

ENCLOSURE 2

U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-219/85-21

Docket No. 50-219

License No. DPR-11

Priority -

Category C

Licensee: GPU Nuclear Corporation

P.O. Box 388

Forked River, New Jersey 08731

Facility Name: Oyster Creek Nuclear Generating Station

Meeting At: NRC Region I, King of Prussia, PA

Meeting Conducted: June 13, 1985

Prepared by: _____

M. T. Miller
M. T. Miller, Radiation Specialist

7/3/85
date

Approved by: _____

W. J. Pasciak
W. J. Pasciak, Chief, BWR Radiological
Protection Section

7/23/85
date

Meeting Summary: Enforcement Conference at NRC Region I, King of Prussia, Pennsylvania, on June 13, 1985, to discuss the findings of Routine Inspection No. 50-219/85-18. The topics discussed at the meeting were: the events of June 6 and June 7, 1985, involving the apparent false statements to NRC Inspectors with regard to an apparent violation of Technical Specification 6.10; the results of your investigation of the causes and extent of management involvement in the events identified in Inspection Report No. 50-219/85-18; and the corrective actions taken or planned.

The meeting was attended by NRC and Licensee Management and lasted about two hours.

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DETAILS

1. Participants

GPU Nuclear Corporation

P. R. Clark, President, GPUN
P. B. Fiedler, Vice President, Director, Oyster Creek
R. W. Heward, Jr., Vice President, Director, Radiological and Environmental Controls
J. R. Thorpe, Director, Licensing and Regulatory Affairs
J. E. Hildebrand, Director, Radiological Controls, TMI-2
D. W. Turner, Director, Radiological Controls, Oyster Creek
R. F. Feuti, Manager, QA Modifications/Operations, Oyster Creek

Nuclear Regulatory Commission

T. E. Murley, Regional Administrator
J. M. Allan, Deputy Regional Administrator
R. K. Christopher, Director, Office of Investigations, Philadelphia Field Office
T. T. Martin, Director, Division of Radiation Safety and Safeguards
W. F. Kane, Deputy Director, Division of Reactor Projects
E. L. Conner, Section Chief, DPR
M. M. Shanbaky, Chief, PWR Radiological Protection Section
W. H. Bateman, Senior Resident Inspector, Oyster Creek
J. M. Gutierrez, Regional Attorney
D. J. Holody, Enforcement Specialist
M. T. Miller, Radiation Specialist, BWR Radiological Protection Section

2. Purpose

The Enforcement Conference was held at the request of NRC Region I to discuss the NRC observations on June 6-7, 1985 concerning apparent false statements; the results of the licensee's investigation into the cause and possible extent of management involvement; and the licensee's planned and completed corrective actions.

3. Discussion

NRC management stated that the enforcement conference was requested to discuss the findings from the routine radiological controls inspection conducted June 3-7, 1985, (Report No. 50-219/85-18). The NRC inspector provided a summary of the events and statements made by the licensee on June 6 and June 7, 1985. (Inspection Report No. 50-219/85-18 had not been transmitted to the licensee prior to the enforcement conference.) The licensee was requested to: provide his perception of the above events of June 6-7, 1985; provide results of the investigation into the

cause for these events and the extent of possible licensee management involvement; and provide the planned and completed corrective actions.

4. Licensee Presentation

Licensee management stated that the description of the events concerning the apparent false statements as described by NRC staff during the enforcement conference was accurate and that their investigation found no differences from NRC's description of the events. Licensee management stated they conducted two separate investigations, one to address the cause for the apparent false statements, and an independent audit to determine if there had been evidence of programmatic breakdown which could have been an underlying cause of these events.

Licensee management stated that both investigations were completed and discussed the results:

- The initiating event for the apparent false statements was the apparent violation of Technical Specification 6.10 for failure to issue a 0-500 mrem self reading dosimeter. This problem was viewed by the individuals involved as a penalty which would create severe problems for GPU Nuclear and would jeopardize their employment
- The supervisor involved in this event suggested to the HP technician and a Fire Protection technician that false statements to conceal the evidence that supported the apparent violation of Technical Specification 6.10 should be made to NRC inspectors. The HP Technician made the false statements, however, the Fire Protection Technician did not make a false statement to the NRC.
- The investigation indicated that this event was not caused by management programmatic problems. However, it was determined that some personnel had no understanding of the NRC enforcement policy with regard to severity levels, which may have partly led to personnel attitudes toward NRC inspectors.
- The investigation also indicated that significant management attention is directed to emphasize the importance of identifying all errors/oversights.

Licensee management described the corrective action implemented and planned as a result of the investigations. Those actions included:

- The individuals who had made apparent false statements had their employment with GPU Nuclear terminated on June 11 or June 12, 1985.
- A sampling of work completed by the individuals would be reviewed to determine if there was any other evidence of dishonesty.

- A dose of 7 mrem was assigned to the fire protection technician's exposure history and a radiation survey briefing would be provided to all personnel entering a locked High Radiation Area in response to the apparent violation of Technical Specification 6.10.
- A memorandum dated April 4, 1983 concerning integrity of employees was re-posted on June 10, 1985 and will be reissued and discussed in formal training. The details of NRC enforcement policy will also be discussed.

5. Concluding Statements

Licensee management concluded by stating their belief that the events concerning the apparent false statements were isolated and that no further investigations would be made unless directed by NRC.

NRC Region I management acknowledged the results of the licensee investigations and their plans and actions presented appeared to adequately address NRC concerns, at this time. NRC Region I management stated that the licensee would be informed of the need for and nature of appropriate enforcement action relative to the apparent violations at a later time.