.

Thank you for being a part of the solution!

The Event Screening Committee

Received 10-6-98

RIII - 98-A-0146 (23)

[redacted]

To: [redacted]
Dept: RP

~~THIS DOCUMENT IDENTIFIES AN ALLEGER~~

Thank You for completing a **PIF** for the problem you identified:

Title:	**found digi calibrator (beaky) on and souce in the up position**
PIF No.:	[redacted]
NTS No.:	[redacted]
Significance Level:	**CAQ**
Report Type:	**RCR**
Investigating Dept:	**CA**
Screening Date:	[redacted]

Event Screening Committee Comments:

WHY IS THIS A REPEAT EVENT?!! FIX THIS!! WHY DO OTHERS HAVE UNCONTROLLED KEYS TO AREA? HOW ARE WE CONTROLLING SOURCES IN GENERAL?

If you need further information, please contact the IRP Coordinator or the Event Screening Committee.
A copy of the PIF investigation will be sent to you after it has been completed.

Thank you for being a part of the solution!

The Event Screening Committee

Received 10-6-98
O.L.K.

RIII-98-A-0146

~~SENSITIVE ALLEGATION MATERIAL~~

ALLEGATION ACTION PLAN AMS NO. RIII-99-A-0130

****

Licensee: Byron

Docket/License No: 50-454

Assigned Division/Branch: DRS / OB

****

Allegation Review Board Membership: Chairman - G. Grant

R. Paul - OI / B Berson D. Hills

~~J. Hopkins~~ / R. Doornbos / B. Clayton ~~M. Jordan.~~ R. Bailey

~~J. Grobe~~ / S. Reynolds (DRS) Frank Collins - Hq OGC

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: No immediate threat to public health and safety.

OI ACCEPTANCE: (YES) NO (Priority: (HIGH) NORMAL LOW)

OI has Accepted Concern(s) No(s). #1

Signature of Accepting OI Official: Mary Kay Ferdig 9-13-99

Basis for OI Priority: _____

ACKNOWLEDGMENT LETTER: PRINT IN FINAL X REVISE ____ N/A ____

REFERRAL LETTER: YES ____ NO X

ARB MINUTES PROVIDED TO J. Dyer / D. Hills / OI

COMMENTS:
The CI **did** object to having identity released.

The CI **did** object to having the concern(s) forwarded to the licensee.

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6+7C
FOIA- 2000-0243

Allegation Review Board Chairman

8/2/99
Date

B/4

1

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-99-A-0130

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 1
A potential compromise of test material may have occurred on July 27, 1999, when the Shift Operation Supervisor (SOS) discussed relative information with one licensed crew prior to performing an evaluation scenario.

Regulatory Basis:
10 CFR 55.49

I. Action Evaluation: The following method of resolution is recommended:

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC
***** ***D. Refer to OI.***
Recommended Priority: HIGH
Recommended Basis: The matter, if it is proven, is of very significant regulatory concern. The potential consequences for safety, given the position of the person involved, any apparent lack of integrity of that person, and the safety significance of the underlying matter, if the violation should be found willful, are high and likely would result in prompt regulatory action by the NRC. The person involve in the willful violation very likely would be removed from licensed activities for a substantial period.
E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
G. Other (specify) -

Responsible for Action - OI / Operations Branch to review OI materials.

II. Special Considerations/Instructions:

If OB is unable to provide a violation the issue will be raised at a follow-up ARB.

OI will accept the case pending a violation being provided by OB.

~~SENSITIVE ALLEGATION MATERIAL~~

NEW ALLEGATION: RIII-99-A-0130

July 30, 1999

MEMORANDUM TO: D. Hills, Chief, Operations Branch, DRS

FROM: J. Hopkins / R. Doornbos, RIII - OAC

SUBJECT: **RECEIPT OF NEW ALLEGATION: RIII-99-A-0130 (Byron)**

On July 29 and 30, 1999, RIII received an allegation concerning a potential exam compromise.

On July 30, 1999, R. Bailey, Operations Branch, Acting Branch Chief, reviewed the concerns with OAC and agrees:

- all of the concerns were identified,
- all of the concerns were correctly characterized,
- the regulatory basis for each concern was correctly identified,
- with the proposed action to resolve each concern,
- with the recommended OI priority and basis for the priority, and
- with the proposed completion date.

An Allegation Review Board (ARB) has been scheduled for August 2, 1999. Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases - Jordan
DRS Division Director For Rx Cases
B. Clayton (Wrongdoing Cases)

Ex.647

From: [redacted]
To: CH_DO.ch_po(RLD2)
Date: Thu, Jul 29, 1999 10:27 PM
Subject: Compomise of LCT simulator exam.

Ex.648

[redacted]

July 29, 1999

Roger D.
NRC
US NRC

Roger,

First I would like to keep my identity confidential. Since I am not the only one that has raised this concern my request should be obtainable. You must paraphrase my allegation so that my identity is kept confidential. I also must insist that the NRC investigate this concern their selves. This is a matter of grave importance and requires prompt action.

My Allegation is as follows,

The Byron Simulator Exams were Compromised by the Byron SOS. After being notified of the deception, Training failed to take action or initiate a Problem Identification Form. One of the Instructors raised the concern that the exam was compromise. I was told rebuked and yelled at for raising the concern.

The SOS covered a Steam Generator Tube Rupture event Tuesday morning during the weekly Requal Training Introduction. Prior to covering the scenario he forced all the training personnel to leave the class room. We thought he was going to discuss training policy that was controversial with the opinions of training. Hindsight reveals that this was done so training would not know he was compromising the exam.

The SOS covered the steps of the procedure, the anticipated plant response, the ways and places to shorten communications and various other think that would allow us to meet the NRC required tube rupture response times and to ensure that non of the SROs fail the exam. During the last cycle, following the failure of an on shift crew the SOS had expressed concern to me that he could not afford to loose anymore SROs.

As soon as the Introduction (coaching session) was complete we took a 10 minute break and proceeded to the simulator where we took our simulator exam. The exam consisted of the Design Bases S/G Tube Rupture that we were just coached on a few minutes earlier. During

THIS DOCUMENT IDENTIFIES AN ALLEGER

Rec'd 7/30/99 via e-mail

the examination we knew exactly what was going to happen next, since we were just coached in how to meet the times for this event. We were commended for our prompt isolation of AF to the ruptured steam generator. Is it any wonder that we isolated AF promptly since we knew ahead of time what was coming.

The examination was compromised. We believe that the training instructors were made to leave the room during the training introduction so they would not have initially been aware that the LCT testing was being compromised. While we were in the exam one of the other SROs that had been in the introduction and that was scheduled to take the simulator exam immediately following our exam brought the cheating situation to the attention of the [redacted] When we were finished with the exam we were sequestered all the instructors were nervous. It is not normal to sequester us following our simulator exam and to make a big deal of simulator exam security following our out of the box simulator exam set. The exam security was more rigorous following the cheating being brought to the lead instructor. EX.6

Another but related concern it the fact after concerns being raised by one of the on shift SROs and one of the Licensed Requal Instructors training did not initiate a PIF. Additionally I was told that the instructor was chastised for raising the concern.

It should be noted that in the past if we did not pass the out of the box simulator exam we were not allowed to fill a licensed position until we successfully passed a retake exam.

Sincerely,

[redacted] EX.6&7

THIS DOCUMENT IDENTIFIES AN ALLEGER

From: Ronald Bailey
To: Roger Doornbos
Date: Thu, Jul 29, 1999 12:42 PM
Subject: Byron Potential Wrongdoing

Roger

See attached file for input on Byron SGTR testing and potiential wrongdoing from a CI.

CC: David Hills, Mary Ann Bies

July 29, 1999

MEMORANDUM TO: Roger Doornbos, Allegations Coordinator
EICS

VIA: Dave Hills, Chief
Operations Branch, DRS

FROM: Max Bailey, Reactor Inspector
Operations Branch, DRS

SUBJECT: VERIFICATION OF OPERATOR ACTIONS DURING SGTR DESIGN BASIS EVENT AT BYRON STATION - POTENTIAL WRONGDOING

On July 1, 1999, I was present during a conference call with Byron Station Management to discuss past licensed operator performance during a Design Basis Steam Generator Tube Rupture Event which was conducted during a normal requalification training cycle. The Training Group Supervision acknowledged that the dynamic scenarios were conducted in a "training mode" versus an "evaluation mode." During the training mode, licensed operators are not formally evaluated, and the simulator crew is expected to stop and discuss actions. Based upon a demonstrated inability of some of the licensed operator crews to meet the FSAR time limits, the plant management determined a need to perform timed evaluations of each licensed operator crew during a DBE-SGTR. It was my understanding that the evaluation would be performed at the beginning of each training week during the current cycle (9905) which started July 20, 1999. In addition, I was informed that the operators would have no foreknowledge of the scenario content and would be considered an "Out-of-The-Box" evaluation (i.e. meaning never seen before).

On July 8, 1999, I observed an evaluation scenario for half of a licensed operator crew to determine the crew's ability to address a DBE-SGTR within the prescribed time limits. The crew was successful with minor deficiencies as noted by the licensee evaluators. On July 20, 1999, I observed two evaluation scenarios for one licensed operator crew to address a DBE-SGTR. The crew was successful with minor deficiencies as noted by the licensee evaluators. Following the completion of the evaluation process, I was approached by the CI to discuss my observations. For which, I replied that my observations agreed with the evaluators and I was questioning some of the operators as to whether they had been forewarned.

On July 28, 1999, the same CI contacted me in the regional office to discuss some questions that he had about the evaluation process. One question regarded the NRC's understanding of what the expectations were for disclosing the content of an evaluation scenario. I responded with a reference to the NUREG-1021 guidelines which noted that individuals being evaluated should not have foreknowledge of the scenario content. In addition, I restated my understanding that the licensee's management would perform timed evaluations using "Out-of-The-Box" scenarios which had not been discussed with any licensed operator being evaluated.

On July 29, 1999, the same CI contacted me in the regional office to inform the agency that a potential compromise of test material had occurred on July 27, 1999, when the Shift Operation Supervisor (SOS) discussed relative information with one licensed operator crew prior to performing an evaluated scenario set. Details surrounding the potential compromise have been provided by the CI. See attached memo discussing a Byron PIF that was generated as a result of these events. Information regarding the history behind the DBE-SGTR timed actions has been presented to the agency. The only new information provided centers around the SOS action to discuss specific operator actions during a SGTR event.

ATTACHMENT:

BYRON PIF

PROBLEM

The SOS covered a steam generator tube rupture event Tuesday morning during the weekly training introduction. We covered the procedure, expectations and techniques on how to meet the time requirements of a Design Bases S/G Tube Rupture. We then went to the simulator for our Simulator Demo Exam which consisted of the Design bases S/G Tube Rupture that we were just coached on a few minutes earlier. The SOS may not have been aware that he was violating the testing procedure since he is new in the position, but I do believe that the training department should have been able to identify the anomaly. During the examination we knew exactly what was going to happen next, since we were just coached in how to meet the times for this event. We were commended for our prompt isolation of AF to the ruptured steam generator, is it any wonder that we isolated AF promptly since we knew a head of time what was coming.

The training examination was compromised. The training instructors were made to leave the room during the training introduction so they may not have initially been aware of that LCT was testing being compromised. The LCT training lead was made aware of the compromise and as far as we could tell failed to follow up on the allegations.

This coaching prior to the examination does not seem to be any different than illegally making a copy of the test and passing it around to the students without the knowledge of the training department simulator to the Dresden Event.

I am concerned that training failed to act once they were informed of the compromising situation and allowed licensed personnel to fulfill positions requiring an active license on Wednesday following the event.

HOW

The PIF details that the class was briefed on the procedure, expectations, techniques to successfully and optimally address a SGTR. The same education has been an assigned tailgate session for the Shift Managers for personnel while on shift. A package had been prepared and delivered to Shift Managers earlier in the month on lessons learned. I believe that both the tailgate material and the conversation held before the "out of the box" set were to educate crews on how to succeed.

WHY

As Operators are obligated to protect the health and safety of the public, successful event mitigation is imperative. During "training" sets earlier in the year and last, the crews times had been longer then desired to mitigate a SGTR. This prompted an aggressive action plan. Two crews were taken to the simulator and evaluated without any notice, they passed. Material was prepared and an education was done immediately by the Shift Managers on shift. Finally material was given the morning of the evaluated set. The evaluation done during the "out of the box" set certainly assessed the improvements that the extra training would have provided. The reference to the SOS coaching is correct as he is driving the department's improvement in this area. The debate appears to be wether the crew should be coached immediately prior to an evaluated set.

SOLUTION

This coaching and history that has prompting the SGTR drilling may not be clear to all personnel. The objectives for specific training sets may not be shared with the crews. Example, two crews were evaluated without notice on the SGTR to see if there was a Station issue. There was not. Then the SOS may have needed to see the impact on the tailgate material and if the lessons learned served to improve each crews performance. The coaching done previous to the set would have established a level of consistency to evaluate the effectiveness of the action plan. The crew may not understand that the evaluations serve more then to consider groups or individuals performance, they also consider the programmatic issues.

The solution offered is that the SOS and training should communicate what the objective of a given evaluation is. The SOS and training should also appreciate the sanctity that the originator applies to exam security. I feel that there was no compromise to the program, the program was being validated, that the crews "educated baseline" is being established. These are the "out of the box" sets and not the annual demos.
(completed by S.Swanson under R. Williams log in)

~~SENSITIVE ALLEGATION MATERIAL~~

October 4, 1999

MEMO TO: R. Gardner, Chief, Electrical Engineering Branch, DRS

FROM: J. Heller, Senior Allegation Coordinator

SUBJECT: REVIEW OF CONVERSATION RECORD FROM A CONCERNED INDIVIDUAL (ALLEGATION NO. RIII-99-A-0150 -- (BYRON)

On October 1, 1999, during a conversation with an individual I was informed that the individual believes he/she was blacklisted from work at Byron because he/she had raised concerns when he/she was previously employed at Byron. The conservation record is attached.

Action

1. Please review the attached conversation record to identify any new safety concerns and/or enforceable items. Please provide the results of your review in a memo to EICS via OAC3. **The results of your review are due to OAC3 by October 18, 1999.** The review date was picked to support the metric for conducting the initial ARB and providing the acknowledgment letter to the concern individuals.

   This memo should state the concerns and/or enforceable items and the regulatory basis for the concerns and/or enforceable items. The memo should be provided in both hard copy and electronic form (e-mail address for the memo is OAC3).

2. If there are any new concerns, please make a recommendation if the concerns should be added to the existing AMS file, or if a new allegation file should be opened and a new ARB should be held.

3. If you call the concerned individual EICS will need a record of the conversation. Please provide that record to OAC3

Attachment(s): as stated

cc w/o attachment:
J. Grobe, Director, DRS
M. Jordan
AMS File No. RIII-99-A-150

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6-7C
FOIA- 2000-0243

D/5

PG 1/3

(3)

~~SENSITIVE ALLEGATION MATERIAL~~

CONVERSATION BETWEEN: CONCERNED INDIVIDUAL (CI) AND JIM HELLER

DATE & TIME: October 1, 1999 AT 8:45 A.M.

SUBJECT: CONCERNS RELATED TO DISCRIMINATION OF A CONTRACT ELECTRICIAN AT BRYON

CONTENT: The CI originally talked to the Byron office assistant on September 30 and left a home telephone number. The CI called the Byron Office later that day and left a message on the answering. Brain Kemker replayed the message for me, gave me the CI telephone number, and we agreed that I would contact the CI. I unsuccessfully called the CI on September 30. I successfully called the CI on October 1, 1999.

The CI's stated that the local union hall steward initially informed him/her that he/she would be working at Byron under a contract with Pope construction. When the CI arrived in the area on [redacted] the union clerk informed the CI that his/her name had been crossed off the work list. Several attempts by the CI to determine why and who deleted his/her name were unsuccessful. The CI stated that he/she was [redacted] years old and had worked as a contract electrician for the last [redacted] years. The CI was last employed by Pope construction at Byron during the '99 steam generator replacement outage (April - June of '99). During that outage Pope construction initially hired him/her as a contract electrician. At the beginning of the outage, several Pope supervisors left [redacted] The CI suggested that the supervisor turnover was due to the poor outage management.

Ex. 6

During the '99 outage [redacted]

Ex 6

Pg 2/3

~~SENSITIVE ALLEGATION MATERIAL~~

[redacted] Ex. 6+7C

At the conclusion of the CI work assignment the CI exited with a member of the Byron outage staff. The CI stated that the purpose of the exit was to discuss strengths and weaknesses. Before the exit a fellow working noted that the CI prepared a list of items to be discussed during the exit. The coworker cautioned the CI not to discuss weaknesses because they have blacklisted individuals who raised issues. The CI thought the coworker warning was a joke. The CI stated that he/she discussed the weaknesses documented above at the exit. During the exit the CI stated that the Byron individual conducting the interview referred several issues to the engineering staff.

The CI now believes that the coworker was not joking about blacklisting individuals. The CI now believes that they (unknown if it was Pope of Byron) blacklisted him/her because he/she discussed problems during the exit.

I asked the CI if access to the plant was denied because he/she had a recent positive fitness-for-duty test or any other problems that would prevent access authorization. The CI stated that he/she has never had an access authorization.

The CI does not object to referring the concerns to the licensee
The CI does not object to releasing his/her name to the licensee

Licensee should conduct a sample field inspection of the routed cables to determine if bend radius was exceeded during cable pulls and if any cable insulation was nicked.

Concern #4

Licensee to determine who was the Foreman that signed work packages as worker when he did not perform work activity. Was the work done on safety related equipment ?

NOTE: Today I contacted (Ken Kover) the system engineering supervisor at Byron in the Nuclear engineering group that was involved with replacement of these cables in the Spring and Fall of 1999. He stated that Byron replaced the CRDM mechanism cables and the Digital Rod Position Indication cables on unit 1 only. He stated that the reason these cables had to be replaced was because of erroneous indications due to nicked originally installed cables. This was due to inadequate cable pulling technique used during original cable installations 13 years ago. He also confirmed that all cables replaced were non-safety related cables. This issue is apparently a generic industry issue with the DRPI system in PWRs.

He provided the following DCP numbers used during the cable replacement project:

DCP 9600412 -- DRPI and CRDM cables
DCP 9800266 -- DRPI cables
DCP 9800267 -- cables to junction panel

Number of NSR cables replaced in Fall 53 CRDMs and 106 DRPIs
Number of NSR cables replaced in Spring 53 CRDMs and 106 DRPIs

~~SENSITIVE ALLEGATION MATERIAL~~

ALLEGATION ACTION PLAN AMS NO. RIII-99-A-0150

Licensee: BYRON

Docket/License No:

Assigned Division/Branch: DRS -- EEB

Allegation Review Board Membership:

Chairman - G. Grant ~~/ G. Pederson~~

Mary Kay Fabee ✓

~~R. Paul~~ - OI / B Berson

L. Williamson

J. ~~Hopkins~~ Hovell / ~~R. Doornbos / B. Clayton~~

M. Fitzgibbons

✓

J. Grobe / S. Reynolds (DRS)

M. Farber

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: _____

OI ACCEPTANCE: ✓ YES NO (Priority: ✓ HIGH NORMAL LOW)

4-99-059

OI has Accepted Concern(s) No(s). 5

Signature of Accepting OI Official: Mary Kay Fabee for Lex Williamson

Basis for OI Priority: _____

ACKNOWLEDGMENT LETTER: PRINT IN FINAL ✓ REVISE ____ N/A ____

REFERRAL LETTER: YES ____ NO ____ no referral until OI interview the CI. OKH

ARB MINUTES PROVIDED TO DYER | OI | 10/26/99

COMMENTS:

The CI **does not** object to referring the concerns to the licensee
The CI **does not** object to releasing his/her name to the licensee

RIV - OI will interview CI before we send any issues to Licensee. OI interview to be conducted by 11/20/99

Allegation Review Board Chairman

10/25/99
Date

B/6

~~SENSITIVE ALLEGATION MATERIAL~~

CONVERSATION BETWEEN: CONCERNED INDIVIDUAL (CI) AND JIM HELLER

DATE & TIME: October 1, 1999 AT 8:45 A.M.

SUBJECT: CONCERNS RELATED TO DISCRIMINATION OF A CONTRACT ELECTRICIAN AT BRYON

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Ex 6, 7C

During the '99 outage

[redacted]

Ex 6 & 7C

0979 | 2

EK647

At the conclusion of the CI work assignment the CI exited with a member of the Byron outage staff. The CI stated that the purpose of the exit was to discuss strengths and weaknesses. Before the exit a fellow working noted that the CI prepared a list of items to be discussed during the exit. The coworker cautioned the CI not to discuss weaknesses because they have blacklisted individuals who raised issues. The CI thought the coworker warning was a joke. The CI stated that he/she discussed the weaknesses documented above at the exit. During the exit the CI stated that the Byron individual conducting the interview referred several issues to the engineering staff.

The CI now believes that the coworker was not joking about blacklisting individuals. The CI now believes that they (unknown if it was Pope of Byron) blacklisted him/her because he/she discussed problems during the exit.

I asked the CI if access to the plant was denied because he/she had a recent positive fitness-for-duty test or any other problems that would prevent access authorization. The CI stated that he/she has never had an access authorization.

The CI does not object to referring the concerns to the licensee
The CI does not object to releasing his/her name to the licensee

9/10/12

SENSITIVE ALLEGATION MATERIAL

ALLEGATION ACTION PLAN AMS NO. RIII-99-A-0150

****

Licensee: BYRON

Docket/License No: 50-454

Assigned Division/Branch: DRS -- EEB

****

Allegation Review Board Membership:

Chairman - ~~G. Grant~~ GROBE

R. Paul - OI / B Berson

~~R. Gardner~~ FARBER

J. Hopkins / ~~J. Adams~~ / B. Clayton

~~M. Jordan~~

J. Grobe / S. Reynolds (DRS)

GENERIC CONCERNS: If Yes Explain: _____

DISCUSSION OF SAFETY SIGNIFICANCE: No immediate threat to public health and safety.

OI ACCEPTANCE: **YES** NO (Priority: **HIGH** NORMAL LOW)

OI has Accepted Concern(s) No(s). **5**

Signature of Accepting OI Official: SEE INITIAL ARB DATED 10/25/99

Basis for OI Priority: _____

ACKNOWLEDGMENT LETTER: PRINT IN FINAL _____ REVISE _____ N/A ✓

REFERRAL LETTER: YES ✓ NO _____

ARB MINUTES PROVIDED TO _Dyer / OI / EEB 12/21/99

COMMENTS:

The CI **does not** object to referring the concerns to the licensee
The CI **does not** object to releasing his/her name to the licensee

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 6 + 7C
FOIA- 2000-0243

John A. Grobe
Allegation Review Board Chairman

12/20/99
Date

B/7

11

~~SENSITIVE ALLEGATION MATERIAL~~

AMS No. RIII-99-A-0150

Each stated concern or NRC identified issue should be documented on a separate sheet. Each concern must be documented and written with enough detail to allow thorough follow up.

Concern No. 5 The CI stated that he/she was blacklisted for raising concerns at Byron (see concerns 1 to 4) to Pope and Licensee management

Regulatory Basis:

I. Action Evaluation: The following method of resolution is recommended (circle):

A. Send to Licensee Requesting Response in _____ Days. (Describe the general areas we expect the licensee to address.)
B. Priority RIII Follow up and Closure Memo to OAC
C. Follow up During Routine Inspection Within _____ Days and Closure Memo to OAC

****** ***D. Refer to OI.***

Recommended Priority: HIGH NORMAL LOW

Recommended Basis: MD 8.8, Part III, Section B

E. Outside NRC's Jurisdiction. Describe Basis Below.
F. Too General for Follow-up. Describe Basis Below.
G. Other (specify) -

Responsible for Action - OI _____

II. Special Considerations/Instructions:

WITHHOLD ENTIRE PAGE
Ex. 6+7C

October 4, 1999

MEMO TO: R. Gardner, Chief, Electrical Engineering Branch, DRS

FROM: J. Heller, Senior Allegation Coordinator

SUBJECT: REVIEW OF CONVERSATION RECORD FROM A CONCERNED INDIVIDUAL (ALLEGATION NO. RIII-99-A-0150 -- (BYRON)

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Action

1. Please review the attached conversation record to identify any new safety concerns and/or enforceable items. Please provide the results of your review in a memo to EICS via OAC3. **The results of your review are due to OAC3 by October 18, 1999.** The review date was picked to support the metric for conducting the initial ARB and providing the acknowledgment letter to the concern individuals.

   This memo should state the concerns and/or enforceable items and the regulatory basis for the concerns and/or enforceable items. The memo should be provided in both hard copy and electronic form (e-mail address for the memo is OAC3).

2. If there are any new concerns, please make a recommendation if the concerns should be added to the existing AMS file, or if a new allegation file should be opened and a new ARB should be held.

3. If you call the concerned individual EICS will need a record of the conversation. Please provide that record to OAC3

Attachment(s): as stated

cc w/o attachment:
J. Grobe, Director, DRS
M. Jordan
AMS File No. RIII-99-A-150

~~SENSITIVE ALLEGATION MATERIAL~~

CONVERSATION BETWEEN: CONCERNED INDIVIDUAL (CI) AND JIM HELLER

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Ex 6, 7C

During the '99 outage [redacted]

Ex 6, 7C

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The CI does not object to releasing his/her name to the licensee

~~SENSITIVE ALLEGATION MATERIAL~~

FOLLOW UP ARB: RIII-99-A-0150

December 13, 1999

MEMORANDUM TO: R. Gardner, Chief, Electrical Engineering Branch, DRS

FROM: J. Heller / J. Adams, RIII - OAC

SUBJECT: RECEIPT OF NEW ALLEGATION: RIII-99-A-0150 (Byron)

On October 1, 1999, EICS received a call (conservation record attached) from a concerned individual (CI) stating that he/she had been blacklisted from employment as a contract electrician at Byron. The ARB held on October 25, 1999, determined that OI would interview the CI before we send any issues to the licensee. On November 16, 1999, RIV OI forwarded the subject interview transcript to RIII. A copy was provided to the RIII Electrical Engineering Branch on November 13, 1999, for review. On December 1, 1999, DRS/EEB completed its review and did not identify any additional safety concerns. DRS/EEB recommends no change in the OI priority for concern 5.

A follow up ARB has been scheduled to review the next course of action for concerns 1 through 5. **I have scheduled an Follow Up Allegation Review Board (ARB) for December 20, 1999.** Please review the attached information to prepare for the ARB.

cc w/attachments:
ARB Copy
OI
RC
DRP Br Chief For Rx Cases -- Jordan
DRS Division Director For Rx Cases
B. Clayton (Wrongdoing Cases)

10

December 1, 1999

MEMORANDUM TO: J. Heller, Senior Allegation Coordinator

FROM: John A. Grobe, Director, Division of Reactor Safety
Original /s/ Steven A. Reynolds (for)

SUBJECT: DRS REVIEW OF OI INTERVIEW TRANSCRIPT (BYRON)
(OI CASE NO. 4-1999-059) (AMS NO. RIII-1999-A-0150)
(AITS S00-2031)

By memorandum dated November 23, 1999, the Division of Reactor Safety was requested to review the subject interview transcript to determine if there are any new safety concerns and whether the OI investigation priority should be changed or an OI investigation is no longer warranted.

DRS completed the review and did not identify any additional safety concerns. After the voluntary layoff of the CI during the outage earlier in 1999, the response from the business manager at the Rockford union hall was that the CI was not welcome at Byron. There was no further explanation given to the CI at the time of the refusal for re-employing the CI. Therefore, we recommend that the OI investigation priority should not change and be continued as HIGH.

cc: L. Williamson, Director, OI RIV

CONTACT: D. Chyu, DRS
(630) 829-9616

(9)

MEMORANDUM TO: J. Heller, Senior Allegation Coordinator

FROM: John A. Grobe, Director, Division of Reactor Safety

SUBJECT: DRS REVIEW OF OI INTERVIEW TRANSCRIPT (BYRON) (OI CASE NO. 4-1999-059) (AMS NO. RIII-1999-A-0150) (AITS S00-2031)

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cc: L. Williamson, Director, OI RIV

CONTACT: D. Chyu, DRS
(630) 829-9616

DOCUMENT NAME: G:DRS\AITS2031.WPD

To receive a copy of this document, indicate in the box: "C" = Copy without attachment/enclosure "E" = Copy with attachment/enclosure "N" = No copy

OFFICE	RIII		RIII		RIII			
NAME	DChyu:jp		RGardner		JGrobe			
DATE	11/ /99		12/ /99		12/ /99			

OFFICIAL RECORD COPY

November 23, 1999

MEMORANDUM TO: J. Grobe, Director, Divisjon of Reactor Safety

FROM: J. Heller, Senior Allegation Coordinator

SUBJECT: OI INTERVIEW TRANSCRIPT (BYRON)
(OI CASE NO. 4-1999-059) (AMS NO. RIII-1999-A-0150)

By memorandum dated November 16, 1999, the Office of Investigations' RIV Field Office Director has forwarded the subject interview transcript to Region III and a copy is enclosed for evaluation by your Electrical Engineering Branch. (The transcript was received by RIII today, November 23.) Your review should determine if there are any new safety concerns identified and whether the OI investigation priority should be changed or an OI investigation is no longer warranted. Please document the results of your review in a memo to me **by December 14, 1999**, and provide a copy of the results of your review to Mr. Len Williamson, Director, OI Region IV Field Office. If new concerns are identified they must be discussed at an allegation review board no later than December 23, 1999.

The interview transcript must be kept in a secure cabinet and access granted on a need to know basis. At the time all of the actions are completed by your Division, the report must be returned to the Enforcement and Investigation Coordination Staff for disposition. No portions of the interview transcript can be reproduced or released without the specific approval of the Director, Office of Investigations.

Attachment: As stated

cc w/o attachment:
OI:RIII
OI:RIV (via e-mail)
RC: B. Berson
R. Gardner
AMS File No. RIII-1999-A-0150

CASE No. 3-1998-014

United States
Nuclear Regulatory Commission

Report of Investigation

BYRON NUCLEAR STATION

Alleged Deliberate Violation of a Radiation Protection Procedure by a Contract Senior Health Physics Technician

Office of Investigations

Reported by OI: RIII

C/1

Portions withheld, EX5, 6, +7C

Title: BYRON NUCLEAR STATION

ALLEGED DELIBERATE VIOLATION OF A RADIATION PROTECTION PROCEDURE BY A CONTRACT SENIOR HEALTH PHYSICS TECHNICIAN

Licensee:

Commonwealth Edison Company
1400 Opus Place, Suite 500
Downers Grove, IL 60515

Docket No.: 50-454; 50-455

Case No.: 3-1998-014

Report Date: June 25, 1998

Control Office: OI:RIII

Status: CLOSED

Reported by:

Joseph M. Ulie, Special Agent
Office of Investigations
Field Office, Region III

Reviewed by:

Richard C. Paul, Director
Office of Investigations
Field Office, Region III

SYNOPSIS

This investigation was initiated on March 30, 1998, by the U.S. Nuclear Regulatory Commission, Office of Investigations, Region III, to determine if a NUMANCO Senior Health Physics Technician (HPT) had deliberately violated any required procedures.

Based on the evidence developed during this investigation, it is concluded that the NUMANCO Senior HPT, deliberately violated a Byron Nuclear Station radiation protection procedure and/or NUMANCO procedure, in that, he was observed by three individuals to be inattentive-to-duty (loitering/sleeping) in the Unit 1 Containment (radiologically posted area) on December 19, 1997.

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DETAILS OF INVESTIGATION

Applicable Regulations

Technical Specifications, Section 6: Administrative Controls

10 CFR 50.5: Deliberate misconduct.

Purpose of Investigation

This investigation was initiated on March 30, 1998, by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region III (RIII), to determine if a NUMANCO Senior Health Physics Technician had deliberately violated any required procedures.

Background (Exhibit 1)

On December 23, 1997, [redacted] at the Byron Nuclear Station (BNS) notified Steven ORTH, Senior Radiation Specialist, Plant Support Branch 2, Division of Reactor Safety (DRS), RIII, about an incident that occurred at the BNS on December 19, 1997. At approximately 10:00 P.M., a Bechtel Carpenter Supervisor (General Foreman), Steven BARNHART, found a NUMANCO Senior Health Physics Technician (HPT), Lester KRAFT, sleeping (inattentive-to-duty/loitering) in containment, a radiologically posted area. The Carpenter Supervisor informed Darrell DIGIOVANNI, another Bechtel supervisor, who summoned Richard BRYANT, a Bechtel Pipefitter Supervisor. BRYANT witnessed the HPT sleeping and then woke him. KRAFT was subsequently terminated from employment at the BNS.

Coordination with the NRC Staff

On January 5, 1998, an Allegation Review Board (ARB) was held to discuss the details involving this allegation, and it was decided to request additional details of the incident from Commonwealth Edison (ComEd). OI:RIII was requested to review ComEd's investigation report and determine what other action may be necessary. Subsequently, on March 30, 1998, another ARB was held on this allegation and OI:RIII was requested to investigate this allegation further. As a result, OI:RIII opened an investigation into this allegation.

Coordination with the Regional Counsel

Bruce BERSON, RIII Counsel, participated in the ARB held on March 30, 1998, which determined that if true, the allegation [redacted] EX.5

[redacted]

Allegation: Alleged Deliberate Violation of a Radiation Protection Procedure by a NUMANCO Senior Health Physics Technician

Evidence

Document Review

By memorandum to G. SHEAR, Chief, Plant Support Branch 2, DRS, dated March 2, 1998, J. HOPKINS, Senior Allegation Coordinator, RIII, provided ComEd's investigation report relevant to the inattentive-to-duty allegation. The ComEd investigation concluded that the contract HPT was sleeping in containment on December 19, 1997 (Exhibit 2).

Section F.3.k of the BNS Radiation Protection Procedure No. BRP 5000-7 specifies that each person entering a radiologically posted area (which includes containment) is responsible to adhere to certain rules including not loitering in radiation fields or airborne radioactivity areas (Exhibit 9, pp. 1-4).

On page 11 of the NUMANCO Field Employee Handbook, a "Disciplinary Action Chart" lists various violations including "sleeping at work", and the related disciplinary action(s) associated with the violation(s). The chart shows that for a first offense of sleeping at work, suspension and/or termination are possible disciplinary actions, which could be taken against an offender (Exhibit 10, pp. 10-11).

Interview of BARNHART (Exhibit 3)

Steve BARNHART, is a former Bechtel Corporation Carpenter General Foreman, who worked on the back shift (6:30 P.M. to 6:30 A.M.) at the BNS from approximately June 1, 1997 to approximately February 1, 1998 (Exhibit 3, p. 4).

BARNHART acknowledged he found an individual (later determined to be KRAFT) that was sleeping in containment during the shift he worked on or about December 19, 1997. He said while he was looking for tools that may have been

hidden or misplaced by other workers in his group, he observed an individual for several seconds inside/under one of the accumulators on the 426' elevation lying completely still in a prone (horizontal) position with his eyes closed and head propped up. According to BARNHART, he shined a flashlight in the individual's face, who was about six feet from him inside a 20" porthole under an accumulator, but the individual did not react at all. BARNHART added that this area was a relatively dark location (Exhibit 3, pp. 4-8).

> AGENT'S NOTE: KRAFT was reportedly found sleeping at the "B" safety injection accumulator area in the Unit 1 containment building.

According to BARNHART, containment and/or the area where he found this individual was a radiologically posted area (Exhibit 3, p. 8).

BARNHART said he did not recognize this individual but assumed the individual was a pipefitter because there were a lot of pipefitters on-site. He said he informed the General Foreman (Bechtel), DIGIOVANNI, of the pipefitters. BARNHART said he first asked DIGIOVANNI if he was missing anyone from his crews but because DIGIOVANNI was extremely busy, DIGIOVANNI said he didn't know. DIGIOVANNI told BARNHART he would take care of it. BARNHART said that was the last he heard of it (Exhibit 3, pp. 8-9).

BARNHART denied knowing KRAFT or who he worked for. He said he believed he never had any run-ins or trouble with this individual (KRAFT) prior to seeing him sleeping at that time (December 19, 1997). BARNHART denied that his reporting this individual for sleeping was any sort of payback for any reason and denied that he had falsely accused this individual of sleeping (Exhibit 3, pp. 9-10).

Statement of BRYANT (Exhibit 4)

Richard BRYANT, a Mechanical Superintendent for the Bechtel Corporation, in his statement indicated that on December 19, 1997, at approximately 10:00 P.M., he received a call from DIGIOVANNI, telling him that a person had been seen sleeping in the "B" accumulator area. According to BRYANT's statement, DIGIOVANNI asked him to take one other guy with him to get the person (sleeping in the "B" accumulator area) and to take that individual to their supervisor (Exhibit 4).

BRYANT's statement said he and Rand TAYLOR, did in fact, find a person sleeping (KRAFT), and woke him up. BRYANT's statement said that he and

TAYLOR, after learning who the individual's supervisor was, escorted KRAFT to his supervisor (Joe SALLIS) and explained (to SALLIS) finding KRAFT asleep (Exhibit 4).

Statement of TAYLOR (Exhibit 5)

Rand TAYLOR, a Bechtel Corporation pipefitter, in his statement specified that on December 19, 1997, BRYANT instructed him (TAYLOR) to follow him (BRYANT) for the purpose of witnessing someone sleeping. TAYLOR's statement said he and BRYANT proceeded to the 426' elevation "B" accumulator area (of containment)(Exhibit 5).

According to TAYLOR's statement, BRYANT knelt down and looked in the manway under the accumulator while he (TAYLOR) looked over BRYANT's shoulder. TAYLOR said he observed an individual sleeping (KRAFT). TAYLOR's statement said BRYANT hollered inside twice to raise the individual's attention. TAYLOR's statement said he then observed the individual walking from the rear of the vessel carrying a radio (believed to be a two-way walkie talkie) and G-M (believed to be a Geiger-Mueller counter). TAYLOR's statement said BRYANT stopped the individual and asked who his (KRAFT's) supervisor was, and then escorted the individual to his supervisor (SALLIS)(Exhibit 5).

Statement of SALLIS (Exhibit 6)

Joe SALLIS, Radiation Protection Supervisor, NUMANCO, in his statement indicated on December 19th, at around 10:15 P.M., BRYANT had escorted Lester KRAFT, one of his technicians to him, explaining that he (BRYANT) had found KRAFT sleeping under the "B" accumulator tank. According to SALLIS' statement, KRAFT denied that he had been sleeping (Exhibit 6).

SALLIS' statement said he consulted with Mark SAYERS, ComEd Radiation Protection Supervisor, who suggested that KRAFT be sent home for the rest of the shift, which SALLIS did. SALLIS' statement indicated he told KRAFT to contact Gerald PARKER, the NUMANCO Site Coordinator the next day (Exhibit 6).

Memorandum of PARKER (Exhibit 7)

PARKER's (NUMANCO Site Coordinator) memorandum says at 2205 (10:05 P.M.) on December 19, 1997, a NUMANCO Contract Radiation Protection Technician was discovered asleep inside the base of the "B" accumulator, at the 426' elevation of the reactor containment building (Exhibit 7).

PARKER's statement indicated that the technician (KRAFT) had reported for work at 1800 hours (6:00 P.M.) for his normal scheduled shift and that his physical appearance had not indicated him (KRAFT) to be tired nor sleepy. In addition, PARKER's statement stated that KRAFT did not report to his supervision any medication being taken that would hinder his work performance. According to PARKER's statement, at 2000 hours (8:00 P.M.), KRAFT was assigned to containment at the 426' elevation rover, meaning he was to provide radiological support for all work on that elevation. His (KRAFT's) schedule indicated he would provide this coverage from 2000 hours through 2300 hours (11:00 P.M.) (Exhibit 7).

According to PARKER's statement, at 2200 hours (10:00 P.M.), a Bechtel Carpenter Supervisor discovered KRAFT asleep and mistakenly thinking he was a pipefitter, summoned two Bechtel Pipefitter Supervisors who witnessed KRAFT sleeping. PARKER's statement says KRAFT stated he was not asleep, however, gave no defense as to the allegation (Exhibit 7).

KRAFT's employment with NUMANCO was terminated as of December 20, 1997, and he will not be considered for future assignment within ComEd, according to PARKER's memorandum (Exhibit 7).

Interview of KRAFT (Exhibit 8)

Lester KRAFT, the former NUMANCO HPT, indicated he was not currently working in the nuclear industry or at any NRC regulated facility (Exhibit 8, pp. 5-6).

KRAFT denied he was sleeping or that he was lying down horizontally during the shift he worked on December 19, 1997. He said he was sitting on a bag underneath the accumulator with his back up against the accumulator. KRAFT said he might have closed his eyes for up to approximately ten seconds, and that is when someone may have happened to observe him (KRAFT). When KRAFT was asked if he had dozed off at anytime during the December 19, 1997 shift, he stated, "I can't really say whether I did or not. I mean, when he (believed to be BRYANT) said something to me, I looked right at him, so I would say no." KRAFT admitted to feeling drowsy while sitting at the accumulator location. He said his head was leaning up against the wall of the accumulator but not propped up on any protective clothing. KRAFT said he chose that particular (accumulator) location because it had a covering over it and because there were a lot of things being moved all around the containment. He said he had been at the accumulator location for about 20 to 30 minutes (Exhibit 8, pp. 10-11, 14-17, 21-22).

According to KRAFT, he began taking a prescription medication, Dilaudid, on about December 19, 1997, for back pain, but indicated he was not able to produce a prescription, or medication bottle (nor any other relevant record) (Exhibit 8, pp. 12-14, 20).

> AGENT'S NOTE: At the time OI:RIII arranged to meet with KRAFT, he (KRAFT) was asked to bring to the interview a prescription record of the medication he was taking on December 19, 1997 and/or the medication bottle. Neither of which, KRAFT claimed during his interview he could locate (Exhibit 8, p. 13; Exhibit 13).

KRAFT indicated he did not know the individuals who escorted him to his supervisor (Exhibit 8, p. 15).

When asked directly if he believed that he may have been the victim of payback from others on-site while at the BNS, he responded, "Possibly, because one of their (Bechtel) people was fired as a result of an HPT telling a worker to put on his gloves, and the worker basically cussed her out, and he was fired. So apparently, there was some word going around that they were going to get one of us fired. So maybe." KRAFT indicated he didn't really have any other specific information to support this concern (Exhibit 8, pp. 15-16).

KRAFT understood that containment was a radiologically posted area and he acknowledged that he understood sleeping on duty was against the rules (Exhibit 8, pp. 9, 20).

Agent's Analysis

KRAFT was initially observed by BARNHART on the 426' elevation of containment in an accumulator area lying completely still in a prone or horizontal position with his eyes closed and head propped up reportedly sleeping. He said he shined a flashlight in KRAFT's face but KRAFT did not react at all. BARNHART added that this area was a relatively dark location and under an accumulator that could only be accessed by going through a 20" porthole, giving rise to the possibility that KRAFT may have been trying to conceal himself. Further, it is believed that it would have taken several minutes from the time that BARNHART notified DIGIOVANNI till the time BRYANT responded with TAYLOR to the accumulator location. Yet, according to BRYANT's and TAYLOR's statements, they too found KRAFT sleeping in apparently the same location. In addition, TAYLOR said in his statement that BRYANT had to shout twice to raise KRAFT's attention once they arrived at the accumulator location.

The evidence indicates three individuals observed KRAFT's inattentive-to-duty (loitering/sleeping) while he (KRAFT) remained in the same location, and each believed KRAFT was "asleep". KRAFT admitted the possibility that his eyes were closed for several seconds, and that he remained in the accumulator area for a 20 to 30 minute time period. KRAFT acknowledged that he understood sleeping on duty was against the rules, and also said he understood that containment was a radiologically posted area, where loitering was a violation of the rules.

With regard to KRAFT's concern that he may have been the subject of payback from (others on-site) those who reported him for sleeping, even he (KRAFT) admitted he didn't know either of the individuals (BRYANT and TAYLOR) who escorted him to his supervisor on December 19, 1997, nor did KRAFT have any other specific facts to support this concern.

Conclusion

Based on the evidence developed during this investigation, it is concluded that the NUMANCO Senior HPT, deliberately violated a BNS radiation protection procedure and/or NUMANCO procedure, in that, he was observed by three individuals to be inattentive-to-duty (loitering/sleeping) in the Unit 1 Containment (radiologically posted area) on December 19, 1997.

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SUPPLEMENTAL INFORMATION

On June 24, 1998, William P. SELLERS, Esq., Senior Legal Advisor for Regulatory Enforcement, General Litigation and Legal Advice Section, Criminal Division, U.S. Department of Justice, Washington, D.C., was apprised of the results of the investigation. Mr. SELLERS advised that, in his view, the case did not warrant prosecution and rendered an oral declination.

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LIST OF EXHIBITS

Exhibit No.	Description
1	Investigation Status Record, OI Case No. 3-1998-014, dated March 30, 1998.
2	Memorandum to G. SHEAR, Chief, Plant Support Branch 2, DRS, dated March 2, 1998, from J. HOPKINS, Senior Allegation Coordinator, RIII, having attached ComEd's investigation relevant to the inattentive-to-duty allegation.
3	Transcript of Interview of BARNHART, dated May 15, 1998.
4	Statement of Richard BRYANT, undated.
5	Statement of Rand TAYLOR, undated.
6	Statement of Joe SALLIS, unsigned, dated December 20, 1997.
7	Memorandum of Gerald PARKER to Larry BUSHMAN, unsigned and undated.
8	Transcript of Interview of KRAFT, dated May 29, 1998.
9	BNS Radiation Protection Procedure No. BRP 5000-7, Revision 7.
10	NUMANCO Field Employee Handbook, Revision 6.
11	Problem Identification Form No. B1997-04996, dated December 19, 1997.
12	Note from S. ORTH, Senior Radiation Specialist, DRS, to J. HOPKINS, Senior Allegations Coordinator, EICS, dated December 23, 1997.
13	Memorandum of Telephone Discussion With Lester KRAFT, dated June 22, 1998.

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14 Memorandum of telephone discussion with Joseph BAUER, dated June 22, 1998, having attached KRAFT's Nuclear General Training Exam results.

15 E-mail response from S. ORTH, Senior Radiation Specialist, Plant Support Branch 2, DRS, RIII, to J. Ulie, Special Agent, OI:RIII, dated June 22, 1998, discussing the requirement for personnel to follow plant radiation protection procedures.

CASE No. 3-1999-036

United States
Nuclear Regulatory Commission

Report of Investigation

BYRON NUCLEAR GENERATING STATION

Deliberate Violation of Compromising the Integrity of a Senior Reactor Operator Simulator Test

Office of Investigations

Reported by OI: RIII

C/2

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Title: BYRON NUCLEAR GENERATING STATION

DELIBERATE VIOLATION OF COMPROMISING THE INTEGRITY OF SENIOR REACTOR OPERATOR SIMULATOR TEST

Licensee:

Commonwealth Edison Company
1400 Opus Place, Suite 500
Downers Grove, IL 60515

Docket No: 50-454

Case No.: 3-1999-036

Report Date: January 19, 2000

Control Office: OI: RIII

Status: CLOSED

Reported by:

Mary Kay Fahey, Senior Special Agent
Office of Investigations
Field Office, Region III

Reviewed and Approved by:

Richard C. Paul, Director
Office of Investigations
Field Office, Region III

WARNING

DO NOT DISSEMINATE, PLACE IN THE PUBLIC DOCUMENT ROOM OR DISCUSS THE CONTENTS OF THIS REPORT OF INVESTIGATION OUTSIDE NRC WITHOUT AUTHORITY OF THE APPROVING OFFICIAL OF THIS REPORT. UNAUTHORIZED DISCLOSURE MAY RESULT IN ADVERSE ADMINISTRATIVE ACTION AND/OR CRIMINAL PROSECUTION.

SYNOPSIS

This investigation was initiated by the U. S. Nuclear Regulatory Commission, Office of Investigations, Region III (RIII), on September 13, 1999, to determine whether a deliberate compromise of test material occurred on [redacted], after a [redacted] at the Byron Nuclear Generating Station discussed pertinent information with a licensed crew prior to performing a simulator training exam.

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Based upon the RIII staff's determination that had this discussion taken place no regulatory violation would have occurred, this allegation was unsubstantiated.

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Ex. 6 & 7C

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LIST OF INTERVIEWEES

Exhibit No. EX. 61

[redacted] Byron 2

[redacted] Byron 3

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DETAILS OF INVESTIGATION

Applicable Regulations

10 CFR 50.5: Deliberate Misconduct
10 CFR 50.59(c): Requalification Program Requirements
10 CFR 55.49: Integrity of Examinations and Tests

Purpose of Investigation

This investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region III (RIII), on September 13, 1999, to determine whether a deliberate compromise of test material occurred [redacted] after [redacted] at the Byron Nuclear Generating Station (Byron), discussed pertinent information with the licensed crew prior to performing simulator training exam.

Background (Exhibit 1)

On July 29 and 30, 1999, two allegers brought similar concerns to the NRC concerning the fact that [redacted] discussed a steam generator tube rupture event during the weekly requalification training introduction [redacted] thereby compromising the simulator exam which followed.

On July 29, 1999, [redacted] Byron, contacted RIII to discuss a potential compromise of test material which had occurred [redacted] had learned that the [redacted] discussed pertinent information with the licensed operator crew prior to performing an "evaluated scenario set."

On July 30, 1999, [redacted] Byron, contacted the NRC and reported that the [redacted] discussed a steam generator tube rupture event [redacted] during the weekly requalification training introduction. Prior to discussing this scenario, the [redacted] asked all training personnel to leave the class room. The [redacted] discussed the steps involved in the steam generator tube rupture procedure, the anticipated plant response, methods for shortening communications and various other items that would allow the crew to meet the NRC-required tube rupture response times and to ensure that none of the SROs failed the simulator exam.

Following the introduction, the crew took a short break and a portion of the crew proceeded to the simulator. The simulator exam consisted of a scenario for the design basis steam generator

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Portions withheld, EX 6 & 7C

tube rupture that the crew had been coached on a few minutes earlier. [redacted] alleged that the simulator exam was compromised.

On September 7, 1999, RIII Operations Branch, Division of Reactor Safety (DRS), determined that a violation of 10 CFR 55.49, requiring that licensees shall not engage in any activity that compromises the integrity of any test or examination required by that part, and 10 CFR 50.59(c), requalification program requirements, had occurred.

Interview of [redacted] (Exhibit 2)

On October 12, 1999, [redacted] was interviewed by OI at Byron regarding the allegation he had reported to RIII. [redacted] provided substantially the following information:

[redacted] stated that Tuesday, [redacted] was the first morning of a week's requalification training for one of the licensed crews. [redacted] stated that as he prepared to enter the classroom for the introduction, he was told by Terry HOLDER, [redacted] licensed instructor, that [redacted] had "kicked out all the instructors." [redacted] suggested that he and HOLDER speak to Tim HORAN, the Operations Training Supervisor, about this. HORAN, however, told [redacted] and HOLDER that if [redacted] wanted to speak with the operators, he could (Exhibit 2, pp. 5-6).

Later that day [redacted] instructor, Ernest TOPPING, was in the requalification classroom for a presentation of a lesson. Two of the SROs in the class told TOPPING that they did not want anything to do with the exam compromise. [redacted] stated that TOPPING was bothered by the fact that there may have been an exam compromise (Exhibit 2, pp. 6-7).

Also later that day, during the question period following the steam generator tube rupture simulator scenario, [redacted] overheard [redacted] say to one of the reactor operators, "Didn't you listen to what I told you this morning?" [redacted] felt that [redacted] implied that something was discussed about how to conduct a steam generator tube rupture (Exhibit 2, p. 6).

[redacted] stated that later that afternoon, HORAN, Dale SPOERRY, Training Manager, and [redacted] met with Rich LOPRIORE, the Byron Station Manager, concerning this matter. [redacted] and several of the training instructors waited around to see what happened, however, it got late and everyone left (Exhibit 2, pp. 6-7).

The next day, Wednesday, [redacted] contacted Ronald "Max" BAILEY, Reactor Engineer, RIII, and asked some general questions about the NRC's expectations during the steam generator tube rupture procedures. [redacted] also spoke with LOPRIORE and asked what had transpired at the

Portions withheld - Ex 4 + 7C

meeting concerning the potential exam compromise. LOPRIORE gave [redacted] a vague answer. SPOERRY met with the training instructors and told them that no Problem Identification Form (PIF) had been written about the incident and SPOERRY claimed no knowledge of any meeting the evening before (Exhibit 2, pp. 7-10).

On Thursday, July 29, 1999, [redacted] again met with HORAN and SPOERRY. [redacted] told them that it was not the expectation to do the timing of the steam generator tube rupture in this fashion. He told them that this was pre-conditioning, or telling the crew how to perform prior to being tested. [redacted] stated that a PIF needed to be written since what happened on [redacted] was not [redacted]'s expectation of doing the right thing. [redacted] stated that the discussion became heated and HORAN and SPOERRY disagreed with [redacted] about the philosophy of whether pre-conditioning had occurred. [redacted] told them that if a PIF was not written, he would write it and he would contact the NRC. [redacted] explained to them that he was not satisfied with the station's response all the way up to the Plant Manager and it was his right to bring the concern to the NRC if he thought the response was inadequate (Exhibit 2, pp. 13-14).

[redacted] told OI that generally, during a simulator exam, the crew does not have any idea what scenario has been selected. He stated that he felt that the integrity of the [redacted] exam was compromised. [redacted] explained that while these simulator exams are not specifically required by Part 55, Byron's administrative procedures include these type of "out-of-the-box" scenarios as part of their operator requalification program. [redacted] explained that the term "out-of-the-box" meant that the crew was evaluated on a scenario prior to having any training (Exhibit 2, pp. 8, 19-21).

Interview of [redacted] (Exhibit 3)

On October 19, 1999, [redacted] was interviewed by OI at Byron regarding the allegation he had reported to RIII. [redacted] provided substantially the following information:

[redacted] stated that he is a [redacted] at Byron and was [redacted] in the [redacted] requalification training class. [redacted] recalled that [redacted] addressed the class and began by stating that he wanted all of the instructors out of the room. [redacted] stated that Peter KNARR, TOPPING, and possibly Gary WOLFE were the training instructors for this training class. After they left the classroom, [redacted] closed the door and discussed a steam generator tube rupture scenario on the simulator. [redacted] stated that [redacted] did not tell the class that this was going to be the scenario for the simulator which would follow, but he went through the steps in the procedure which had been problems in the past, and explained how to perform each step more quickly. [redacted] stated that it was not obvious that this was going to be the scenario once they entered the simulator. However, [redacted] stated that once the crew entered the simulator, they could not believe the scenario selected was a steam generator

Portions withheld EX 6 & 7C

tube rupture. "It was kind of like a joke, almost. We kind of smiled. Basically, we knew everything that was going to happen . . . It was kind of choreographed. It was pretty cool" (Exhibit 3, pp. 5-9).

[redacted] stated that the information [redacted] provided to them prior to the simulator exam was above and beyond the normal kickoff training briefing. He further stated that the crew considered this as a legitimate requalification exam for purposes of being licensed by the NRC. They understood that if they failed the simulator exam, they would have been taken off shift. [redacted] stated that he felt that the simulator exam had been compromised and he subsequently prepared [redacted] (Exhibit 3, pp. 11-13; Exhibit 4).

[redacted] explained that [redacted] from the afternoon crew, raised a concern about the simulator exam being compromised with KNARR. [redacted] stated that [redacted] also raised the same concern to HORAN (Exhibit 3, pp. 14-15).

[redacted] told OI that after he submitted the [redacted] he requested a meeting with LOPRIORE to discuss this concern. [redacted] met with LOPRIORE, and Marceyne SNOW [redacted] LOPRIORE told [redacted] that this was all planned and had been discussed previously with the NRC, that they were going to cover discussion of the steam generator tube rupture scenario in class and then go ahead and run the simulator (Exhibit 3, pp. 18-19).

Coordination with NRC Staff

On October 29, 1999, James HELLER, Senior Allegation Coordinator, RIII, provided a copy of [redacted] October 19, 1999, OI interview to DRS for review to determine what action was required to resolve any technical issues. On November 22, 1999, Operations Branch, DRS, notified the Enforcement and Investigations Coordination Staff that after review they concluded that no violation of NRC requirements occurred (Exhibit 5). At an Allegation Review Board on November 29, 1999, it was determined that OI would close this matter after it was determined that no regulatory violation had occurred.

Conclusion

Based upon the determination by the RIII staff that no regulatory violation has occurred, this allegation was not substantiated.

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Portions withheld - EX 6 + 7C

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LIST OF EXHIBITS

Exhibit No.	Description
1	Investigation Status Record, OI Case No. 3-1999-036, dated September 13, 1999.
2	Transcript of Interview of [redacted] dated October 12, 1999. EX. 6 + 7C
3	Transcript of Interview of [redacted] dated October 19, 1999.
4	[redacted] dated July 28, 1999.
5	NRC Memorandum from McNEIL to CLAYTON, dated November 22, 1999.

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