U.S.NRC
United States Nuclear Regulatory Commission
Protecting People and the Environment

NUREG-1830, Vol. 13

Office of Investigations Annual Report FY 2016

Office of Investigations

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Office of Investigations

ABSTRACT

This report provides the U.S. Nuclear Regulatory Commission with an overview of the Office of Investigations' (OI's) activities, mission, and purpose, along with the framework of case inventory with highlights of significant cases that OI completed during fiscal year 2016 (reference Staff Requirements Memorandum COMJC-89-8, dated June 30, 1989). This is the 28th OI annual report.

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DIRECTOR'S MESSAGE

This Annual Report highlights the investigative activities and accomplishments of the Nuclear Regulatory Commission (NRC) Office of Investigations (OI) from October 1, 2015 through September 30, 2016. During this period, the OI concluded 114 investigations and 23 assist to staff. One hundred percent of our substantiated investigations were referred to the Department of Justice. The investigations summarized in this annual report reflect our dedication to promoting the NRC mission to protect public health and safety, promote the common defense and security, and protect the environment.

This Report is my first since being appointed Director of the Office of Investigations in June. I want to thank the Commission and the Office of the Executive Director for Operations for giving me this opportunity to serve the NRC. Additionally, thanks are due to the OI staff, the OI Senior leadership team and the Deputy Director under whose leadership much of the work reported in this period was conducted.

Our activities during this period reflect our continued commitment to excellence in conducting credible, independent, comprehensive, and timely investigations of wrongdoing. OI's mission was mandated in 1982, when the Commission determined the need to establish a separate Office of Investigations to ensure the Commission would have an office dedicated exclusively to the conduct of investigations; staffed with individuals who had the specialized background and training necessary to pursue potential wrongdoing by NRC licensees, applicants, their contractors or vendors.

As the OI Director, I am honored to lead an organization staffed by a cadre of seasoned career Federal criminal investigators (GG-1811) and a highly motivated professional support staff who administer the program in accordance with Commission-approved policies. Additionally, I appreciate the outstanding work performed by the staff and their deep commitment to the mission of the NRC and public service. The OI is committed to maintaining the highest possible standards of professionalism and quality in our investigative activities.

Our work reflects the OI's commitment to helping the NRC fulfill its regulatory responsibilities and we continue to benefit from the support provided by the Commission, agency managers, and technical/professional staff who recognize OI's value and independent role in accomplishing the agency's goals.

Kimberly A. Howell
Director

1 FISCAL YEAR 2016 HIGHLIGHTS

During fiscal year (FY) 2016, the U.S. Nuclear Regulatory Commission (NRC) Office of Investigations (OI) recruited, hired, and maintained a mission-driven, high-performing workforce, and affirmed its commitment to investigative independence, excellence, and adherence to established quality standards. OI is comprised of experienced Federal criminal investigators and professional support staff who continuously exceed the expectations of both internal and external stakeholders. With the goal of continuous program improvement, OI implemented several strategies that enhanced OI's investigative role within the NRC.

OI accomplished the following significant achievements during FY 2016:

- OI closed 114 investigations, 91 percent (104 investigations) of which OI developed sufficient information to reach a conclusion that substantiated or unsubstantiated allegations of willful wrongdoing. This exceeded OI's performance measure of 90 percent.
- Of the above 114 investigations, OI closed 96 percent in 12 months or less. This exceeded OI's performance measures for both reactor and materials investigations.
- Of the 23 assists to staff closed, 100 percent were closed within 90 days, which exceeded OI's performance measure of 90 percent.
- OI processed 61 Freedom of Information Act requests in a timely manner.
- OI referred 100 percent of its substantiated wrongdoing investigations to the U.S. Department of Justice for prosecution consideration.
- OI continued operational law enforcement liaison with Federal, State, and local law enforcement officials throughout the United States in support of the NRC Federal Security Coordinator Program, as required by the Energy Policy Act of 2005.
- The United States Department of Homeland Security (DHS), Homeland Security Investigations, Harrisburg, PA and the Office of Investigations (OI) are working together on a critical infrastructure security protection enhancement project on Chicago Bridge & Iron (CB&I), Baton Rouge, LA. CB&I provides contract employees to the five Exelon nuclear power plants in Pennsylvania: Three Mile Island Unit 1; Peach Bottom Units 1 and 2; and Limerick Units 1 and 2. As part of this initiative, OI and DHS requested information of CB&I contract employees who were granted unescorted access to the power plants between January 1, 2015, and June 30, 2016.

OI Staff Tour of Three Mile Island

This is the third such project that OI has participated in with DHS. It is an excellent example of the close cooperation and joint investigative effort between OI and one of our federal partners to insure the safety and security of a key component of the nation's critical infrastructure.

2 INTRODUCTION AND OVERVIEW

HISTORY, AUTHORITY, AND MISSION

History

In 1982, with the support of the U.S. Department of Justice (DOJ) and the U.S. Congress, the U.S. Nuclear Regulatory Commission (NRC) established the Office of Investigations (OI) as part of an agency effort to improve the quality of its investigative work and to support the NRC's overall mission. On April 20, 1982, the Commission announced the formation of OI to improve NRC's capability "to perform credible, thorough, timely and objective investigations." OI was accorded the responsibility to conduct independent investigations either at the request of specific NRC officials or on its own initiative. OI subsequently hired experienced Federal criminal investigators, which it continues to maintain today, who conduct investigations of alleged wrongdoing in accordance with DOJ guidelines and Quality Standards for Investigations established by the Council of Inspectors General on Integrity and Efficiency.

Authority

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

Additionally, during the course of investigations, OI may uncover potentially safety-significant issues that may, or may not, be related to wrongdoing. In these instances, OI provides this information to the technical staff in a timely manner for appropriate action. OI also provides professional investigative expertise to the NRC staff in the form of assists to staff. Generally, these assists to staff are associated with matters of regulatory concern for which the NRC staff has requested OI's investigative expertise, but that do not initially involve a specific indication of wrongdoing.

Mission

As stated in the NRC's Strategic Plan for FYs 2014-2018, the agency's mission is to license and regulate the Nation's civilian use of radioactive materials to protect public health and safety, promote the common defense and security, and protect the environment. The NRC's vision is to carry out its mission in a manner that ensures it remains a trusted, independent, transparent, and effective nuclear regulator. The NRC's strategic plan defines the strategic goals and objectives that will allow the agency to carry out its mission and identifies activities that will contribute to achieving these goals.

OI aligns with the agency's regulatory programs and strategic values and goals to provide for the safe use of radioactive materials and nuclear power for civilian use. OI's national investigations program consistently operates under the agency's principles of good regulation, openness, efficiency, clarity, and reliability to support regulatory actions that are effective, realistic, and timely.

3 THE OFFICE OF INVESTIGATIONS

The Director of the Office of Investigations (OI) reports to the Deputy Executive Director for Materials, Waste, Research, State, Tribal, and Compliance Programs, and supports the reactor and materials programs.

OI is an independent, national investigations program, which consists of four regionally co-located field offices led by special agents in charge, who report directly to OI senior executives located at OI headquarters. OI field and headquarters offices are staffed by Federal criminal investigators (special agents (GG-1811)) and professional support staff.

All NRC OI special agents have extensive backgrounds and experience in Federal criminal investigations. During FY 2015, the professional cadre of OI special agents possessed an average of 17 years of Federal law enforcement experience. OI special agents have previously served at Federal law enforcement agencies such as the Bureau of Alcohol, Tobacco, Firearms and Explosives; U.S. Department of Energy; Naval Criminal Investigative Service; U.S. Department of Labor; U.S. Air Force Office of Special Investigations; Federal Bureau of Investigation; U.S. Secret Service; U.S. Drug Enforcement Administration; and various offices of Inspectors General.

OI plans and conducts investigations of allegations of wrongdoing to determine whether there are willful and deliberate actions in violations of NRC regulations and criminal statutes. OI also develops and implements policies, procedures, and quality control standards for investigations. OI conducts investigations in accordance with the Quality Standards for Investigations established by the Department of Justice guidelines and Quality Standards for Investigations established by the Council of Inspectors General on Integrity and Efficiency. Additionally, OI maintains proactive investigative partnerships with other Federal, State, and local law enforcement officials.

Susquehanna steam electric station

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4 DIRECTOR AND FIELD OFFICE REVIEW VISITS

The OI Director or Deputy Director annually visits each of the OI field offices, which are co-located in the four NRC regional offices. During these visits, OI senior executives place particular emphasis on enhancing effective communication among OI staff and internal stakeholders to promote organizational excellence. The Director's visit may include individual meetings with each OI employee to discuss a variety of subjects and to effectively address any concerns or questions. Additionally, investigative and support staff at OI headquarters may accompany the Director or Deputy Director during visits to OI field offices, which provide opportunities for effective knowledge transfer and increased operational and programmatic awareness. These visits facilitate, encourage, and demonstrate an open exchange of ideas and expressions of differing views between OI senior management and its field office personnel, as well as between OI and regional senior management.

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

FORVs include meetings with OI personnel to discuss current OI headquarters' initiatives and activities, policy and procedural focus, and special or regional items of interest. During these self-assessments, OI personnel are interviewed to obtain timely feedback about operational matters and to discuss any issues of particular interest to the employee. Additionally, the FORV team meets with internal stakeholders, including the Regional/Deputy Regional Administrator, Regional Counsel, Enforcement Coordinator, Allegation Coordinator, and other regional staff, as appropriate.

At the conclusion of the FORVs, an exit briefing is conducted with the OI field office personnel to discuss the findings and recommendations of the FORV team. A final OI senior management and OI headquarters' review of the FORV teams' findings is conducted to identify and implement best practices with a view toward continuous program improvement and investigative excellence

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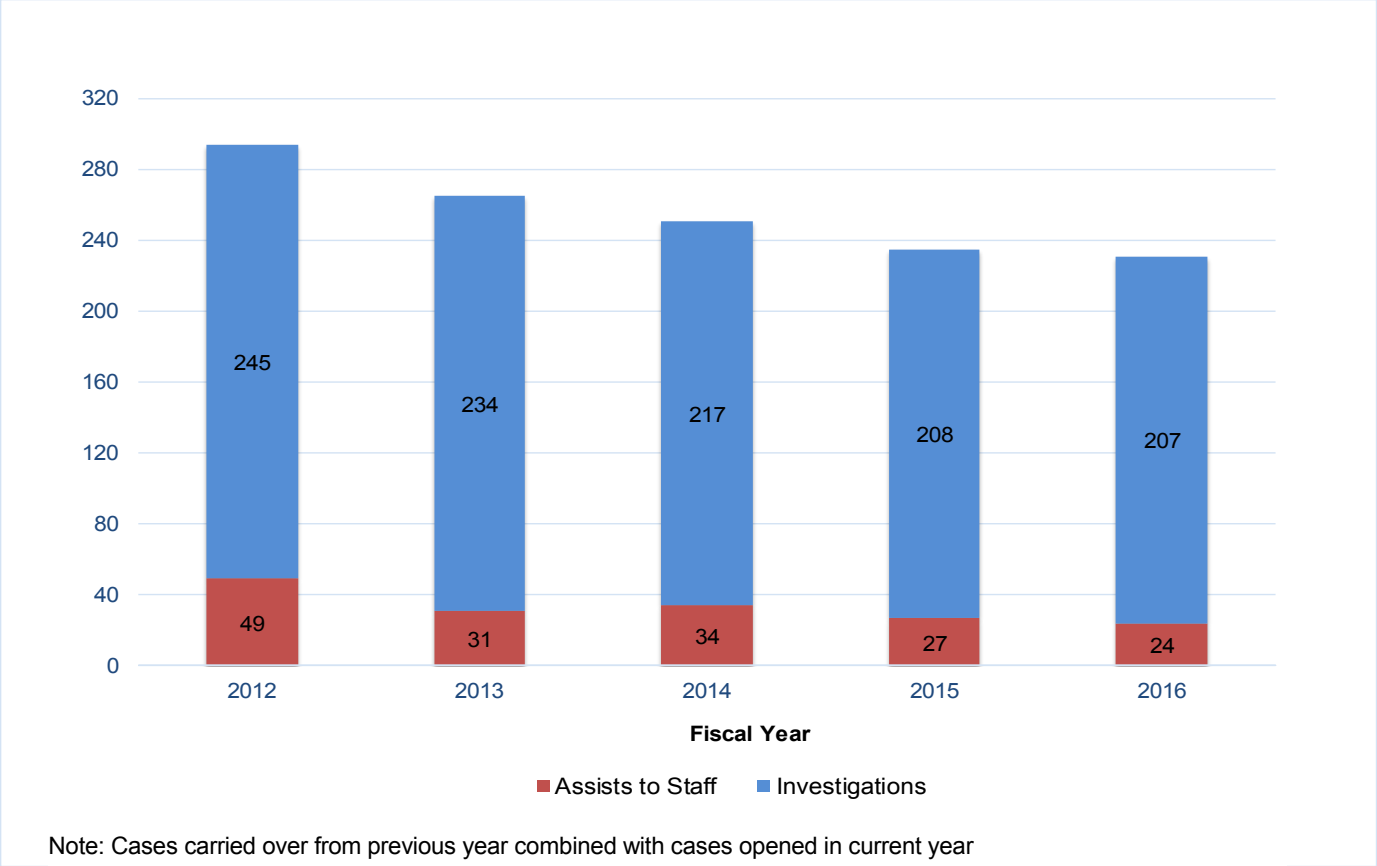
5 CASES

Case Inventory

Figure 1 shows the OI case inventory, which includes all investigations and assists to staff conducted during FY 2012 through FY 2016. The total case inventory in FY 2016 was 231. This total includes 207 investigations, 108 of which were carried over from FY 2015. Also included are 24 assists to staff, 4 of which were carried over from FY 2015.



Note: Cases carried over from previous year combined with cases opened in current year

Figure 1 Case Inventory

The total number of cases in the OI inventory during FY 2016 was 231, which was a 2 percent decrease from 235 in FY 2015

6 CASES OPENED

Table 1 shows the number of cases opened by category during FY 2012 through FY 2016. In FY 2016, there was a 14-percent decrease in total cases opened from FY 2015. There was a decrease of 27 percent in the number of suspected material false statements investigations and a 33-percent decrease in violations of other NRC regulatory requirements. In FY 2016, the number of discrimination investigations increased by 28 percent, and the number of assists to staff cases decreased by 23 percent. OI opened 119 cases in FY 2016 in the categories listed below.

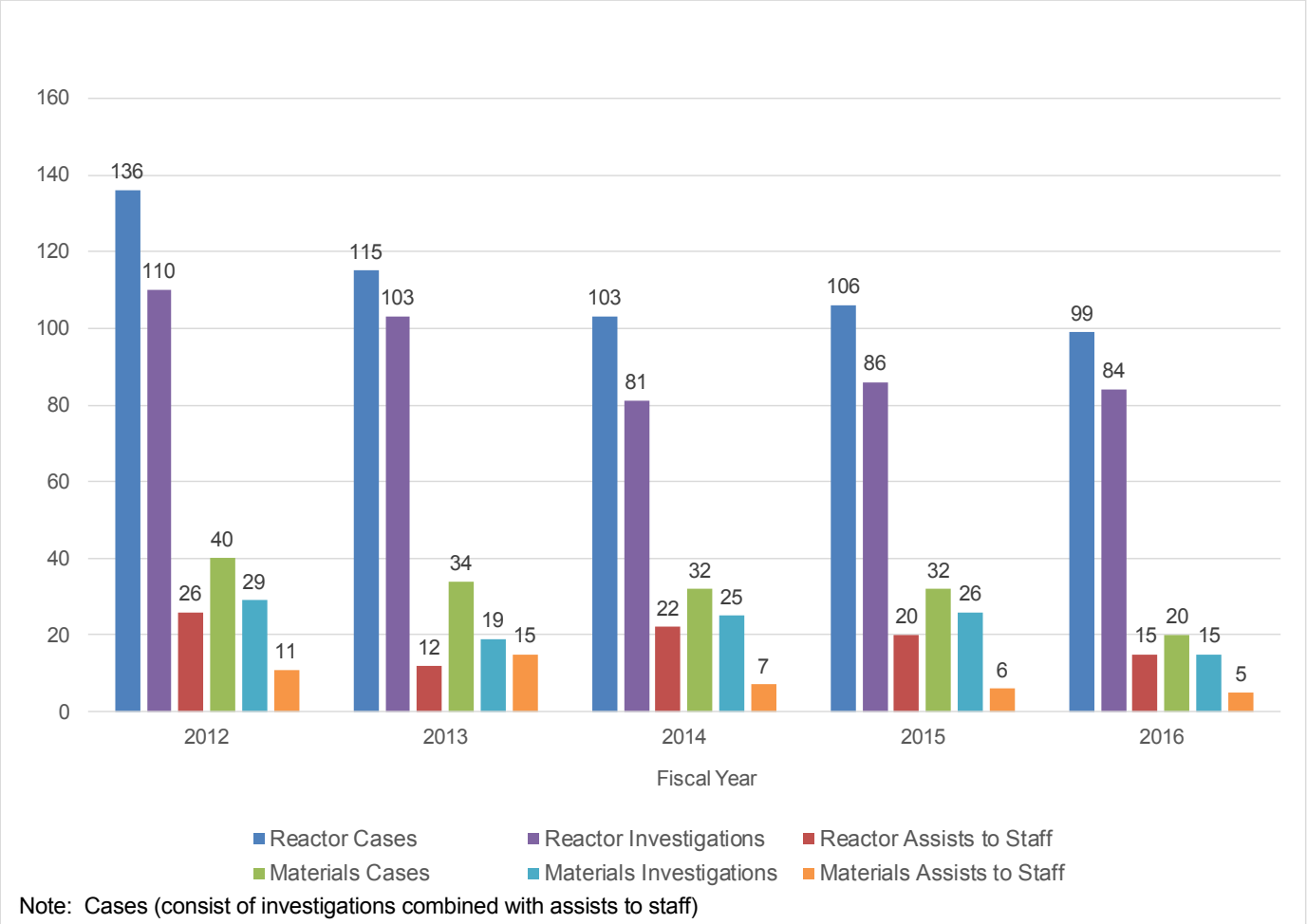
Table 1 Cases Opened by Category

Category	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Total	176	149	135	138	119
Material False Statements	18	20	35	33	24
Violations of Other NRC Regulatory Requirements	73	52	38	43	29
Discrimination	48	50	33	36	46
Assists to Staff	37	27	29	26	20

Note: Of the 119 cases opened in FY 2016 20 percent were comprised of material false statements, 24 percent were violations of other NRC regulatory requirements, 39 percent were discrimination, and 17 percent were assists to staff.

The graph in Figure 2 shows the distribution of cases opened during FY 2012 through FY 2016 for the Reactor and Materials programs. From FY 2015 to FY 2016, the overall number of reactor cases decreased by 7 percent. Of the reactor cases, there was a 2-percent decrease in reactor investigations and a 25-percent decrease in reactor-related assists to staff.

The number of materials cases decreased by 38 percent. Of the materials cases, there was a 42-percent decrease in materials investigations and a 17 percent decrease in materials-related assists to staff.



Note: Cases (consist of investigations combined with assists to staff)

Figure 2 Cases Opened by Reactor / Material

Reactor cases: 99
Reactor investigations: 84
Reactor assists to staff: 15

Materials cases: 20
Materials investigations: 15
Materials assists to staff: 5

7 CASES CLOSED

Table 2 shows the number of cases closed by category during FY 2012 through FY 2016. The total closed during FY 2016 represents a 11-percent increase from the number closed in FY 2015. There was a 3-percent increase in material false statements investigations and a 11 percent increase of investigations involving violations of other NRC regulatory requirements. Discrimination investigations increased by 28 percent and assists to staff remained the same at 23 percent. OI closed 137 cases in FY 2016 in the categories listed below.

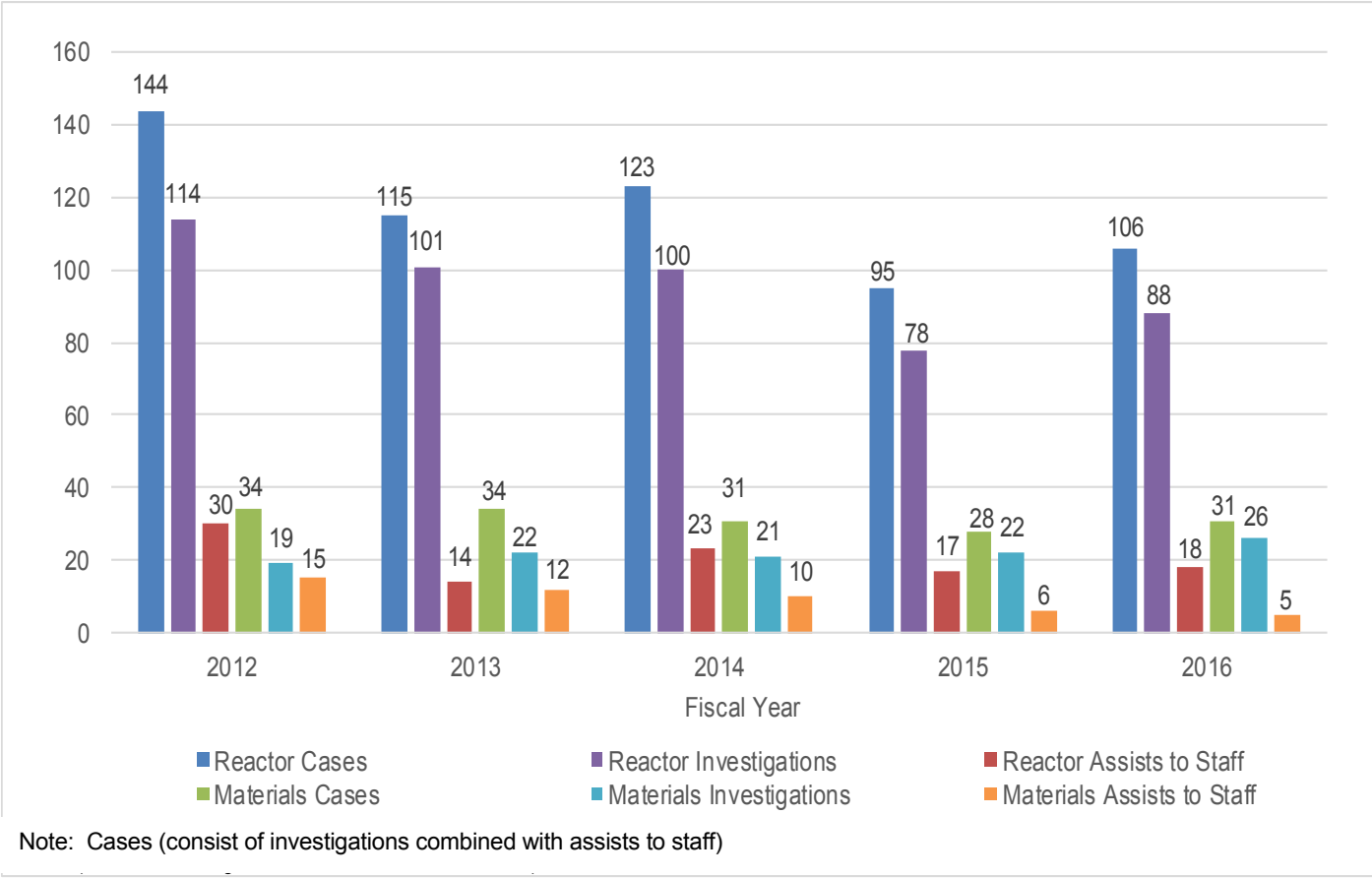
Table 2 Cases Closed by Category

Category	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Total	178	149	154	123	137
Material False Statements	14	24	19	33	34
Violations of Other NRC Regulatory Requirements	63	54	50	38	42
Discrimination	56	45	52	29	37
Assists to Staff	45	26	33	23	23

Note: Of 137 cases closed in FY 2016, 25 percent were comprised of material false statements, 31 percent were violations of other NRC regulatory requirements, 27 percent were discrimination, and 17 percent were assists to staff.

The graph in Figure 3 shows the cases closed from FY 2012 through FY 2016 for the Reactor and Materials programs. From FY 2015 to FY 2016, the overall number of reactor cases increased by 12 percent. Of the reactor cases, there was a 13-percent increase in reactor investigations and a 6-percent increase in reactor-related assists to staff.

The overall number of materials cases increased by 11 percent, with a 18 percent increase in materials investigations and a 17-percent decrease in materials-related assists to staff.



Note: Cases (consist of investigations combined with assists to staff)

Figure 3 Cases Closed by Category

Reactor cases: 106
Reactor investigations: 88
Reactor assists to staff: 18

Materials cases: 31
Materials investigations: 26
Materials assists to staff: 5

Of the 137 cases closed in FY 2016:

- 41 investigations were closed after OI substantiated willfulness on one or more of the allegations of wrongdoing
- 63 investigations were closed after OI investigations did not substantiate willful wrongdoing
- 10 investigations were administratively closed
- 23 of the total number of cases closed were assists to staff

8 SIGNIFICANT INVESTIGATIONS

Chicago Bridge & Iron

This OI investigation substantiated that three former contract Quality Control (QC) inspectors, employed by Applus, RTD, at Chicago Bridge and Iron (CB&I), deliberately falsified certification records. Specifically, OI developed evidence during this investigation that substantiated that three contract QC inspectors deliberately falsified visual inspection (VT) certification records in order to gain employment with Applus, RTD. Additionally, one of the QC inspectors deliberately falsified visual weld inspection reports by signing and thereby attesting to their accuracy and completeness, causing CB&I to be in violation of NRC regulations. Further, the investigation determined that a former Applus, RTD manager deliberately instructed the QC inspector to create and provide Applus, RTD with the false certifications. Lastly, the investigation substantiated that the three quality control inspectors and the former operations manager deliberately made false statements and/or deliberately conspired to make false statements to OI.

The investigation was referred to the U.S. Department of Justice (DOJ) for prosecutorial consideration. On July 28, 2016, the former QC inspector, charged with Title 42, U.S. Code, Section 2273, “Violations of Sections Generally” and Title 10, Code of Federal Regulations, Section 50.5, “Deliberate Misconduct”, pled guilty in Federal district court to knowingly and deliberately submitting false information that was material to the NRC and subsequently visually inspected welds on a nuclear project being built by CB&I. On November 3, 2016, the QC inspector was sentenced to 36 months of probation and to pay $29,385 in restitution. The results of this investigation remain under regulatory review by the NRC staff.

Applied Technical Services

This OI investigation substantiated an allegation that a licensed Radiographer/Assistant Radiation Safety Officer (ARSO), employed by Applied Technical Services (ATS), Inc., deliberately failed to follow NRC regulations and licensee procedures during the performance of radiography operations at a temporary job site on the National Aeronautics and Space Administration (NASA) Langley Research Center in Hampton, VA. The evidence that OI developed during this investigation substantiated that the ATS Radiographer/ARSO deliberately failed to conduct required surveys; to post signage to establish a visible radiological boundary; and to maintain continuous direct visual surveillance of the operation to protect against unauthorized entry into a radiation area or high radiation area in accordance with NRC regulations. On July 28, 2016, the NRC issued a Severity Level III Notice of Violation (NOV) to the individual and a Severity Level III NOV and a $7,000 civil penalty to the licensee.

Novelis

An OI investigation was initiated to determine whether Novelis Corporation employees deliberately performed unauthorized maintenance on a fixed nuclear gauge in violation of a condition of its license, which restricts repair to components related to radiological safety of the gauge to licensed personnel. The OI investigation substantiated that a Novelis Authorized User Technical Specialist deliberately performed unauthorized maintenance on a fixed nuclear gauge on when the shutter operating mechanism failed on two separate occasions. Additionally, OI determined that an Engineering Reliability and Automation Manager engaged in deliberate misconduct on two occasions when the manager directed the employee to perform the unauthorized repairs, despite the objections of the first repair by a Radiation Safety Officer (RSO). Further, the OI investigation

substantiated that the RSO engaged in deliberate misconduct regarding the second gauge repair when he did not object to nor stop the employee's unauthorized repair even though the repair was performed in his presence and under his supervision. On May 13, 2016, the NRC issued a Severity Level III Notice of Violation (NOV) to the manager and a Severity Level III NOV, which included a $7,000 civil penalty, to Novelis.

Davis-Besse

An OI investigation substantiated the allegation that a reactor operator deliberately failed to report a change in a medical condition at Davis-Besse, per a condition of the NRC reactor operator's license. The OI investigation revealed that on multiple occasions, between February 2013 and July 2014, the reactor operator discontinued taking various medications prescribed for a medical condition and failed to report a change in medications as a condition of the reactor operator license. During the course of the investigation, OI independently developed evidence that also substantiated the reactor operator deliberately falsified an NRC Form 396, titled, "Certification of Medical Examination by Facility Licensee" by attesting to the completeness and accuracy of the document. The reactor operator admitted to OI that inaccurate information had been provided on the medical forms to the licensee when he failed to document the discontinuance of taking two of four prescription medications in order to avoid any problems with the submittal of a medical update. As a result of the reactor operator's actions, Davis-Besse provided the NRC with incomplete and inaccurate information on medical records violating the agency's regulations. On September 1, 2016, the NRC issued a Confirmatory Order to FirstEnergy Nuclear Operating Company (FENOC), who operates Davis-Besse, requiring the licensee to address violations identified through this investigation.

Palisades (3-2012-021)

An OI investigation substantiated that personnel at the Palisades Nuclear Plant deliberately provided inaccurate and incomplete information to the NRC regarding a May 2011 Safety Injection and Refueling Water Tank (SIRWT) leak. The OI investigation determined through interviews that the plant personnel believed that an identified SIRWT leak would result in a plant shutdown. Based on this testimony, OI obtained evidence that concluded that four individuals failed to provide complete and accurate information regarding the SIRWT leak in the Palisades' Corrective Action Program (CAP) as required by procedure, allowing the source of the leakage to languish as indeterminable. OI also concluded that engineering and operational staff acted in careless disregard when they failed to follow procedures, allowing the inaccurate and incomplete information to propagate through the Palisades' CAP. On May 16, 2016, the NRC issued a Confirmatory Order to the licensee, requiring the licensee to address violations identified through this investigation.

Acuren USA, Incorporated

An OI investigation substantiated that Radiographers at Acuren USA, Incorporated (Acuren), deliberately conducted radiography operations without proper postings and monitoring, at the licensee's Kenai, AK, facility. The OI investigation established the radiographers failed to maintain continuous direct visual surveillance of the operations, to protect against unauthorized entry into a high radiation area, and failed to conspicuously post signs around the industrial radiography area. The aforementioned actions were initially identified during an unannounced NRC inspection, when NRC inspectors observed high readings on radiation survey meters in an area where no boundaries or physical controls were in place to prevent entry by the public. The OI investigation determined that although the radiographers had knowledge and training of NRC regulations, the

individuals nonetheless engaged in activities designed to circumvent established regulatory requirements. Both radiographers admitted to OI that their actions were not consistent with applicable surveillance protocols and internal licensee procedures. In July 2016, the NRC issued Confirmatory Orders to the two radiographers and a $7,000 civil penalty to Acuren, for violations of NRC regulations related to its industrial radiographic operations in Kenai, AK.

Monticello

This OI investigation was initiated to determine if two former contract technicians employed at the Monticello Nuclear Generating Plant (Monticello), Northern States Power Company, doing business as (dba) Xcel Energy, failed to perform nondestructive examinations (NDE) on six spent fuel dry cast canisters, in accordance with procedures. This investigation was also conducted to determine whether the contract technicians falsified records when recording the NDE examination results. OI established through testimony and evidence that both contract technicians knew the procedures and understood the requirements that they needed to follow, yet they deliberately failed to perform NDE examinations on the canisters in accordance with procedural requirements. Additionally, OI substantiated through evidence obtained during the course of the investigation that the contract technicians deliberately provided inaccurate information when they recorded the NDE examination results. Further, OI independently developed evidence that substantiated that a contract supervisor overseeing the two technicians who performed the NDE examinations acted with careless disregard while conducting supervisory responsibilities. On December 21, 2015, the NRC issued a Confirmatory Order to Monticello, Northern States Power Company, dba Xcel Energy, requiring the licensee to address violations identified through this investigation.

Salem 2

This OI investigation substantiated that the Plant Manager, Salem 1, deliberately failed to follow procedures regarding troubleshooting work being performed on a safety related system. In his testimony to OI, the Plant Manager admitted that his conduct was in violation of regulatory requirements when he provided an employee with a wrench and gave permission to strike a relief valve in an effort to mechanically agitate it during a refueling outage. Based on the totality of the evidence developed during this investigation, OI determined that the Plant Manager clearly understood the requirements and understood that his conduct of approving an action outside the troubleshooter was in violation of procedures. The results of this investigation remains under regulatory review by NRC staff.

Botsford Hospital

This investigation substantiated that a Medical Physicist, employed by Botsford Hospital Cancer Clinic, deliberately falsified a medical treatment chart for a patient receiving two radiation treatment plans in an attempt to cover up a misadministration during a high dose radiation medical procedure. The misadministration was identified during an internal audit by the licensee when the auditor noted that the computer records did not match the intended treatment plan. When the auditor questioned the medical physicist about the discrepancy, the medical physicist refused to acknowledge any error. OI established through testimony and evidence that the physicist correctly administered the initial cancer treatment plan during the first day of treatment. However, he mistakenly reapplied the initial cancer treatment plan during the second cancer treatment when he should have administered the second treatment plan. After realizing the error, the physicist subsequently falsified the second treatment plan chart to revise the treatment results. OI determined that the medical physicist cut and paste new figures onto the treatment chart to falsely indicate that the patient had received the proper amount of radiation as directed in the second

treatment plan when in fact the patient had not. OI concluded that the medical physicist altered the records and submitted falsified documentation concerning the high dose radiation treatment to indicate that the procedure had been conducted correctly. The physicist was terminated from the hospital. The results of this investigation remains under regulatory review by NRC staff.

Core Laboratories, Inc.

An OI investigation substantiated that Core Laboratories, Inc., doing business as ProTechnics, a company that manufactures a radioactive tracer used in mining and fracking operations, acted with careless disregard when it failed to perform required surveys of radioactive material, and failed to ensure proper disposal of radioactive material. The OI investigation determined that ProTechnics had been supplying radioactive tracers to a mining and drilling company for several years in West Virginia; however, the radioactive flowback waste from the mining operations was being disposed of in municipal landfills that were not licensed to accept radioactive material. Based on the evidence obtained by OI, ProTechnics representatives knew that the company was injecting radioactive tracers into the wells, but failed to monitor their product by performing surveys or sampling of flowback waste at the well sites. Additionally, the OI investigation concluded that on at least three occasions, radioactive waste was taken to a disposal site without having been surveyed by ProTechnics. The illicit disposal was discovered when one of the landfills installed a radiation alarm, which alarmed on a truck carrying flowback waste from a mine that was traced by ProTechnics. The evidence OI obtained revealed that ProTechnics failed to manage the disposal of waste that contained tracer radionuclides, where for several years, quantities of short-lived radioactive waste had been disposed of in two municipal landfills in West Virginia, which did not have radiation detectors. The results of this investigation remains under regulatory review by NRC staff.

JANX Integrity Group

This investigation substantiated that a former radiographer and assistant radiographer, failed to follow NRC mandated regulations while performing radiography operations. The OI investigation concluded that the radiographer deliberately failed to follow a radiography two-man rule in violation of NRC regulations, and that the assistant radiographer deliberately failed to use a survey instrument during radiographic operations. The assistant radiographer also deliberately failed to conduct required operability checks of radiography equipment prior to using the equipment in violation of NRC requirements. The results of this investigation remains under regulatory review by NRC staff.

Louisiana Energy Services (LES), LP

An OI investigation substantiated that the Director of Security and Regulatory Affairs employed by Enrichment Technology United States (ETUS) deliberately failed to report or record possible compromises of classified information to URENCO USA (UUSA) officials at the Louisiana Energy Services (LES) site as required by licensee procedure and NRC regulation. Additionally, the OI investigation substantiated that a UUSA Facility Security Officer (FSO) deliberately failed to record possible compromises of classified information, and that the ETUS FSO and UUSA FSO deliberately provided incomplete or inaccurate information to the NRC.

OI did not substantiate that a UUSA Security Manager deliberately failed to record possible compromises of classified information. However, the UUSA FSO deliberately provided information material to the NRC, which was known to be incomplete or inaccurate.

The results of this investigation remain under regulatory review by the NRC staff.

Diablo Canyon

This OI investigation substantiated that a former Firefighter, employed at Diablo Canyon Power Plant (DCPP), which is operated by Pacific Gas & Electric Company, deliberately failed to perform penetration seal inspections and falsified records associated with such inspections. The OI investigation stemmed from allegations that the firefighter signed inspection reports, documenting that the firefighter inspected all penetration seals in the plant's cable spreading room, without actually having conducted the inspections. OI obtained evidence which revealed information that the firefighter provided information in the inspection reports he knew to be incomplete and inaccurate. Specifically, OI determined that the firefighter not only failed to conduct the aforementioned inspections, but also made express annotations and markings on an associated work order, indicating that he had completed such inspections. In his interview with OI, the firefighter confessed to knowingly falsifying the inspection records and not performing penetration seal inspections assigned to him. The results of this investigation remain under regulatory review by the NRC staff.

Diablo Canyon

Browns Ferry

This OI investigation substantiated that an Operations Shift Manager (OSM), employed by Browns Ferry deliberately manipulated an electrical switch in violation of Section 4.2.0 of the Operations Department Procedures (OPDP-1) "Conduct of Operations," restricting equipment manipulation to qualified personnel. The OI investigation determined that the OSM entered a switchboard room and manipulated what he believed was the breaker control switch for the supply breaker to the 4KV 'B' Shutdown Board. However, the manipulation of the switch resulted in the de-energizing of the '2A' 480V Shutdown Board, which caused a plant transient. The OSM's deliberate actions also violated procedure when he subsequently provided incomplete and inaccurate information on

the cause of the transient to be included in the plant logs and corrective action program. The OSM admitted to being fully responsible for his inappropriate actions and subsequently resigned.

Due to the OSM's acknowledgement of his involvement in the incident and his recognition of the significance of his actions, no enforcement action was taken against the OSM. The NRC issued two Severity Level IV, Notices of Violation, to the licensee.

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(12-2010)
NRCMD 3.7

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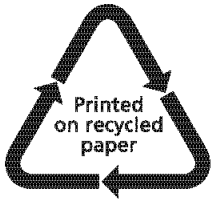

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