October 2, 2008

MEMORANDUM TO: Chairman Klein
Commissioner Jaczko
Commissioner Lyons
Commissioner Svinicki

FROM: R. W. Borchardt ***/RA Bruce Mallett for/***
Executive Director for Operations

SUBJECT: SENIOR EXECUTIVE REVIEW PANEL – EVALUATION OF OFFICES OF INSPECTOR GENERAL AND INVESTIGATIONS REPORTS ON PEACH BOTTOM

In the Staff Requirements Memorandum (SRM) - COMSECY-08-0009, "Report of the Senior Executive Review Panel-Peach Bottom Lessons Learned," dated June 9, 2008, the Commission directed the Senior Executive Review Panel (SERP) to reassemble after the Offices of the Inspector General (OIG) and Investigations (OI) completed their reviews of security-related concerns at the Peach Bottom nuclear power plant. In the SRM, the Commission also directed the SERP to determine if there are additional lessons-learned and whether additional action is needed, and to provide the information to the Commission for its consideration. The OI and OIG completed their investigations on July 25 and August 22, 2008, respectively. The SERP reconvened on September 25, 2008, and examined the OIG event inquiry findings as well as the results of the Peach Bottom OI report.

The OIG report, or event inquiry, identified findings in four areas. A copy of the findings from the report is enclosed for your reference. The SERP determined that the lessons-learned and actions previously identified in the March 4, 2008, SERP report addressed the four areas of findings in the OIG report. The SERP did identify some areas that merit further consideration and action to address: (i) the U.S. Nuclear Regulatory Commission (NRC) staff responses to the OIG's questions as noted in the OIG report, and (ii) statements in the report indicating why certain NRC actions were taken and that NRC's response was inconsistent with the guidance in Management Directive 8.8, "Management of Allegations" (MD 8.8).

Below is a summary of the actions identified for each OIG report finding:

- The SERP reviewed Finding No. 1 and Finding No. 4 and did not identify any new lessons-learned. The SERP determined that there was a clear basis for the difference in regulatory response to the March and September 2007 allegations that was consistent with the guidance in MD 8.8.

CONTACT: Diana Diaz-Toro, OEDO
301-415-8744

- Regarding Finding No. 2, the report states that the referral of the March 2007 allegation to the licensee was inconsistent with MD 8.8 because the allegations were against licensee management. The SERP determined that the March 2007 allegation was not against all licensee management. The staff therefore referred the allegation to the licensee at a senior level of management with instructions that the evaluator be independent of the organization involving or affected by the alleged concern. The SERP determined that the intent of MD 8.8 was to allow referrals to licensee management not related to the alleged concern, but this is not clearly stated. Therefore, the SERP recommended that the language in MD 8.8 be clarified to reflect this intent.

- Regarding Finding No. 2, the report states that the March 2007 allegation referral was inconsistent with MD 8.8 because three questions on page 33 of the MD 8.8 have answers that suggest otherwise. The SERP determined that the existing guidance only suggests these questions and responses be considered; and they were considered in the March 2007 case. The SERP determined that the word, "consider", is appropriate and no changes are needed in the MD 8.8. The SERP suggests that there are lessons-learned from this case, and these should be reviewed with staff during the fundamentals allegation training.

  In addition, the SERP determined that action C.2.a [page 6 and 7] of the March 4, 2008, SERP report, should be further clarified. Action C.2.a recommended expanding the inspection procedures for all program areas to include guidance for review of all open allegations or past allegations trends pertaining to the areas to be inspected during inspection preparation. The OIG report implies there may be a potential to not inspect allegations during inspections because they have been referred to licensees for follow-up. Based on this potential the SERP determined that the inspection procedures should be further clarified to state that the inspectors can review aspects of allegations even when the allegations have been referred to the licensee, as considered appropriate.

- Regarding Finding No. 3, the report states that the staff's attempts to verify the information the licensee provided were not sufficient. The SERP determined that additional consideration should be given to how and what actions can OI implement to confirm the accuracy of information that licensees provide, in cases where wrongdoing is suspected. As a result, the SERP agreed to further discuss the matter with OI to ensure that the previously identified SERP finding in Enclosure 2 (Additional Findings/Actions Identified by the SERP) to the March 4, 2008, SERP report, covers this matter.

- While not a finding in the OIG event inquiry report, Page 7 recounts that a staff member said he may have been less sensitive to the March 2007 security concerns because past allegations had been unsubstantiated. The SERP considered this matter and determined that the NRC should ensure that this sensitivity is covered during the inspection and allegation basic training fundamentals.

The OI report was an investigation into whether the licensee followed NRC requirements with regard to the inattentive security officers at Peach Bottom. The SERP determined that the lessons-learned regarding allegation follow-up and inspections to detect inattentive security officers as identified in the March 4, 2008, SERP report, encompass the lessons that can be gleaned from the OI report. Based on statements made by security officers during interviews, the SERP determined that consideration should be given to how and what actions can the NRC

implement, on a case-by-case basis, to enhance awareness of licensee's employees regarding the purpose of NRC visits to the licensee without sharing allegation sensitive information.

I agree with the SERP findings. It should be noted that, to date, we have taken several actions to address the lessons-learned identified in the March 4, 2008, SERP report. The findings from this most recent review will further enhance the quality and effectiveness of the NRC's allegation and inspection process. The specific actions will be added to the actions identified in the March 4, 2008, SERP report and will be tasked to appropriate program offices for coordinated implementation.

In accordance with the Chairman's September 2, 2008, memorandum, the staff is also developing a response to the OIG regarding the event inquiry report's findings. If you have any questions or comments, please let me know.

Enclosure:
Findings from the Office of Inspector General's Event Inquiry

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Office	TRPB/OEDO	DEDR/OEDO	EDO/OEDO
Name	DDiaz-Toro	BMallett	RBorchardt (BMallett for)
Date	10/01/08	10/02/08	10/02/08

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FINDINGS

1. OIG determined that Region I was inconsistent in its assessment of the safety significance of two allegations, made within 6 months of each other, conveying similar concerns about inattentive security officers at Peach Bottom.

   In late March 2007, the Region I NRC resident inspector assigned to Peach Bottom received a letter from a former Wackenhut security manager who alleged that security officers at Peach Bottom came to work exhausted, were inattentive on duty, and covered for each other so they could nap during shifts. On March 27, 2007, Region I staff received the letter and assigned an allegation number to the security concerns. On March 29, 2007, Region I responded to this allegation by convening an ARB meeting. During the meeting, the ARB determined that the allegation did not pose an immediate safety issue. The ARB's decision was based on a review of previous, similar security related allegations that had not been substantiated. The ARB also decided to repanel 2 weeks later to determine NRC's next steps. During the second ARB, on April 11, 2007, ARB participants again determined that the March security concerns did not pose an immediate safety issue and decided to refer the concerns to Exelon, the license holder for Peach Bottom. The concerns were referred by Region I to Exelon by an April 30, 2007, letter.

   On September 10, 2007, Region I received a second allegation about inattentive security officers at Peach Bottom. On that date, the region's Public Affairs Officer received a telephone call from a WCBS television reporter who claimed to possess a videotape depicting inattentive security officers on duty at the plant. Based on this telephone call, Region I promptly convened an ARB on the same day, and the ARB decided that the allegation posed a potential significant safety issue. The ARB also decided that because the reporter did not provide any specifics, the NRC staff should contact the reporter the same day to obtain additional details. The Region I staff contacted the reporter who would not provide any additional details but reiterated that security officers were inattentive at Peach Bottom and that the reporter had a video which showed the Peach Bottom inattentive officers. A second ARB meeting was convened on September 10, 2007, and the ARB was informed that the reporter would not provide further details of the Peach Bottom officers' inattentiveness. Shortly thereafter, resident inspectors assigned to Peach Bottom began increased monitoring of security officer activities, including night shift inspections of security officers for inattentiveness. On September 20, 2007, Region I staff reviewed the video and also convened an AIT.

2. OIG determined that MD 8.8 encourages the NRC staff to refer "as many allegations as possible" to licensees and establishes criteria for doing so. However, in referring the Peach Bottom security concerns to Exelon, Region I staff did not follow MD 8.8's direction that allegations against licensee management should not be referred. Two of the three concerns – officers feared retaliation from Exelon management for raising safety concerns and Exelon management was aware that officers were inattentive on duty but was not taking proper actions to address the inattentiveness – fall into this category.

In addition to the above, the referral of the allegation by Region I to Exelon was not consistent with MD 8.8 guidance for referral in the following areas:

- *Has the alleger raised objections to releasing the allegation to the licensee?* The former Wackenhut security manager requested anonymity regarding the March 2007 letter and that NRC not inform Exelon of the letter's existence.

- *Are resources available within the region or program office to conduct an investigation or inspection?* On the date of the referral letter to Exelon, April 30, 2007, Region I began a baseline security inspection that continued through May 4, 2007. However, this inspection did not include the concerns in the March 2007 letter.

- *What is the licensee's past performance in dealing with allegations, including the likelihood that the licensee will effectively investigate, document, and resolve the allegation?* The March 2007 letter stated the licensee was aware of inattentive officers at Peach Bottom but past efforts to address the inattentiveness had failed.

3. OIG determined that other than making a telephone call to clarify the frequency of random communication checks and the number of officers involved in such checks, Region I did not probe or attempt to verify the information provided by Exelon in its May 30, 2007, assessment report.

   - Region I staff did not question how random observations of BRE towers were conducted or documented even though the staff believed that random observations of the BRE towers were generally not possible because of the BRE tower configuration. Region I staff did not question this information even though they believed that supervisory post checks, the licensee's other means of observing officers on post, would have limited success for catching inattentive security officers given that officers would always have advance notice and could prepare themselves accordingly.

   - Region I staff did not inquire into the licensee's sampling of security officers and managers interviewed in an effort to determine their knowledge of inattentive security officers on duty. None of the security officers from the team that included the inattentive officers on the video were interviewed and no Wackenhut security managers were interviewed.

   - Region I staff did not question the viability or enforceability of Exelon's program requirement for security officers to get up, walk around, and be active for 2-3 minutes approximately every 15 minutes.

4. OIG also determined that, in conjunction with referring the March 2007 concerns to Exelon for evaluation, Region I could have taken the following steps:

   - Contacted the former Wackenhut security manager to obtain additional information because the Region I staff believed the alleger's letter lacked specificity.

- Provided more detailed information to Exelon pertaining to the March 2007 security concerns. Specifically, in its April 30, 2007, letter to Exelon, Region I could have informed Exelon that security officers were coordinating with each other or waking each other up to respond to radio checks. They also could have conveyed the alleger's suggestion to monitor the plant personnel staging areas.

- Provided the March 2007 concerns to the NRC resident inspectors assigned to Peach Bottom for increased monitoring of security officer activities.

- Tasked the Region I security inspectors to look into the matter during a baseline security inspection conducted at Peach Bottom from April 30 to May 4, 2007.