From: <VMBLANCH@aol.com>
To: WND2.WNP3(jaz),udl.internet3("JAZWOL@aol.com")
Date: 6/12/96 10:38pm
Subject: Statute of Limitations??

6/12/96

John A. Zwolinski, Deputy Director Division of Reactor Projects -I/II
Office of Nuclear Reactor Regulation
Washington, DC 20555-0001
Dear Mr. Zwolinski:
In your e-mail of last week you stated with respect to the lack of a civil penalty for multiple Severity Level 1 violations against Georgia Power:

"The statute of limitations, as the name implies, is not in NRC regulations but is a statute set out at 28 U.S.C 2462. It provides: "Except as otherwise provided by an Act of Congress, an action, suit or proceeding for the enforcement of any civil fine, penalty, or forfeiture, pecuniary or otherwise, shall not be entertained unless commenced within 5 years from the date when the claim first accrued if, within the same period, the offender or the property is found within the United States in order that proper service may be made thereon."

This message was transmitted to a large number of knowledgeable individuals and the following response was received. I would appreciate it if you or the Office of General Counsel or Enforcement could respond to this issue as soon as possible and specifically address the following transmittal from a concerned citizen.

"Paul:
You may distribute this (REDACTED). You also may want to send this to the NRC and ask them whether they agree or disagree with the analysis.
I was interested to see the citation to 28 USC 2462. I was/am puzzled by the
NRC's excuse of the statute of limitations. Now I am even more skeptical.
The NRC should have applied the doctrine of "continuing violation" to issue a civil penalty in this case. In fact, the NRC still should be able to issue a civil penalty under this doctrine.
Section 234 of the Atomic Energy Act--which is the basis for the issuance of civil penalties for violations of section 211 of the Energy Reorganization Act (the employee protection provision)--states that "If any violation is a continuing one, each day of such violation shall constitute a separate violation for the purpose of computing the applicable civil penalty."
This doctrine has been recognized by the NRC as a valid legal rationale to issue escalated penalties for violations that are not self-corrected after their initial occurrence. It is especially clear in the case of willful or intentional violations, where the violator willfully or knowingly committed the violation, since in these cases the failure to correct the violation also is willful or knowing. (The case is less clear for non-willful violations). Each day that a violation is not remedied by the violator is considered to be a "continuing violation" for the purposes of computing civil penalties.
The NRC attorneys and enforcement staff have recognized that the continuing violation provision in section 234 authorizes the NRC to issue a civil penalty that is greater than $100,000 (which is the statutory maximum for a

single violation) for a violation that is not immediately remedied by the violator. Under this provision, each day the violation continues is a new violation for purposes of computing the civil penalty. In these cases, the NRC may issue a total civil penalty of $100,000 multiplied by the number of days that the violation goes unremedied or unreported to the NRC.

The NRC attorneys have concluded that the continuing violation theory applies in a number of contexts. The one that I am most familiar with is with failure to report information or material false statements. Each day that a licensee fails to report information that should have been reported constitutes a "continuing violation" of the reporting requirement. I am not sure whether there is a NRC legal analysis regarding whether it applies to section 211 violations, but there is no reason it should not. The statutory provision contains no limitations on the types of violations to which it applies.

Thus, each day that the licensee continues to unlawfully discriminate against an employee should be considered a "continuing violation." The discrimination does not end on the day the employee is fired. That is only the beginning. The unlawful discrimination continues for as long as the former employer continues to discriminate by refusing to rehire or compensate the former employee. The discrimination against the employee thus continues on and on until the DOL remedy is reached.

Because the continuing violation provision considers each day of an uncorrected violation to be a separate violation for purposes of computing the civil penalty, it follows that the statute of limitations for each separate violation runs from the time of each separate violation, not from the initial violation. In other words, the statute of limitations does not run from the time of the initial violation, it runs from each day the violation continues.

In the case at hand, neither of the employees who were discriminated against have been reinstated (contrary to the Secretary of Labor's decision), and a Severity Level I violation has been issued. The NRC needs to be asked why the continuing refusal to rehire the two unlawfully fired employees does not represent a continuing violation. The discrimination against the two employees did not end on the day they were fired. It has continued for years. Certainly, the unlawful discrimination has continued in any common sense of the notion.

One possible argument against the application of this doctrine is that the statute cited states that the action must be brought "within five years from when the claim first accrued." On the other hand, it could be argued that when there is a continuing violation a new claim accrues on each day the violation continues, so that the NRC could bring a civil action against the licensee for each day within the past five years that the licensee continued the able to issue a civil penalty within five years from the last day of discrimination, instead of from when it began.

Another possible argument the NRC staff may use is that the statute of limitations begins to run from the time the employee is fired because it is from that date that the employee has 180 days in which to file a complaint with DOL. This argument compares apples and oranges. The DOL statute of limitations applies to a different action than does 28 USC 2462. Moreover, the "continuing violation" provision applies to the civil penalties authority of the NRC; there is no such provision with respect to the employee's cause of action. The fact that the continuing violation theory does not apply when there is no provision for continuing violations does not mean that the

continuing violation theory does not apply when there is a continuing violation provision. Hence, this possible argument by the NRC would not be persuasive.

The basic philosophy behind a statute of limitations is that "stale claims" should not be pursued; that old matters should be not be dredged up anew. In the case of a continuing wrong, this philosophy does not apply. When the wrong continues up to the present, it is not a stale claim. It is a live issue. The repose in the affairs of man sought to be protected by the statute does not exist. There is a continuing wrong being inflicted upon another individual or society; therefore the statute of limitations should not prevent action. In the case of unremedied employee discrimination, the discrimination certainly continues as long as the employer keeps the employee off the payroll. This is not a stale issue; it is a live one. The application of the statute of limitations to a case where an unlawful act continues without remedy is a denial of basic notions of justice--for every wrong there should be a remedy.

Under the NRC's interpretation of the statute, the licensee has an incentive to continue the violation rather than remedy it. If he can continue the violation for more than five years, he is home scot free--even for acts of discrimination that continue after the five year period. Perversely, under the NRC's rationale (i.e. not to apply the doctrine of continuing violation to employee discrimination), discrimination for a period of longer than 5 years becomes "protected activity."

The NRC should be interpreting the Atomic Energy Act broadly, to achieve the most protection for the public. Instead, the NRC has once again interpreted the Act most narrowly, to protect themselves from having to make decisions that might be objected to by its licensees.

As a matter of public policy, the NRC should have sought to use the continuing violation theory. Congress gave the NRC this authority in section 234 to use, not to avoid. The still can use this authority in this case if they want to. It is not too late."

A response by e-mail would be appreciated as it is much easier to distribute.
Sincerely,

Paul M. Blanch
135 Hyde Rd. West Hartford CT. 06117
860-236-0326

CC: WND2.WNP3(jnh),TWD1.TWP4(wjs,ljn1),WND1.WNP2(dcd),...

From: <VMBLANCH@aol.com>
To: WND2.WNP3(jnh,jaz),TWD1.TWP4(wjs,ljn1),WND1.WNP2(d...
Date: 6/12/96 8:13am
Subject: ENGINEERING TIMES

The following is a reprint from the national magazine for the National Society for Professional Engineers.

Whistleblowing

Engineers Risk Jobs To Make a Change
By David Siegel, StaffWriter

"[A] system that relies upon heroism is neither stable nor efficient. A society that expects martyrdom from its citizens is neither wise nor noble."
- Samuel Florman, P.E., THE INTROSPECTIVE ENGINEER

In November of 1993, Energy Department Secretary Hazel O'Leary publicly celebrated the efforts of whistleblowers and later announced a policy of "zero tolerance for reprisal" against those who "put their careers on the line to protect their colleagues, neighbors, and the American taxpayer."

Looking back on O'Leary's comments, NSPE member and DOE employee Joseph Carson says O'Leary has done more for whistleblowers than any of her predecessors, but adds that "the rhetoric has not met the reality." For the last two years, the plight of a DOE whistleblower has been Carson's reality.

Engineer whistleblowers were recently back in the national spotlight when two senior engineers for a New England utility company made the cover of "Time" for revealing safety violations at a nuclear power plant in Waterford, Connecticut. Regardless of the merits of individual cases, whistleblowers often risk their careers, relationships, and peace of mind to do what they believe is right. In hindsight, they offer few encouraging words to others in similar predicaments. The toll, they say, is just too great.

Is there anything a profession should do to help col'eagues in such trying times? Samuel Florman wrote, in his recently released THE INTROSPECTIVE ENGINEER, "Why do we not exert our efforts toward putting in place systems and procedures that will eliminate-or at least greatly reduce-the need for such martyrdom?"

March 15, 1996 was a day which Joe Carson had been anticipating for a long time. DOE's Inspector General finally issued its report stemming from a March 1994 fire at the agency's Brookhaven National Laboratory on Long Island. The fire and subsequent investigation has consumed Carson's life since then. Now, due in part to his allegations, the Inspector General has recommended sweeping changes in the way DOE conducts accident investigations.

The fire at Brookhaven broke out in a nuclear reactor used for research purposes. In this experiment, neutrons were drawn from the reactor core to bombard a target of uranium-235. When the Plexiglas holding the uranium in place ignited, the radioactive isotope fell to the floor outside its shielded cave. Several lab workers were contaminated and radioactive elements were released from the building's stack. Lab officials claimed the radioactive release was negligible, and the workers were decontaminated.

After the fire, DOE ordered an investigation and appointed six experts, including Carson, to the team. Soon after the investigation began, Carson - who worked as a nuclear safety assessor in the agency's office of

Environment, Safety, and Health - began to disagree with the investigation's direction. While the investigation's leader wanted to focus on the physical cause of the fire, Carson saw management-related deficiencies that allowed the experiment to operate without proper safety analysis as the fire's "root cause. "

Carson shared his concerns with DOE's Office of Nuclear Safety and Enforcement and the manager of DOE' s Chicago Operations Office, who appointed the investigation team. Later, still displeased with the investigation, he left the team. In the summer of 1994, convinced that his allegations were accurate, Carson presented evidence of safety violations to members of Congress and to DOE's inspector general. After being reprimanded by agency officials, he turned to the Government Accountability Project, a Washington, D.C.-based organization that offers legal services to whistleblowers and alleged whistleblower reprisal against the agency's Assistant Secretary for Environment, Safety, and Health. Last November, with a hearing pending before the Merit System Protection Board, DOE rescinded its reprimand and paid Carson's attorney's fees.

According to the Inspector General's report released in March, Carson had "a valid concern" that the Board was not going to adequately investigate and report on specific management systems and organizations as a root cause of the fire. While the IG did not find evidence that managers gave explicit directions to improperly limited the investigation of management, the report states that the investigators did not think they should be critical of management, and therefore did not adequately probe management issues as a root cause. The report added that this may not be an isolated case, but may be "a more general problem with DOE accident investigations."

To address these concerns, the report states that investigation boards are expected to examine management systems and organizations as a root cause and to fully report its finding. Among its other recommendations: require training for accident investigators; review how Carson's concerns were handled and consider new guidelines on employee concerns; expedite the appointment of a manager for the Employee Concerns Oversight Office; and conduct further analysis of the Brookhaven fire, focusing on management systems.

"IG reports are rarely very critical of the agency because the IG is not aggressive," says Robert Seldon, General Counsel for the Government Accountability Project, who represented Carson. "So to see a report that agrees with many of his statements and essentially causes agencywide change in accident investigations, you can only conclude that Joe Carson has been vindicated."

Despite the report, after spending more than 3000 hours and $30,000, Carson can't help feeling like the agency is getting off easy. For the last two years, the strain has been enormous. "You feel like people you trusted are treating you like garbage. It burns," he says. Although he believes he has influenced DOE policy, "to effect real change I believe my experiences - which illustrate a too-common reality in America's workplaces - have to contribute to a positive dialogue about whistleblower reprisal and the high financial and social costs."

According to Glenn Podonsky, DOE's deputy undersecretary for oversight, "broken" is the only way to describe the department's accident-investigation process. "We realized that an awful lot of money was being spent and that there was a lot of miscommunication on what was the root cause; what was the basis for the accident taking place and how could it have been prevented?" Podonsky explains that DOE is like any large corporation that doesn't have an effective system for dealing with employee concerns, but points out that

Secretary O'Leary has made DOE managers more accountable than ever before. He says the careerists must follow through. "It can no longer be the typical Washington bureaucracy just saying 'we were here when they came, we'll be here when they leave.' This is serious business. We're talking about people's lives and the safety of the workers."

Despite the urgings of friends to see the positive side, Carson says blowing the whistle hasn't been worth it. "That's the most dismal thing of all. I'd have to tell anybody, at this point, if you can live with yourself, look the other way," he says. "It's just too hard. The system is too corrupt and everything is stacked against you. I wouldn't directly advise people to neglect their professional obligations. I'd ask them if they could live with themselves neglecting their professional obligations. If they could, I could not in good faith advise them - knowing how the system is stacked against them - to blow the whistle."

George Galatis, one of the engineer whistleblowers featured in "Time" says if he had it to do it all over, he wouldn't blow the whistle. He's now considering divinity school. Another engineer, Paul Blanch, was employed by the same company as Galatis - Northeast Utilities. He discovered that a safety device was flawed and after he raised the concern, was subjected to severe retaliation. An investigation into Blanche's claims led to a $100,000 fine against Northeast. Now jobless, he is a full-time activist for nuclear safety. Blanch's advice: "Unless a person is prepared for it. I don't think they should [blow the whistle]. There are no rewards," he says. "I went into it very naively. I don't think a 'whistleblower' ever starts out to be a whistleblower. The ones I know were just doing what's required by the regulations to identify safety concerns. Most people don't realize what they're getting into."

The Government Accountability Project offers survival strategies to whistleblowers and legal counsel, but knowing what to expect remains key. Seldon says many go into it without understanding the price to pay for even "rather innocent disclosures," or the feelings of betrayal they could experience. "We always counsel whistleblowers not to undertake something like this without a lot of thought and without consulting their families," he says. "It could include [things] beyond the loss of a job. It could include being blacklisted. I don't tell people to look the other way, but I say 'don't do it lightly.'"

Both Carson and Blanch believe NSPE and other engineering groups can, as Florman wrote, reduce the need for martyrdom by highlighting the "dismal realities" faced by whistleblowers and calling for change. At DOE, Glenn Podonsky says the department will continue down the path of honesty and integrity. And, at least in terms of accident investigations, he says, "the past is not prologue."

Editorial appearing in June 1996 "Engineering Times"

Mixed Messages from Whistleblowers

When whistleblowers speak of their experiences, messages often collide. They talk about protecting the public or coworkers, doing the right thing, and being committed to high ideals. "The world needs more people who are willing to speak up," they say. But in the same breath they send severe warnings, bordering on dissuasion, to those in similar dilemmas. Be prepared to lose your friends and job, bring stress upon your family, or become, as one engineer whistleblower recently referred to himself, "road-kill."

Whistleblowing is familiar territory for professional engineers. Every day PEs go to work, guided by a code of ethics, with the protection of public health, safety, and welfare foremost in their minds. By virtue of the PE

license, they are committed to a standard, which may include an obligation to report matters to higher authorities or withdraw from providing further service.

Although organizations exist to provide legal support to some whistleblowers, professional engineers should ask if there is anything they can do to help their colleagues facing such challenges. The trials are often more than one person can bear, and can leave whistleblowers battered, bruised, and second-guessing themselves. There is, however, at least one thing a profession can provide - strength in unity.

In 1993, Energy Department Secretary Hazel O'Leary announced a campaign to celebrate whistleblowers and to quell the fear of reprisal. Some offer praise tinged with skepticism, saying the rhetoric hasn't met the reality.

Certainly it will take time to change ways of thinking that are buttressed with decades of institutional momentum. Nonetheless, it is a beginning. Engineers - who likely share the sentiment of being very fond of the truth, but not at all of martyrdom - can ease the plight of whistleblowing colleagues by raising awareness of the issue. Encouraging procedures in the public and private sectors that will reduce the need for such ordeals is in the best interests of the profession and society. These efforts would be an important step toward quieting the sound of colliding messages.

From: <VMBLANCH@aol.com>
To: WND2.WNP3(jnh,jaz),TWD1.TWP4(wjs,ljn1),WND1.WNP2(d...
Date: 6/11/96 8:42pm
Subject: From a Friendly allegator

The NRC has changed the title they refer to people who raise valid (or invalid) safety complaints from "whistleblowers" to "allegators". Please be cognizant of your new position and of your added responsibilities and prestige.

It does add up to some semantic fun to be had:

* Perhaps a senior manager who guides and attempts to steer a whistleblower towards the companies perspective could be called a "Navigator".

* When the NRC sees the local environment swarming with allegators, perhaps they can conclude they are in the middle of a swamp.

* Harrassed CEO's can go home and tell the family that they had a bad day at work because they were up to their neck??? in allegators, and the folks back home would finally understand for once what they are talking about.

* There may be a fine and hell to pay for it later, but think of the momentary satisfaction a manager could derive from finally getting rid of a safety concern-spouting thorn in their side with the simple words "See you later, allegator!"

Keep me anonymous if you pass this on because I fear retaliation from other writers if my name became associated with bad puns or metaphors.

From: Tom Carpenter <tomcgap@halcyon.com>
To: WND2.WNP4(cam,wtr),KPD1.KPP2(djv,ttm),NCD2.CH1(rcp...
Date: 6/11/96 11:49am
Subject: Energy Secretary Honors Whistleblower

PRESS ADVISORY

Immediate Release
June 11, 1996

Contact:
Tom Carpenter/206-292-2850

Energy Secretary to Present National Award
for Moral Courage to Hanford Whistleblower

U.S. Secretary of Energy Hazel R. O'Leary will present a national award for moral courage on June 13, 1996 to a well-known whistleblower, Casey Ruud, a Department of Energy environmental specialist from the State of Washington.

Ruud was selected to receive the 1996 $10,000 Cavallo Prize for Moral Courage for his work uncovering serious health and safety deficiencies regarding the processing and storage of hazardous and radioactive materials at Hanford Nuclear Reservation. Ruud was nominated for the award by Senator Ron Wyden (D-Oregon), who will also be present at the ceremony. The award will be presented in Washington, D.C.

Under the leadership of Energy Secretary Hazel O'Leary, Ruud was recognized for his actions and employed with the Department of Energy at Hanford as an environmental specialist overseeing the management of high-level nuclear wastes stored in the underground tank farms. Secretary O'Leary has received praise for her support and encouragement of whistleblowers, and her enactment of a five-point Whistleblower Initiative designed to better protect whistleblowers.

"Casey Ruud is receiving this award from the hands of a Cabinet Secretary who has done more to protect and encourage whistleblowers than any other government official in this, or any other administration. It is befitting that these two should be honored for their achievements."

said Tom Carpenter, an attorney with the non-profit Government Accountability Project, which co-nominated Ruud for the award.

In 1986, Ruud, a private contractor auditor, reported breaches of safety and security at the reservation's plutonium production plants and ordered their shut-down because of the hazardous safety and environmental conditions. These safety and security violations included shoddily-designed and operated facilities where accountability was so lax that plutonium was found in open drums stored in the hallway. His disclosures, first to plant officials and later to members of Congress, effectively shut down all of Hanford's plutonium production plants.

In response, Ruud was laid off from Hanford in 1988 after enduring over a year of harassment from supervisors. Subsequently, he was harassed and forced off the job at a nuclear weapons facility in South Carolina where he worked as a contractor, after former Hanford officials recognized him there.

Since then, a Department of Labor judge has recently concluded that Ruud was wrongly dismissed and harassed.

In 1992, Ruud obtained work for the Washington State Department of Ecology, where he audited Hanford's environmental compliance. In 1993, Ruud's ordeal was chronicled in the nationally-acclaimed book, Atomic Harvest.

Gerald Pollet, Executive Director of Heart of America Northwest, also a co-nominator, lauded Ruud's recent success in identifying radioactive contamination deep in the soils beneath the leaking high-level nuclear waste tanks:

"Casey is an asset to the Northwest public, which depends upon people like him to give us honest and timely information about Hanford issues. Under Secretary O'Leary's leadership, we have not only Casey, but more openness and opportunity for public dialogue."

The Cavallo Award is presented annually to three individuals whose moral courage, in the face of personal sacrifice and retaliation, led them to speak out in the public interest when it would have been easier to remain silent.

The award will be presented to Ruud, as well as two other Cavallo Award recipients, Ben Lomeli, a U.S. Bureau of Land Management hydrologist, and Matthew Napiltonia, a decorated Navy SEAL, in a June 13th ceremony in Washington, D.C.

Thursday, June 13, 1996
5:00 - 7:00 p.m.
Rayburn House Office Building, Room 338B
Independence Avenue and South Capitol Street
Washington, D.C.

##################
For more information, contact Tom Carpenter,
(206) 292-2850 or John Lawrence, Cavallo Foundation, (617) 354-5238.

Government Accountability Project
810 First Street, NE
Washington, D.C. 20002
(202) 408-0034

West Coast Office
1402 Third Avenue, Suite 1215
Seattle, Washington 98101
(206) 292-2850

From: <VMBLANCH@aol.com>
To: WND2.WNP3(jnh,jaz),TWD1.TWP4(wjs,ljn1),WND1.WNP2(d...
Date: 6/11/96 9:54pm
Subject: OIG REPORT TEXT

--PART.BOUNDARY.0.21340.emout12.mail.aol.com.834544465
Content-ID: <0 21340 834544465@emout12.mail.aol.com.276224>
Content-type: text/plain

ATTACHED IS A COPY OF THE LATEST OIG REPORT ABOUT THE NRC'S INEFFECTIVENESS AS TO PLACING MILLSTONE ON THE WATCH LIST.

--PART.BOUNDARY.0.21340.emout12.mail.aol.com.834544465
Content-ID: <0 21340 834544465@emout12.mail.aol.com.276225>
Content-type: text/plain;
name="OIG MILLSTONE 5/31/96 TXT"
Content-Transfer-Encoding: quoted-printable

NRC STAFF ACTIONS TO ADDRESS
NORTHEAST UTILITIES SYSTEM (NU)
1991 SELF-ASSESSMENTS
CASE NO. 96-02S May 31, 1996

CHRONOLOGY

Date Event

5/28/91 NRC SALP report 89-99 issued

5/29/91 NU announced formation of 3 task groups to analyze various =

aspects of its nuclear program (Allegation Root Cause Task Group; =

Operability, Reportability, and Communications Task Group; and =

NE&O Performance Task Group)

6/91 Millstone discussed at NRC Senior Management Meeting

8/14/91 NU announced formation of a fourth task group to assess the level= =

of procedural compliance at Millstone (Procedure Compliance =

Task Force)

8/26/91 NU Allegations Root Cause Task Group Final Report issued with 10 =

C.F.R. 2.790 request that report be withheld from public disclosure

8/26/91 NU Operability, Reportability, and Communications Task Group =

Final Report issued

9/26/91 NU NE&O Performance Task Group Final Report issued with 10 = C.F.R. 2.790 request that report be withheld from public disclosure

10/4/91 NU Procedure Compliance Task Force Final Report Summary = issued with 10 C.F.R. 2.790 request that report be withheld from = public disclosure; report reflected procedure non-compliance = was 30-50 percent

10/25/91 NU Millstone Nuclear Power Station, Unit 2, Employee Concerns = report issued with 10 C.F.R. 2.790 request that report be withheld = from public disclosure

12/23/91 NU Procedure Compliance Review Group 11 Final Report issued- = report reflected 99 percent procedure compliance

1 92 Millstone discussed at NRC Senior Management Meeting

3/92 NU developed Performance Enhancement Program (PEP)

5/92 NRC established Millstone Assessment Panel (MAP)

6/92 Millstone discussed at NRC Senior Management Meeting
1

8/4/92 NRC SALP report 90-99 issued

1/93 Millstone discussed at NRC Senior Management Meeting

6/93 Millstone not discussed at NRC Senior Management Meeting

10/19/93 NRC SALP report 92-99 issued

1/94 Millstone discussed at NRC Senior Management Meeting

6/94 Millstone discussed at NRC Senior Management Meeting

8/26/94 NRC SALP report 93-99 issued

1/95 Millstone discussed at NRC Senior Management Meeting

6/95 Millstone discussed at NRC Senior Management Meeting

1/96 Millstone discussed at NRC Senior Management Meeting

1/96 Millstone placed on the NRC problem plant list

EXECUTIVE SUMMARY

The Office of the Inspector General (OIG), U.S. Nuclear Regulatory Commis= sion (NRC), =

initiated this inquiry based on information received from Ernest Hadley, = an attorney =

for We the People, Inc., who alleged wrongdoing on the part of the NRC st= aff =

regarding certain self assessments conducted by Northeast Utilities Syste= m (NU). =

Specifically, in letters dated March 4 and 28, 1996, Hadley advised the O= IG that in 1991, =

NU submitted to the NRC certain self-assessment reports regarding license= d activities =

at the Millstone Nuclear Power Station (Millstone) Units 1, 2, and 3 whic= h identified =

management and operational deficiencies and which were highly critical of= NU's =

performance at Millstone. Hadley questioned the staff's review of the de= ficiencies =

identified in these reports, and he noted that several of these reports w= ere withheld =

from the public. Hadley alleged that the NRC had colluded with NU to con= ceal =

extensive and significant safety problems from public disclosure,

The OIG examined the NRC staff's actions to address the performance defic= iencies =

identified by the licensee. OIG also reviewed inspections and other eval=

uations =

conducted by the staff to determine how the staff documented licensed act= ivities at =

the Millstone site. In addition, the OIG addressed whether the staff han= dled the public =

disclosure of the NU self-assessment documents in accordance with NRC reg= ulatory =

requirements.

The OIG event inquiry disclosed that in spite of the increased regulatory= scrutiny in =

the form of inspections and evaluations, the NRC staff has determined tha= t the =

deficiencies identified at Millstone in the 1991 NU self-assessments have= persisted. =

The staff has continued to document a general declining level of performa= nce at the =

Millstone site since 1991. The NRC Executive Director for Operations, th= e Director of =

Nuclear Reactor Regulation, and the Region I Regional Administrator advis= ed OIG =

that given the indicators of poor performance at Millstone, the NRC shoul= d have =

taken more aggressive action including placing the Millstone site on the = NRC watch =

list as early as 1993.

The OIG inquiry also disclosed that the NRC staff handled the public disc= losure of NU's =

self assessment documents in accordance with the requirements contained i= n title 10, =

Code of Federal Regulations, Section 2.790 (10 C.F.R. 2.790). This regula= tion allows the =

licensee to submit a withholding request and supporting affidavit with ea= ch =

document it sought to have withheld from the public. OIG determined that= when self- assessments are provided to the NRC, licensees often request that they be=

withheld =

from public disclosure and that the NRC generally grants the request.
3

BASIS

The Office of the Inspector General (OIG) initiated this inquiry based on= information =

received from Ernest Hadley, an attorney for We the People, Inc., who all= eged =

wrongdoing on the part of the U.S. Nuclear Regulatory Commission (NRC) st= aff =

regarding certain self-assessments conducted by Northeast Utilities Syste= m (NU) =

regarding licensed activities at the Millstone Nuclear Power Station (Mil= lstone) Units =

1, 2, and 3. Specifically, in letters dated March 4 and 28, 1996, Hadley = advised the OIG =

that in 1991, NU submitted to NRC certain internal self-assessment report= s which =

identified management and operational deficiencies and were highly critic= al of NU's =

performance at Millstone. Hadley questioned the NRC staff's review of th= e =

deficiencies identified in these reports, and he noted that several of th= ese reports =

were withheld from the public. Hadley alleged that the NRC had colluded = with NU to =

conceal extensive and significant safety problems from public disclosure.=

SCOPE

The OIG reviewed regulatory actions taken by Region I and the Office of N= uclear =

[illegible]ctor Regulation (NRR) staff to address performance deficiencies identi= fie[illegible] in the =

1991 NU self assessment reports. OIG also examined NRC Inspection Report= s (IRs), =

Systematic Assessment of License Performance (SALP) reports, and other ev= aluations =

prepared by the staff to determine how the staff documented licensed acti= vities at the =

Millstone site. OIG also reviewed the manner in which the NU self-assess= ment =

reports were withheld from public disclosure to ascertain if this action = was in =

accordance with title 10, Code of Federal Regulations, Section 2,790 (10 = C.F.R. 2.790).

The OIG inquiry focused on the actions taken by the NRC staff to address = the =

deficiencies identified by the licensee. The OIG did not address the ade= quacy of NLT's =

efforts to resolve deficiencies identified in their self-assessment repor= ts.

The OIG reviewed the following documents:

NU self-assessment reports conducted in 1991 as well as several others =

conducted by NU in similar program areas;

NU Performance Enhancement Program (PEP) documents; Millstone =

Assessment Panel (MAP) meeting minutes-,

selected NRC Inspection Reports covering the period 1988 to 1995; Systema= tic =

Assessment of Licensee Performance (SALP) reports;

Senior Management Meetings briefing papers, Institute of Nuclear Power =

Operations (INPO) Evaluation Reports pertaining to deficiencies areas; =

documents provided by NU; and,

other NRC documents relevant to NU self-assessments.

During this event inquiry, OIG interviewed NRC Senior Resident Inspectors= - Region I -

managers and staff, the Regional Administrator; NRR past and present Proj= ect =

Managers- the NRR Director and managers- the Deputy Executive Director fo= r =

Nuclear Reactor Regulation, Regional Operations and Research; and the NRC= =

Executive Director for Operations. In addition, the OIG interviewed cert= ain members =

of the NU task groups who conducted the self assessments and an NU manage= ment =

official.

BACKGROUND

Northeast Utilities System (NU) is the parent company of several subsidia= ries, =

including Northeast Nuclear Energy Company and Northeast Utilities Servic= es =

Company. The nuclear facilities associated with NU include the Millstone= Nuclear =

Power Station, Units 1, 2, and 3 located in New London County, Connecticu= t.

The NRC has several mechanisms in place to evaluate plant performance and= licensee =

efforts to improve poor performance. These include Inspection Reports, t= he =

Systematic Assessment of Licensee Performance (SALP) program, and Senior =

Management Meetings (SMMs). In addition, licensees may develop their own=

=

assessment programs to gauge plant performance, or they may request outsi= de
=

organizations such as the Institute of Nuclear Power Operations (INPO) to=
 evaluate =

their plant operations.

The SALP program is an integrated NRC effort to evaluate licensee perform=
ance and =

management effectiveness on a periodic basis through the collection of av=
ailable =

observations and data such as Inspection Reports (IRs) and Licensee Event=
 Reports =

(LERs). The program supplements the normal regulatory processes used to =
ensure =

compliance with NRC rules and regulations. The SALP program is intended = to
be =

sufficiently diagnostic to provide a rational basis for allocating NRC re=
sources. For =

example, the program may focus inspection activities to be conducted duri= ng
the next =

SALP period. Also, the program is intended to provide meaningful feedbac= k
to =

licensee management regarding the NRC's assessment of its facilities' per=
formance =

in four functional areas. Currently, the functional areas are: Plant Ope=
rations, =

Maintenance, Engineering, and Plant Support.

An NRC SALP Board, composed of regional and headquarters staff members, m=
eets =

approximately every 18 months to review the observations and data on lice=
nsee =

performance in the four functional areas. After the SALP report is issue= d,
the NRC =

schedules a public meeting to present the assessment. At the meeting, th= e
licensee =

must be prepared to discuss the findings and present any initiatives they= plan to take =

to address the concerns noted in the SALP report.

During mid-1991, in response to an overall decline in performance as docu= mented in =

a SALP report which highlighted declining trends in functional areas, NU = conducted =

a series of internal self-assessments to analyze various aspects of its n= uclear program =

and provide recommendations for improvement. Between August and December= 1991, =

NU completed the following self-assessments reports: "Allegations Root Ca= use Task =

Group Final Report"; "Operability, Reportability, and Communications Task= Group =

Final Report"- "Nuclear Engineering and Operations (NE&O) Performance Tas= k Group =

Final Report"; "Procedure Compliance Task Force Final Report"; "Millstone= Nuclear =

Power Station, Unit No. 2, Employee Concerns"; and "Procedure Compliance = Review =

Group II Final Report."

In early 1992, based on the results of its self-assessments, NU developed= a =

Performance Enhancement Program (PEP) to focus on the actions it planned = to take =

to improve its performance. The PEP was organized as a three-phase effor= t: Phase I =

would determine the underlying causes of NU's performance deficiencies; P= hase 11 =

would detail action plans to address the deficiencies and lead to improve= d =

performance; and Phase Ill would detail the verification and validation o= f

the =

successful implementation of the action plans. The PEP was a five-year p= lan, =

although many of the key elements were scheduled to be completed within t= hree =

years.

In May 1992, the NRC Region I Regional Administrator, established a Mills= tone =

Assessment Panel (MAP) to review the adequacy of the PEP and to maintain = an =

ongoing review of NU corrective actions and Millstone performance. The M= AP =

developed a list of 23 performance issues which encompassed the significa= nt =

concerns the NRC had regarding Millstone's performance. In addition, the= MAP =

conducted a public meeting near Millstone to receive comments on NU's PEP= =2E

The NRC had instituted a Senior Management Meeting (SNM) process at the =

recommendation of a Special Review Group (SRG) in 1986, after a 1985 loss= -of-water =

event at the Davis Besse Nuclear Power Plant revealed weaknesses in the N= RC's =

integration of licensing, inspection and operating experience. The Execu= tive =

Director for Operations (EDO), the regional administrators, and the headq= uarters =

program office directors meet semi-annually to discuss plants with margin= al =

performance and significant operating problems.

The S@ process begins with a screening meeting between senior managers an= d staff =

from the Office of Nuclear Reactor Regulation, the Office for Analysis an= d Evaluation =

of Operational Data, the Office of Enforcement, the Regional Administrato= r,

and =

selected personnel from the regions. These meetings are held approximate= ly 10 to 12 =

weeks before each SNM to discuss the overall performance of each plant in= the =

respective regions. Plants with operating problems or having experienced= =

significant events are designated discussion plants for the SMM. A narra= tive =

summary is prepared by the staff for each discussion plant which identifi= es the basis =

for adding a plant to the discussion plant list and any significant chang= e in the =

plant's status since the previous SMM.

The SMM is conducted under the direction of the EDO. The performance of = all =

discussion plants identified in each region is reviewed. This includes r= eviewing =

SALP ratings, significant plant activities, management and station person= nel =

performance, and risk perspectives from a probabilistic risk assessment (= PRA) =

standpoint. In addition, the performance indicator data and enforcement = history are =

evaluated to determine the appropriate status for each plant.

During the SMM, senior managers determine which plants, if any, to place = on the =

NRC problem plant list/watch list. Plants are placed in the following ca= tegories: =

Category I includes plants which are removed from the problem plant list = due to =

their corrective action and require no further monitoring. Category 2 in= cludes =

plants which are authorized to operate

but require close monitoring by NRC. Plants remain in this category unti= l the =

licensee demonstrates a period of improved performance. Category 3 inclu= des plants =

which are in shutdown condition due to significant weaknesses. These pla= nts remain =

in this status until the licensee can demonstrate that adequate programs = have been =

implemented to ensure substantial improvement. NRC Commission approval i= s =

required for restart of these plants. Plants that are placed in Category= 2 or Category 3 =

are referred to as being on the NRC problem plant list or NRC watch list.= Not all =

plants discussed at the SNM are placed on the problem plant list. The ED= O may decide =

to take other action such as issuing a trending letter or directing that = a diagnostic =

evaluation be conducted at a particular plant. A trending letter advises= the utility's =

chief executive officer or board that the plant performance is close or t= rending =

toward problem plant status. In addition, licensee senior managers of ea= ch plant =

discussed during the SMM, but not placed on the problem plant list, are c= ontacted by =

the regional administrator and informed of NRC's concerns.

The Institute of Nuclear Power Operations (INPO) was founded by the nucle= ar =

industry and is a private organization whose stated mission is to promote= the highest =

levels of safety and reliability in the operation of nuclear plants. INP= O is funded =

entirely by utilities, and its board is made up of industry executives. = INPO sends a =

team of inspectors every 18 to 24 months to each plant to review operatio= ns.

INPO =

inspectors stay about two weeks and issue a detailed report to the licens= ee.
INPO =

findings and recommendations are intended to assist licensees in their on=
going =

efforts to improve all aspects of their nuclear programs.

DETAILS

1. NRC STAFF ACTIONS TO ADDRESS PERFORMANCE DEFICIENCIES IDENTIFIED BY NU SELF-ASSESSMENT REPORTS.

Review of NRC Inspection Reports:

OIG reviewed a selection of inspections conducted by the NRC Region I at = the
=

Millstone Units 1, 2, and 3 from 1989 to 1995. In reviewing these inspec=
tions, OIG =

grouped them according to the SALP periods within which they were conduct= ed.
=

Generally, Region I performed numerous routine inspections and special te= am
=

inspections which were conducted jointly with the NRR staff. Throughout =
this =

period, inspectors documented continuing problems in the management and =

operational areas identified by NU in the self-assessment reports. For e=
xample, =

between June 1989 and December 1990, a special allegation team inspection=
at =

Millstone resulted in violations for failure to follow procedures; a spec= ial
mid SALP =

cycle inspection found inadequate surveillance procedures at Unit I and n= oted that =

improvements were needed in reportability and operability evaluations. I= n addition, =

several other NRC inspections noted untimely notification and reporting o= f problems =

with equipment/systems (Region I Inspection Reports (IRs) 336/89-13; 245/= 90-80; =

336/89-24; and 423/89-23).

During the period December 1990 to February 1992, several special team in= spections =

noted weaknesses in operability determinations, deficiencies in engineeri= ng design =

(erosion/corrosion) programs, and inadequate response to correct program =

weaknesses (IRs 245/91- 80, 423/91-80, and 336/91-81). Also, several ins= pections =

listed violations for failure to take timely corrective actions and lack = of procedures- =

and failure to follow design procedures (IRs 245/91-16, 245/91-81, and 24= 5/91-04).

During the period February 1992 to April 1993, NRC inspections noted that= NU needed =

improvement in its identification of root causes- development and timely =

implementation of effective corrective actions, and attention to detail i= n procedural =

compliance (IRs 423/92-23245/93-10; and 336/91-31).

During the period April 1993 to July 1994, several NRC inspections noted = weaknesses =

and/or issued violations for inadequacy of procedures and procedural adhe= rence; =

design control- and failure to have operability determinations completely= =

incorporated in procedures (Ms 245/9332- 245/94-201; and 245/94-36).

In addition, in September 1993, NRC issued a special inspection report wh= ich =

reviewed circumstances surrounding NU's inability to stop a reactor coola= nt leak =

from the letdown system isolation valve 2-CH-442. The valve could not be= isolated =

from the reactor coolant system and failure of this valve could have caus= ed a small =

break loss of coolant accident.

9

The NRC inspection noted that from June to August 1993, NU repeatedly had= been =

injecting sealant into the valve area and that all four valve studs were = damaged. The =

repair activities were conducted by a NU contractor. On August 5, 1993, = excessive =

leakage from the 2-CH-442 valve resulted in a forced shutdown of Millston= e Unit 2 (IR =

336/93-18).

In December 1993, NRC took escalated enforcement action against NU. The = NRC Notice =

of Violation noted that the two-month-long event activities reflected a "= breakdown in =

the quality assurance program and management controls of a safety signifi= cant =

repair activity" which represented "a significant lack of attention and c= arelessness =

toward licensed activities." The civil penalty was escalated by 375 perce= nt due to NU =

management's failure to recognize the safety consequences of the repair a= ctivity (IR =

336/93-18 and Enforcement Action 93-228).

Review of Systematic Assessment of Licensee Performance (SALP) Reports

OIG reviewed SALP reports for Millstone Units 1, 2, and 3 which covered t= he period =

June 1989 to July 1994. One SALP report was issued approximately every 1=

4 to 18 =

months for all three units. The NRC did not issue a SALP report for the = 1994-1995 time =

period after Millstone was placed on the NRC problem plant list in Januar= y 1996. OIG =

determined that at the beginning of the SALP review period, the Millstone= units were =

evaluated in seven functional areas. The seven areas were: Plant Operati= ons; =

Radiological Controls-,
Maintenance/Surveillance- Emergency Preparedness- Security and Safeguards= - =

Engineering and Technical Support; and Safety Assessment/Quality Verifica= tion. =

However, in 1993, the NRC changed the SALP functional areas to Plant Oper= ations; =

Maintenance; Engineering; and Plant Support. Generally, OIG found that t= he SALP =

reports for Millstone showed a decline in performance. SALP ratings drop= ped from =

primarily Categories I and 2 to ratings in Categories 2 and 3. Also, SALP= reports noted =

problems with procedural adherence, corrective action effectiveness and t= he =

adequacy of root cause analyses at all three Millstone units.

Indications of a declining trend in performance was noted by the NRC in S= ALP =

Report 89-99 for the period June 16, 1989, to December 15, 1990. While a= ll three units =

were rated in Categories I and 2, the need for improvements in performanc= e-based =

audits and self assessments and in addressing safety deficiencies and sys= tem =

operability issues in a timely manner was noted. Further, the SALP noted= that NU had =

failed to adequately address the root causes of some employee concerns an= d

that =

lapses in attention to detail and adherence to procedures had occurred.

SALP Report 90-99 for the period December 16, 1990, to February 15, 1992,= reflected =

that all three Millstone units showed a decline in performance and all un= its were =

rated in Categories 2 and 3. The SALP noted that all units were subjected= to long =

forced outages for programmatic and/or equipment problems. In addition, = the SALP =

noted that procedural adherence continued as a problem at all three units= =2E

Subsequently, SALP Report 92-99 for the period February 16, 1992, to Apri= l 3, 1993, =

noted that performance had improved only marginally at all three Millston= e units =

and that long-

10

standing problems remained at all three units, particularly in the areas = of =

procedural adherence, reportability, and corrective action effectiveness.= All units =

were rated in Category 2, except for ratings in Category I for Radiologic= al Controls =

and Ratings in Category 3 for Safety Assessment/Quality Verification. Th= e SALP =

reflected that while the PEP addressed the areas of concern, significant = performance =

improvement was not seen due to the low degree of completion of PEP actio= n plans.

SALP Report 93-99 for the period April 4, 1993, to July 9, 1994, reflecte= d that all three =

Millstone units were rated Category 2 or Category 3 in each of the four f= unctional =

rating areas. The SALP noted examples of poor implementation of procedur= es and =

procedural adherence; plant management ineffectiveness in correcting know= n =

weaknesses at Units I and 2; and inadequate management attention to resol= ve certain =

engineering issues in a timely manner.

Review of Senior Management Meetings (SMMs)

A review of briefing documents from SMMs disclosed that senior managers f= irst =

discussed the Millstone site at the SNM in June 1991. Further, with the = exception of =

the June 1993 SNM, Millstone was a discussion plant for nine Sm. from Jun= e 1991 =

through January 1996. SNM documents disclosed that the basis for designa= ting all =

three Millstone units as a "discussion plant" included programmatic weakn= esses in =

NU's timely resolution of design deficiencies; resolution of employee saf= ety concerns; =

procedural adherence; staff attention to detail; and elimination of signi= ficant =

personnel error. During this period, the SMMs also noted a significant i= ncrease in =

the number of escalated enforcement actions and civil penalties levied ag= ainst NU.

The SMM documents disclosed that beginning in the early 1990's, the Mills= tone site =

experienced declining performance that principally impacted Units I and 2= =2E The =

NRC's focus at the time was in the areas of resolution of employee concer= ns, =

corrective actions, and operability determinations. During this period, = there was an =

increase in the number of allegations received by the NRC; therefore, the= NRC began =

to develop concerns with NU's history of harassment and intimidation of e=
mployees, =

the allegation volume, the corrective action processes, regulatory perspe=
ctive and =

regulatory compliance.

Although the June 1992 and January 1993 SMMs noted there was an increased=
 =

number of escalated enforcement-actions taken against NU, they also noted=
 some =

improvement in site performance. In addition, the January 1994 S@ noted =
that NU's =

PEP had achieved limited effectiveness, but that a substantial NU managem= ent
=

reorganization reflected a "strong effort" to improve performance at Mill=
stone.

Following the January 1995 SMM, the EDO, the NRR Director, and the Region=
 I =

Administrator met with the NU Board of Trustees on March 17, 1995, to dis=
cuss the =

NRC's concerns with lingering performance problems at the Millstone facil=
ity. =

These problems included the handling of employee concerns, procedural adh=
erence, =

corrective action process
11

effectiveness, communication between units, and the historic emphasis on =
cost =

savings versus performance.

During the January 1996 SNM, it was noted that NU's performance at Millst= one
had =

concerned NRC for the last five years. Further, the NRC senior managers,=
 in view of =

the history of serious operational problems at the site and NU management=
=D5s' =

inability to consistently sustain performance improvements across all thr= ee
units =

and to effectively resolve many employee safety concerns, concluded that = the =

Millstone site should be placed on the NRC watch list.

In a letter dated January 29, 1996, from the EDO to the President, Energy= Resources =

Group, NU, the NRC advised that the Millstone site was placed on the NRC = problem =

plant list as a Category 2 plant. The letter noted longstanding performa= nce concerns =

in the areas of untimely corrective actions and operability and reportabi= lity =

determinations for identified design deficiencies and the failure to impl= ement =

licensee procedures which precipitated significant plant events and in so= me cases =

endangered plant staff.

Interviews of NRC Region I Staff

Two former senior resident inspectors at Millstone Units 1, 2, and 3, adv= ised the OIG =

that the NRC monitored NU's corrective actions through the " process by f= ocusing =

inspection activities in the problem areas. Also, in December 1995, Regi= on I assigned =

a senior resident inspector to each of the Millstone units. The two form= er senior =

resident inspectors stated that there was an increase in the number of in= spections =

conducted by the NRC and in the level of resources devoted to the Millsto= ne site. For =

example, they noted that the number of resident inspectors assigned to Mi= llstone was =

increased in 1992, and additional resources were provided to assist resid= ent inspectors =

in handling the increased number of allegations being received by the NRC= =

regarding Millstone. One former senior resident inspector noted that the= expanded =

inspection activity resulted in an increased number of violations, escala= ted =

enforcement actions, and civil penalties levied against NU.

The senior resident inspectors told OIG that given the NRC regulatory fra= mework, the =

staff took adequate measures to try to force NU to resolve their performa= nce =

problems. They noted that during 1992-1993, there was some improvement i= n NU's =

performance- however, the improvements were not timely or long term. One= senior =

resident inspector felt that NRC could not have taken additional action b= ecause NU =

was essentially operating safely- therefore, there was no basis for shutt= ing down the =

site. The other senior resident inspector stated that the NRC probably c= ould have =

been more forceful in exercising regulatory oversight of NU. He said tha= t in his =

opinion, NRC had sufficient basis for placing NU on the NRC watch list af= ter the 2-CH-
442 valve event in August 1993, but the agency did not take the opportuni= ty to do so. =

He noted that this event was not only safety significant, but it provided= the NRC =

meaningful insight into NU management's performance. He added that NU =

management's approach allowed the 2-CH-442 event to occur, and the event = was an =

example of management's disregard for safety.

Several Region I Division of Reactor Project (DRP) managers told the OIG = that the =

region conducted extensive inspections and devoted significant resources = to

the =

Millstone site. The region used the " to track specific performance issu= es and to focus =

inspection activities in these areas to follow up on NU corrective action= =2E Several =

managers stated that at first it appeared that the MAP process was effect= ive and that =

NU was addressing NRC's concerns. They also stated that it appeared that= =

improvements were being made until the 2-CH-442 event occurred at Unit 2.=

The DRP managers attributed the NU performance deficiencies to licensee =

management. The DRP managers cited poor management organization and over= sight, =

inconsistency in dealing with the three units, and preoccupation with cos= t =

containment. Managers noted that NU developed great corrective action pl= ans but =

was ineffective at following through on their commitments. One manager s= aid that it =

always appeared that NU was addressing NRC's concerns by establishing a n= ew =

program or initiative or instituting a significant management reorganizat= ion. For =

example, he noted that after the 2-CH-442 event, NU initiated a major man= agement =

reorganization. He added that whenever NU took such action, the NRC then= needed a =

period of time, possibly a year or two, to determine the effectiveness of= the new =

program or initiative. He stated that for several years, NU was one "sig= nificant =

event" away from being placed on the watch list.

The current DRP Branch Chief stated that in April 1994, the regional admi= nistrator =

directed the MAP to refocus its efforts to gain closer oversight of all M=

illstone units. =

According to the Branch Chief, during this time NU was disagreeing with t= he MAP =

findings regarding their performance problems; consequently, the MAP and = NU =

officials were meeting periodically to discuss NU's continuing deficienci= es. He noted =

that one of the major problems involved the verification and validation a= spects of the =

PEP. The Branch Chief added that by early 1995, NU accepted the NRC's vi= ew that they =

still had significant problem areas and they recognized that the PEP was = ineffective. =

He said that NU then incorporated the remaining PEP issues into their Imp= roving =

Station Performance (ISP) plan.

The Branch Chief said he attributed NU's performance deficiencies to a la= ck of =

leadership and a refusal by management to accept fault. He noted that NU= =

management practices regarding employee concerns and work control problem= s =

were due to management's inability to follow through on commitments and t= o NU =

corrective actions which tended to be narrowly construed. However, he sa= id that he =

had recommended against placing Millstone on the NRC problem plant list.

The former Deputy Director of DRP and the former Director of DRP advised = the OIG =

that the NRC took appropriate actions to address NU's performance deficie= ncies. The =

former DRP Deputy Director noted that the MAP process enabled the region = and NRR =

staff to closely monitor licensed activities and to allocate and coordina= te resources at =

the Millstone site. The former DRP Director said that the NRC took a num= ber

of =

actions to monitor the implementation of NU corrective actions including = initiating =

the MA-P and a PEP Special Review Group; increasing staff resources devot= ed to =

Millstone; and initiating an aggressive

inspection program. Both managers stated that NU management was not effe= ctive in =

implementing long term improvements. In addition, the former Deputy Dire= ctor =

stated that senior Region I and NRC Headquarters managers were fully awar= e of the =

status of licensed activities at Millstone. He noted that senior manager= s thoroughly =

discussed Millstone and reviewed SALP reports, plant performance and prog= rammatic =

issues every six months at prebriefing meetings and SMMS.

The current Deputy Director of DRP told OIG that Region I has conducted n= umerous =

inspections at Millstone and has used essentially every available inspect= ion tool to =

improve plant performance. He noted that the only inspection not conduct= ed by =

Region I was a diagnostic evaluation. He said that there were probably a= dditional =

actions the NRC could have taken such as placing Millstone on the NRC wat= ch list =

sooner. He stated that he recommended to the Region I Administrator that= Millstone =

be placed on the NRC watch list in 1993. He noted that while NU could ha= ve improved =

performance, their deficiencies did not mean that they were operating the= plant =

outside the NRC regulatory framework. According to the Deputy Director, = the NRC did =

not have an adequate basis for shutting down the plant.

The current Director of DRP stated that NRC inspection activities have be= en directed =

by the MAP as well as the SALP reports. Accordirg to the DRP Director, t= he NRC =

inspections have been monitoring performance deficiencies over the past f= our or =

five years. He noted that the NRC inspections consistently identified NU= 's failure to =

adequately implement corrective actions. He added that the NRC met with = NU =

management throughout the inspection process to discuss inspection findin= gs and =

recurring problems. He recalled that during this time period, " recogniz= ed that a =

major problem with NU's validation and verification feature of the PEP pr= ogram was =

that NU was focusing on numbers rather than the quality of corrective act= ions. He =

added that while NU proposed good program initiatives, they had problems =

implementing their plans.

The DRP Director said that in late 1993, after noticing continued perform= ance =

problems at Millstone, he suggested to the Region I Administrator that th= e site be =

placed on the NRC watch list. He said that the regional staff had convey= ed the =

appropriate information to senior NRC officials so that members of the SA= lP and =

SMMs had an accurate representation of the status of licensed activities = at the =

Millstone site.

The Regional Administrator, Region I, advised the OIG that the region ini=

tiated the =

MAP to establish a mechanism for measuring the success of NU's corrective= actions. =

He noted that such panels are typically established for plants that are o= n the problem =

plant list or in an extended shut down. He said that initially the MAP w= as successful =

in having NU include several items in the PEP such as the verification an= d validation =

aspect of the program. In his view, the " was successful in focusing ins= pection =

activities in the problem areas and directing initiatives above and beyon= d the core =

inspection program. The Regional Administrator noted that additional res= ources =

were assigned tc resolving the large number of allegations being reported= to the =

NRC, and both the region and NRR mounted certain

initiatives to specifically target PEP issues. For example, during late = 1993-1994, NRR =

conducted an engineering team inspection and Region I reviewed the NU Nuc= lear =

Safety Concerns Program. Nevertheless, he added that while NU had initia= ted many =

new procedures, upgraded processes, and added personnel, the NRC was stil= l =

observing a large number of allegations, numerous personnel errors, work = control =

problems, and procedural adherence problems.

The Regional Administrator told OIG that there appeared to be an interval= of =

continuous improvement during the SALP period ending in June 1993; the PE= P =

appeared to be responsive to NRC's concerns, and NU appeared to be making=

=

improvements. However, he noted that after the August 1993 2-CH-442 even= t, coupled =

with steam generator replacement issues at Unit 2, there was a recognitio= n that while =

there were improvements at Units I and 3, Unit 2 performance was continui= ng to =

decline. At this juncture, the MAP and senior management focus shifted t= o Unit 2. He =

noted that after the unit went into an outage in 1994, NU agreed to an NR= C =

confirmatory action letter to remain shut down.

The Regional Administrator advised the OIG that in hindsight, NU official= s have been =

good at doing critical self-assessments and good at planning corrective a= ction- =

however, they have not been effective in correcting their longstanding pr= oblems. =

He noted that whenever the NRC identified a problem, NU would attempt to =

understand the problem and develop a grandiose program to address the iss= ue. He =

added that NU has made "a lot of promises too many times" and while there= may have =

been a temporary period of improvement, it was not long term. He said he= believed =

that NU was committed to resolving the problems, but may not have had the= capacity =

to do so.

The Regional Administrator told OIG that he had received a page that purp= orted to be =

a part of an "LRS 1991 report," (LRS Incorporated has been a consultant t= o NU) which =

was disturbing because it laid out a game plan that recommended to NU to = interact =

with the NRC at multiple levels in order to defuse certain "perceptions g=

enerated" by =

the NRC. The Regional Administrator provided OIG a copy of the LRS docum= ent. This =

document noted that the NRC had certain "perceptions" including the Mills= tone site =

had pervasive procedural non-compliance, recurring design issues at Unit = 1, and =

problems in attention to detail at Unit 2. The document discussed redirec= ting the work =

of various NU task groups to assure coverage of NRC's areas of connects o= r =

"perceptions." In addition, the paper suggests that "NU mount a full cour= t press at all =

levels of the NRC to prevent the Millstone Site from being placed on the = troubled =

plant list." [Note: In response to OIG questions, the Regional Administra= tor said he did =

not specifically recall from whom, when or how he had received the LRS do= cument =

or whether he subsequently discussed it with the NRC staff].

The Regional Administrator acknowledged that several of his management st= aff may =

have recommended that Millstone be placed on the watch list- however, he = noted that =

other managers recommended against it. He also noted that in 1995, the M= AP =

recommended against placing Millstone on the NRC watch list. He said in = hindsight, =

Millstone should have been placed on the NRC watch list sooner. He added= that until =

January 1996, NRC senior

managers felt that NU was making improvements which were sufficient to =

counterbalance the deficiencies that were still present.

Interviews of NRC Headquarters Staff

Several current NRR Project Managers and one former Project Manager assig= ned to =

the Millstone site told OIG that they reviewed inspection reports and pro= vided =

information and observations to NRR managers which were relevant to the S= ALP =

process and SMMs. While several of the Project Managers were aware that = NU had =

conducted self-assessments, they were not generally familiar with the con= tents of =

these reports.

The former Director, Project Directorate 1-4, NRR, who was also the MAP c= o-chairman =

between 1992 and 1994, advised that the MAP initially met monthly to asse= ss the PEP's =

performance in implementing corrective action. Further, the MAP reviewed= =

inspection reports and discussed findings with the resident inspectors in= order to =

assess NU implementation of corrective actions. According to the Project= Director, =

there were improvements in many areas until 1993, when conditions at Mill= stone =

become static. He stated that because there were improvements in NU perf= ormance, =

he never thought the site should have been placed on the NRC watch list d= uring his =

tenure.

The current Director, Project Directorate, NRR stated that during 1995, t= he MAP =

reviewed NU's procedural program, corrective action program, and safety c= oncerns =

program. In addition, the " focused on the Millstone Unit 2 re-start pro= ject after the =

unit went into an extended outage. He noted that the MAP periodically me= t with NU to =

review progress being made. However, he said that NU had not met the goa= ls and =

expectations agreed on between NU and the NRC. The Project Director stat= ed that NRR =

and Region I staff met semi-annually to assess NU's performance in the SA= LP issue =

areas and to re-direct inspection resources to those areas of greatest pl= ant =

deficiencies.

The Associate Director for Projects, NRR, advised OIG that discussions du= ring pre- briefing meetings involved plants of greatest concern to the NRC. He rec= alled that =

during past SMMs, NRC managers discussed significant performance and tech= nical =

issues affecting Millstone. According to the Associate Director, senior = managers =

were concerned that the Millstone units were engaged in an unhealthy comp= etition =

because they operated independent of each other and the units were not sh= aring =

information.

The Associate Director stated that over the years there have been numerou= s =

discussions at the SMMs regarding whether Millstone should be placed on t= he NRC =

watch list. The decision not to place Millstone on the watch list prior = to January 1996 =

was a consensus decision reached by NRC managers. In addition, he said t= hat while =

Millstone was not placed on the NRC watch list until 1996, the NRC did ap= ply additional =

inspection resources to the site. Also, he noted that as a result of NRC= concerns, =

senior NRC managers met with the NU Board of Trustees in 1995, to discuss= NU poor =

performance. However, he stated that in hindsight, Millstone probably co= uld have =

been placed on the NRC watch list sooner.

16

The Director of NRR, NRC, advised the OIG that he has attended essentiall= y all SMMs =

since March 1987. From March 1987 to March 1990, he was the Regional =

Administrator in Region 1. He recalled that the SMM discussions in the 19= 90-1991 time =

period, were essentially focused on Millstone Unit 2 concerns with instru= mentation =

and hardware issues as well as a general concern that performance was dec= lining at =

that unit. He said that the protocol for the SNM is to obtain the opinio= n and =

recommendation of the regional administrator as to what action should be = taken =

regarding a particular plant(s) in his region- however, a consensus is ty= pically =

formed as to the appropriate action for each discussion plant. He stated= that the =

consensus reached at the January 1995 SMM, was that senior managers would= escalate =

the agency's concern by meeting with the NU Board of Trustees before issu= ing a =

trending letter or placing Millstone on the NRC problem plant list.

The Director of NRR stated that during the NRC's meeting with the NU Boar= d of =

Trustees, they expressed concern; however, he did not discern any substan= tive =

change in NU performance following the meeting. He noted that subsequent= ly, =

during the S@ in January 1996, senior managers concluded that NU's perfor= mance =

problems were sufficient to place Millstone on the NRC problem plant list= =2E He said =

that discussions during that meeting focused primarily on whether only Mi= llstone =

Units I and 2 or all three units should be placed on the problem plant li= st. The NRR =

Director said that senior managers concluded that fundamentally, the issu= es were =

management oriented- therefore, they decided that all three units deserve= d to be =

placed on the problem plant list.

The Director of NRR stated that in hindsight the NRC could have met with = the Board of =

Trustees or placed Millstone on the NRC problem plant list sooner and tha= t the NRC =

probably should have done so after the August 1993 2-CH-442 event. In ad= dition, he =

stated that while the NRC had focused on team inspections and other activ= ities, the =

agency did not escalate the matter quickly enough. Moreover, it appeared= the NRC =

had "done a very good job of inspecting, finding things, and we have not = done as =

good a job of integrating it." Further, it appeared that some of the comm= itments made =

by NU were not fully implemented and that the NRC was not aggressive enou= gh in =

verifying that NU commitments were in fact implemented.

The Deputy Executive Director for Nuclear Reactor Regulation, Regional Op= erations =

and Research (DEDO), NRC, stated that he was familiar with the self-asses= sments =

conducted by NU because he was responsible for a special review group whi= ch =

reviewed NU's safety concerns program in December 1991. As part of that = effort, he =

had reviewed the self assessments, therefore, he was familiar with the pe= rformance =

deficiencies which were identified by NU. He said he did not recall spec= ific =

discussions regarding the Millstone site during SMMs. However, he did re= call that in =

early 1995, NRC senior managers met with the NU Board of Trustees which w= as =

extremely unusual. He noted that the meeting did not have the response t= hat the NRC =

was looking for because improvement in NU's performance was not forthcomi= ng. =

The DEDO stated that the 2-CH-442 valve event in August 1993, was signifi= cant enough =

to warrant the NRC taking more aggressive action against NU. He added

that although the civil penalty levied against NU for the event was signi= ficant, it =

should have motivated the NRC to scrutinize the Millstone site more close= ly.

The Executive Director for Operations (EDO), NRC, advised the OIG that th= e S@ =

discussions concerning Millstone during the 1991 to 1992 time period were= focused on =

the deficiencies identified by NU in their self-assessments. He added th= at the MAP =

reports indicated that NU's performance was improving at the time. Howev= er, he =

stated that he considered the August 1993 2-CH-442 event a flagrant act w= hich =

indicated that NU management was out of control. He noted that following= the event, =

Millstone was a discussion plant at the January 1994 SNM. The EDO stated= that =

subsequently, in early 1995, he and other senior managers met with the NU=

Board of =

Trustees to discuss the agency's concerns regarding NU's poor performance= at =

Millstone. He added that such action was rarely done; however, in retros= pect, NRC =

should have placed Millstone on the NRC watch list after the 2-CH-442 eve= nt.

The EDO told OIG that at SMMS, the regional administrator generally sets = the tone for =

the desired action to be taken regarding each of the discussion plant(s) = in their =

respective region. In this instance, the Region I Administrator presente= d =

information regarding NU's operational performance which resulted in Mill= stone's =

status as a discussion plant and ultimate inclusion on the NRC watch list= =2E However, he =

noted that the status of a plant is decided through a consensus reached b= y senior =

managers at the SMMs. He stated that because NU had sporadic improvement= s over =

the years, senior managers did not feel justified in placing the Millston= e site on the =

problem plant list sooner. He said that currently, there is no formal cr= iteria for =

placing a plant either on the discussion plant list or the problem plant = list. In =

addition, he said that a plant could remain a discussion plant indefinite= ly.

On May 1, 1996, NRC issued SECY-96-093 which addresses issues related to = SMMs and =

evaluation processes for placing plants on the NRC watch list. More spec= ifically, this =

document addresses the following issues: the preparation for, and conduct= of, SMMS- =

the assumptions and criteria that are used to evaluate the safety perform= ance of =

nuclear power plants; providing greater openness to the industry and publ= ic

about =

the NRC evaluation process; criteria and actions to be taken when a plant= remains on =

the watch list for an extended period; and criteria in determining when a= plant may =

be removed from the watch list.

U. NRC'S HANDLING OF NU SELF-ASSESSMENTS IN ACCORDANCE WITH 10 C.F.R. =

2.790

Background

OIG reviewed NRC rules pertaining to the availability of official records= which are =

located in Title 10 Code of Federal Regulations, Section 2.790 (10 C.F.R.= 2.790), public =

inspections, exemptions, requests for withholding. This regulation gener= ally =

provides that NRC records

and documents are subject to public disclosure in the absence of a compel= ling reason =

for nondisclosure. The regulation also provides that several categories = of records =

may be excluded from public disclosure. Specifically, 10 C.F.R. 2.790(a)= (4) exempts =

records from public disclosure which contain trade secrets and commercial= or =

financial information obtained from a person, which is privileged or conf= idential, =

and 10 C.F.R. 2.790(a)(6) exempts personnel and medical files and similar= files, the =

disclosure of which would constitute a clearly unwarranted invasion of pe= rsonal =

privacy.

The regulation requires the person proposing that a document be withheld = from =

public disclosure submit to the NRC an application for withholding accomp= anied with =

an affidavit identifying the basis for nondisclosure when the document is= submitted. =

The NRC then determines if the information sought to be withheld from pub= lic =

disclosure is a trade secret or confidential or privileged information, a= nd if so, should =

be withheld from the public. If the NRC denies the request for withholdi= ng, a denial =

notice is sent to the individual who submitted the document advising that= the =

document will be placed in the Public Document Room (PDR) in not less tha= n thirty =

days. Section 2.790(c) explicitly states that if the applicant requests = withdrawal of =

the document within the specified period, the document will not be placed= in the PDR =

and will be returned to the applicant. However, information submitted in= a rule =

making proceeding which subsequently forms a basis for the final rule wil= l not be =

withheld from public disclosure by the NRC and will not be returned to th= e applicant =

after denial of the application for withholding.

The NRC staff advised that periodically, licensees voluntarily provide th= e NRC copies =

of their internal review of operations or programs. When these self-asse= ssments are =

provided to the NRC, licensees often request that they be withheld from p= ublic =

disclosure under Section 2.790. In addition, OGC staff advised that the = NRC generally =

grants the licensee's request that the documents be withheld from the pub= lic

under =

Section 2.790(a)(4), since they contain confidential information that wou= ld not =

routinely be released to the public and such disclosure would impair the = NRC's ability =

to obtain frank information in the future.

NRC Staff Handling of NU's Withholding Requests

On August 26, 1991, NU forwarded to the NRC Document Control Desk a copy = of its =

"Operability, Reportability, and Communications Task Group Final Report" = for NRC's =

information and review. This document included a listing of recommendati= ons for =

improvement in the subject areas. Upon receipt of the report, the NRC pl= aced it in =

the NRC Public Document Room (PDR).

Also, on August 26, 1991, NU forwarded to the Regional Administrator, Reg= ion 1, NRC, =

a second task group report entitled, "Allegations Root Cause Task Group F= inal Report." =

Accompanying this report was an affidavit and request by NU that the repo= rt be =

withheld from public disclosure in accordance with 10 C.F.R. 2.790. Accor= ding to the =

affidavit, NU requested that the document be withheld from the public for= several =

reasons. Specifically, NU asserted that information in the report was pr= oprietary, =

the information was contained in

personnel files and involved personnel matters, the information could be = utilized in =

making personnel decisions, and the information made reference to the =

conduct/performance of specific individuals.

On September 26, 1991, and October 4, 1991, NU forwarded to the Regional =

Administrator, Region 1, NRC, a copy of the "NE&O Performance Task Group = Final =

Report" and a copy of the "Procedure Compliance Task Force Final Report,"= =

respectively. In addition, on October 25, 1991, NU submitted to the Regi= on I =

Administrator, NRC, a report entitled "Millstone Nuclear Power Station, U= nit No. 2, =

Employee Concerns." NU requested that each of these reports be withheld f= rom public =

disclosure in accordance with 10 C.F.R. 2.790 and provided supporting aff= idavits with =

their requests.

On November 13, 1991, the Director, Division of Reactor Projects, Region = 1, NRC, =

responded to NU's requests that the Allegations Root Cause Task Group Fin= al Report, =

NE&O Performance Task Group Final Report, and Procedure Compliance Task F= orce =

Final Report be withheld from public disclosure. NRC advised NU that som= e of the =

material contained in the reports could be withheld from disclosure under= 10 C.F.R. =

2.790(a)(6), but that the remaining material should be placed in the NRC = Public =

Document Room. The NRC further advised NU that it could request withdraw= al of the =

reports in accordance with 10 C.F.R. 2.790(c), or provide the NRC with re= asons for =

withholding additional portions.

In a letter dated November 22, 1991, NU informed the NRC of its decision = to withdraw =

the reports from the docket in their entirety rather than allow redacted =

versions to =

be released to the public. On December 5, 1991, NU made a similar reques= t to withdraw =

from the docket the fourth self-assessment it submitted to the NRC on Oct= ober 25, =

1991, as this report was not referenced in the NRC's November 13, 1991, l= etter. NU =

also requested that certain handouts it provided the NRC during meetings = with the =

staff be withdrawn. After considerable debate among the staff, NRC ultim= ately =

agreed to treat all four of NU's reports and related handouts as Section = 2.790 material =

and withhold them from public disclosure.

A Region I manager told OIG that NU's repeated requests for document with= holding =

under Section 2.790 required the NRC to balance several important, compet= ing =

interests. He noted that the task force reports dealt with highly visibl= e issues at a =

highly visible site. During the late 1991 time period, the NRC Chairman = was stressing =

the importance of conducting business in the public. He advised that it = was forced to =

weigh the needs of the licensee to communicate with the NRC in a candid m= anner and =

the licensee's ability to perform critical self-assessment against the pu= blic's need to =

know. According to the Region I manager, in deciding whether to treat th= e NU =

documents as Section 2.790 material, the staff also considered the import= ance of =

protecting the identity of allegers and the personal privacy of individua= ls involved =

in the reports.

The OGC staff advised that licensee documents are generally not reviewed = for Section =

2.790 applicability unless a licensee requests withholding. According to= OGC and =

Region I staff, these requests are reviewed by NRC counsel to ensure that= the request =

complies with Section

20

2.790 requirements-. Regarding the NU self-assessment reports and meetin= g =

handouts relating to Millstone, the staff stated that attorneys from the = NRC OGC and =

Regional Counsel, had reviewed these documents and provided advice to the= staff.

NU'S Two Procedure Compliance Review Reports

As noted above, NU forwarded its "Procedure Compliance Task Force Final R= eport" to =

the NRC on October 4, 1991. On December 23, 1991, NU submitted to the NR= C a second =

"Procedure Compliance Review Group II Final Report." However, NU did not = include =

with the second report a request that the document be withheld from publi= c =

disclosure pursuant to 10 C.F.R. 2.790. The second report noted that 99 p= ercent =

procedural compliance was observed by the task group. This differed shar= ply with =

the findings made in the task force report issued two months earlier, whe= rein =

procedural compliance was observed 30 to 50 percent of the time.

According to Region I staff interviewed by the OIG, both compliance revie= w reports =

accurately reflect the areas and issues addressed in each report. In add= ition, the staff =

stated that they were not surprised by the findings in either report. Re= gion I staff =

explained that the task forces were initiated in response to NRC's recomm= endation =

that NU determine the root cause of Millstone's procedural noncompliance = problem. =

The second procedural compliance review was initiated, in part, to put th= e findings of =

the first procedural compliance review in proper perspective. Several Re= gion I =

managers stated that they did not rely on what NU identified as the level= of or source =

of their noncompliance problems- rather, they focused on NU's efforts to = resolve the =

matter.

The OIG determined that since NU requested withholding of only one of the= two =

procedural compliance task force reports, it appeared that NU was selecti= vely =

controlling the information released to the public. Because NU requested= Section =

2.790 withholding of the task force report which found 50 to 70 percent p= rocedural =

compliance, and did not seek withholding of the task force report which f= ound 99 =

percent compliance, NU provided the public only with the information that= was most =

favorable to it. Accordingly, this selective handling of information gav= e the =

appearance that NU's procedural compliance with NRC and internal requirem= ents =

was near perfect (99 percent).

While several NRC staff members noted the benefits in allowing licensees = to submit =

documents to the NRC under the protection afforded by Section 2.790, the = Director, =

Office of Enforcement, NRC, commented on areas where the rule needed to b= e =

changed. He noted that Section 2.790(c), as currently written, permits a= licensee to =

seek the return of documents it had submitted to the NRC when the NRC den= ies its =

request to withhold the documents from public disclosure. He stated that= the NRC =

should not have to return documents if the NRC relies on them, regardless= of whether =

the document meets the requirements of Section 2.790(a). According to the= Director, =

once the document is submitted to the NRC, the agency should decide how t= he =

document should be categorized. If the licensee is unable to persuade

the NRC to withhold the document from public disclosure, it would be requ= ired to =

challenge the staff s decision in Federal court.

Interviews of NU Personnel

The OIG interviewed members of the NU task groups who were involved in =

conducting the self-assessments in 1991, and a NU management official. T= he task =

group members essentially confirmed the historical basis for NU's initiat= ing the =

internal self-assessments and confirmed their findings.

The NU management official told the OIG that the success of the PEP and t= he =

subsequent five year business plan has been "mixed." He noted that there = have been =

a number of discreet areas where these programs were effective and timely= , and had =

generally accomplished what NU set out to accomplish. However, in other = cases these =

programs were ineffective. Accordingly, he said that the real issue was =

that some of =

the performance deficiencies identified by NU in 1991 were still present,= therefore, =

the PEP has not been effective. He stated that NU procedure compliance p= erformance =

continues to need attention and improvement, and that more recently, NU's= attention =

has focused on design control and integrity of design basis issues.

Regarding the issue that NU sought that the first procedural compliance t= ask group =

report be withheld from public disclosure but did not make a similar requ= est for the =

second report, the NU official surmised that a judgment was made by NU th= at the =

nature of the second report did not rise to the level where NU had concer= ns about =

critical self-assessments having an adverse impact on NU. He stated that= he did not =

believe that the document fell into this category, therefore, it would be= difficult to =

advance an argument that the document could be withheld under 10 C.F.R. 2= =2E790.

The task group leader responsible for conducting the second procedure com= pliance =

review stated that NU management did not conduct the second review to inv= alidate =

the first procedure compliance report. Rather, he said that after NU iss= ued the first =

report, NU management took certain immediate actions including advising e= mployees =

that NU would take disciplinary action, to include termination for non-co= mpliance of =

procedures. He stated that NU management later directed the second proce= dure =

compliance review to gauge the effectiveness of their corrective actions.=

According to the second procedure compliance task leader, the second grou= p sampled =

every department at Millstone and conducted a larger number of observatio= ns than =

the first review group. He also stated that the major difference between= the two =

reports was that the second review group found that NU employees were now= =

completing a procedure change work order, rather than not complying with =

procedures.

FINDINGS

During this inquiry, OIG learned from the staff that in spite of increase= d NRC =

inspections and evaluations the deficiencies identified at Millstone in t= he 1991 =

NU self-assessments have persisted. The staff has continued to document = a =

general declining level of performance at the Millstone site since 1991. = =

Furthermore, the Region I Administrator had information that indicated in= =

1991, NU management intended to conduct "a full court press" to change NR= C =

"perceptions" of poor performance at Millstone and to convince senior NRC= =

management to not place Millstone on the NRC watch list. The NRC EDO, =

Director of NRR, and the Region I Administrator acknowledged to OIG that =

based on the indicators of poor performance at Millstone, NRC should have= =

taken more aggressive action including placing the Millstone site on the = NRC =

watch list as early as 1993. This was especially true in light of the 19= 93 2-CH-
442 event. However, NU's periodic changes in program initiatives and =

management reorganizations caused the NRC staff to allow an excessive =

amount of time for NU's proposed corrective actions to take effect. More= over, =

NU's sporadic improvements in some areas of NRC concern neutralized the =

staff's willingness to take prompt aggressive action.

2. NRC handled NU's 1991 self-assessment documents in accordance with the= =

requirements of 10 C.F.R. 2.790. OIG determined that intentionally or oth= erwise, NRC =

licensees can, to a limited degree, control information released to its r= atepayers, =

stockholders, and the public by strategically requesting protection of in= formation =

provided to the NRC under 10 C.F.R. 2.790. Because the NRC is not require= d to, and in =

practical terms, cannot effectively determine what information constitute= s a trade =

secret or what information is already in the public domain, Section 2.790= requires the =

licensee to submit a withholding request and affidavit with each document= it seeks to =

have withheld from the public. This regulatory framework allows a licens= ee to =

selectively control the information available to the public by requesting= Section =

2.790 withholding for documents which reflect poorly on the licensee and = by not =

requesting withholding for self-assessments which portray the licensee in= a =

favorable manner.

From: <VMBLANCH@aol.com>
To: WND2.WNP3(jnh,jaz),TWD1.TWP4(wjs,ljn1),WND1.WNP2(d...
Date: 6/7/96 3:59pm
Subject: 28 USC 2462

Date: Jun 1996 10:51 AM EDT
From: JAZ@nrc.gov
X-From: JAZ@nrc.gov (John Zwolinski)
To: VMBlanch@aol.com

File: enforc.pol (139264 bytes)

Paul, response to email of this morning....trust attachment came through OK...Its the Enforcement Policy.....Z

The statute of limitations, as the name implies, is not in NRC regulations but is a statute set out at 28 U.S.C 2462. It provides:
"Except as otherwise provided by an Act of Congress, an action, suit or proceeding for the enforcement of any civil fine, penalty, or forfeiture, pecuniary or otherwise, shall not be entertained unless commenced within 5 years from the date when the claim first accrued if, within the same period, the offender or the property is found within the United States in order that proper service may be made thereon."