COMSECY-08-0009

March 5, 2008

MEMORANDUM TO: Chairman Klein
Commissioner Jaczko
Commissioner Lyons

FROM: Luis A. Reyes ***/RA/***
Executive Director for Operations

SUBJECT: REPORT OF THE SENIOR EXECUTIVE REVIEW PANEL - PEACH BOTTOM LESSONS LEARNED

On February 11, 2008, I formed a Senior Executive Review Panel (SERP) to evaluate the findings from the Peach Bottom Lessons Learned Review Team (PBLLRT). Their task was to determine how best to implement the recommendations from the PBLLRT and to determine whether the existing recommendations should be expanded to cover additional areas. The SERP has completed the review and issued a report on March 4, 2008. I am transmitting it to you.

I agree with the SERP's findings and am tasking the offices to implement both the PBLLRT's recommendations for Agency action to address the lessons learned, and the SERP's additional findings that identify where the Agency processes can be enhanced. My expectation is that all of the tasks will be implemented as soon as practicable. I assure you that I will remain engaged in, and informed by, the progress and outcomes of this effort to assure that changes in processes will be implemented by staff in a timely manner.

Enclosure:
Memorandum of March 4, 2008,
from Bruce S. Mallett to Luis A. Reyes

cc: SECY
OCG
OCA
OPA
CFO

CONTACT: James Moorman, OEDO
415-2176

March 4, 2008

MEMORANDUM TO: Luis A. Reyes
Executive Director for Operations

FROM: Bruce S. Mallett, Chair */RA/*
Senior Executive Review Panel
Peach Bottom Lessons Learned

SUBJECT: REPORT OF THE SENIOR EXECUTIVE REVIEW PANEL - PEACH BOTTOM LESSONS LEARNED

This memorandum provides the results of the Senior Executive Review Panel's (SERP) evaluation of the lessons learned regarding NRC actions following review of allegations and inspection activities associated with inattentive security officers at the Peach Bottom nuclear power plant in 2007. It also provides the Panel's recommendations for Agency action to address the lessons learned.

Basis for Panel's Review

Your February 11, 2008, memorandum established the SERP to evaluate the findings from the Peach Bottom Lessons Learned Review Team (PBLLRT) as contained in NUREG 1904, "Review Team Findings with Respect to Inattentive Security Officers at Peach Bottom," dated February 11, 2008, and determine:

- How best to implement the recommendations in the report and proposed list of actions in the February 11, 2008, memorandum, and

- Whether the existing recommendations should be expanded to cover additional areas.

The SERP members included, Bruce Mallett, Martin Virgilio, Jim Dyer, Cynthia Carpenter, Roy Zimmerman, and Eric Leeds. To accomplish the review, the SERP examined the PBLLRT findings and recommendations in detail, interviewed selected Allegation Review Board members, and reviewed referenced inspection reports, NRC guidance documents, allegation materials and input from external stakeholders. The SERP focused on actions the NRC can take to improve our allegation follow-up and inspection process in the same three areas or categories specified in the PBLLRT report and in your February 11, 2008, memorandum (i.e., Forwarding Allegations and Evaluating Licensee Reponses, Communications/ Interactions with Concerned Individuals, and NRC Inspection Process for Detecting Inattentiveness).

SERP Findings and Conclusions

Detailed findings of the SERP are contained in the enclosures to this memorandum. Enclosure (1) provides an itemized listing of the SERP's evaluation/findings and identified actions to address PBLLRT Recommendations. Enclosure (2) provides a listing of findings and recommendations made by the SERP in addition to the PBLLRT findings.

In summary, the SERP found:

- The follow-up and closure of the March 2007 allegation by the licensee and NRC was not sufficient to detect the later discovered inattentiveness by security officers. The NRC follow-up could have benefited from additional independent verification through inspection or investigation assistance. The NRC review of the licensee's response to the allegation did not meet the Management Directive (MD) 8.8, Management of Allegations, guidance for challenging the scope of the licensee's evaluation.

- The PBLLRT scope of review was comprehensive and identified several beneficial recommendations for improving the quality and effectiveness of the allegation and inspection processes. The specific recommendations and actions from the PBLLRT and SERP should be applied to inspection and allegation follow-up related to inattentiveness by security officers and other categories of workers at licensed facilities.

- The decision to refer the March 2007 allegation to the licensee for follow-up and resolution had a technically sound basis and met the criteria for allegation referral identified in existing agency guidance/procedures, given the circumstances of the March allegation. However, the concerned individual (CI) should have been contacted to:

  1) advise the CI of the intended referral to the licensee,
  2) attempt to obtain additional information, and
  3) inform the CI of the close-out of the March 2007 allegation as "unable to substantiate."

  Actions for Items 1 and 3 did not meet the guidance of MD 8.8 in this case. The staff honored a request by the CI not to be contacted.

- The regulatory response to an inadequate licensee follow-up of a referred allegation is not well defined.

- The existing inspection procedures do not specifically address identifying inattentive licensee staff as an objective of routine inspections or include specific guidance on techniques for maximizing methods to detect inattentiveness.

The SERP believes that the actions specified in Enclosures 1 and 2 will improve the NRC practices for responding to allegations in general, as well as, help prevent and detect inattentive personnel involved in both nuclear safety and security activities. The specific actions should be tasked by the Executive Director for Operations to the appropriate program offices for coordinated implementation. These implementation activities should include internal and external stakeholder meetings to explain NRC plans and obtain feedback on proposals for changing procedures.

It should be noted that there are two ongoing activities by the NRC Offices of Inspector General and Investigations that may provide additional lessons learned and actions for further consideration.

If you have any questions or comments, the SERP would be pleased to discuss these matters further with you.

Enclosures:
As stated (2)

The SERP believes that the actions specified in Enclosures 1 and 2 will improve the NRC practices for responding to allegations in general, as well as, help prevent and detect inattentive personnel involved in both nuclear safety and security activities. The specific actions should be tasked by Executive Director for Operations to the appropriate program offices for coordinated implementation. These implementation activities should include internal and external stakeholder meetings to explain NRC plans and obtain feedback on proposals for changed procedures.

It should be noted that there are two ongoing activities by the NRC Offices of Inspector General and Investigation that may provide additional lessons learned and actions for further consideration.

If you have any questions or comments, the SERP would be pleased to discuss these matters further with you.

Enclosures: As stated

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**SERP Findings and Actions to Address the PBLLRT Recommendations**

**A. Process for Forwarding Allegations to a Licensee, Evaluating Licensee Responses, and Documenting the NRC Evaluation of the Licensee Response:**

1. PBLLRT Recommendation

The NRC Office of Enforcement (OE) should evaluate the NRC practice of honoring concerned individual's (CI's) requests not to be contacted unless there is a clear and immediate nuclear safety issue, to determine if additional guidance is needed. The NRC views CIs as an important element in helping to ensure nuclear safety. Therefore, it is important to maintain a good relationship with CIs and be sensitive to their requests. However, in hindsight, additional contact with the CI (via telephone or, if necessary, mail) would not have compromised the CI's identity and may have resulted in the NRC obtaining more specific information to support additional NRC action in this matter, such as the location of other areas besides the Bullet Resistant Enclosures where security officers were inattentive (i.e., the ready room), as well as other information provided to the CI by the security officers he stated that he represented.

Senior Executive Review Panel Findings

The CI was not contacted prior to referring the allegation to the licensee. This is inconsistent with Management Directive (MD) 8.8, Management of Allegations.

The staff interpreted existing allegation guidance to discourage contacting the CI to obtain additional information when the CI requested no further contact.

Actions to Address Findings

a. Expand the existing guidance/procedures to: 1) clarify that the CI should be informed of an intended referral even if the CI requested no further contact, and 2) attempt to obtain additional information from a CI to better define the concern, when needed, even in cases where the CI has requested the staff not to contact them. (OE)

b. In parallel, conduct a workshop with stakeholders to obtain feedback and explore the possible impacts these actions may have on the willingness of concerned individuals to bring their concerns to the NRC. (OE)

2. PBLLRT Recommendation

NRC Region I, the other regional offices, and OE should evaluate whether the ARB disposition form, drafted by the responsible division prior to an ARB, should be revised to provide an additional section that describes: (1) the history/trends of related allegations at the facility (i.e., number of allegations at the facility in the last two years, substantiated OI cases, and whether a large percentage of concerns are focused in the area that is the subject of the allegation) as well as related inspection findings; and, (2) how those inspection findings and the allegation history were considered in the decision to forward the concern(s) to the licensee. Such information could be periodically retrieved from the NRC Allegation Management System and Reactor Planning System and provided to the responsible division.

Senior Executive Review Panel Findings

As identified by the PBLLRT, the basis for the decision to refer the allegation to the licensee was not well documented by the Allegation Review Board (ARB).

The Panel considers the proposed change to the ARB disposition form a good practice.

Actions to Address Findings

a. Modify guidance/procedures regarding how allegation follow-up history, allegation trends, inspection findings, etc. are considered and documented in the decision to refer an allegation to the licensee for follow-up. (OE)

b. Develop a standard form for prompting issues to be considered when the ARB is determining whether to refer an allegation to the licensee for follow-up. Include this form in the guidance/procedures. (OE)

c. Improve the Allegation Management System database so that it can be used more effectively to review the history and trends of related allegations. (OE)

3. PBLLRT Recommendation

NRC Region I has revised its standard letter to forward concerns to licensees to include the following statement: “Your response should describe how each of these attributes were satisfied, and if interviews of individuals were conducted as part of your review, include the basis for determining that the number and cross section of individuals interviewed, as well as the scope of the interviews, is appropriate to obtain the information necessary to fully evaluate the subject concern(s). The NRC will consider these factors in reviewing the adequacy of your evaluation of this concern(s).” This change should be evaluated by OE for incorporation into agency guidance.

Senior Executive Review Panel Findings

As identified by the PBLLRT, the allegation referral letter did not request the licensee to provide information on how it conducted its follow-up of the allegation. MD 8.8 provides limited guidance in this area.

The panel considered the change made to the standard letter a good practice.

Actions to Address Findings

a. Expand the existing guidance/procedures to require that allegation referral letters request a licensee provide descriptive information on both the actions it took to follow-up on the allegation and how it accomplished these actions. (OE)

b. Develop a standard referral form / letter to accomplish the above. (OE)

4. PBLLRT Team Recommendation

NRC Region I, the other regional offices, and OE should evaluate whether sufficient descriptive information is provided to a licensee when available, particularly in matters involving inattentiveness (which are typically very difficult to prove), to maximize the effectiveness of the licensee's investigation without revealing the identity of the CI.

Senior Executive Review Panel Findings

The Panel agrees with the PBLLRT that the allegation referral letter provided limited detail to the licensee in an effort to protect the CI's identity. Providing additional information may have assisted the licensee's follow-up investigation.

The Panel supports protection of the CI's identity unless there is an overriding safety concern as a principle of the allegation program. If sufficient detail cannot be provided without revealing the identity of the CI, either additional NRC direct follow-up should be conducted to supplement the licensee's response or the allegation should not be referred and the NRC should conduct the entire allegation follow-up.

Actions to Address Findings

a. Revise allegation guidance/procedures to require that all pertinent allegation information be followed-up by either 1) referral to the licensee, 2) direct NRC inspection/ investigation, or 3) a combination of both. (OE)

b. Revise guidance/procedures to state that if an allegation is referred to the licensee, the allegation referral letter must request that the licensee contact the NRC to ensure understanding of the scope of the allegation and the staff's expectations for follow-up and response. (OE)

5. PBLLRT Recommendation

NRC Region I, and from a more programmatic perspective, OE, should evaluate its allegation program, procedures, and practices to determine whether they should be changed to require a more structured review process, with additional senior management review, of licensee responses to allegations provided by the NRC. Such a process might include a formalized checklist to verify the adequacy of a licensee response, coupled with either a review by an NRC senior manager, or a follow-up ARB. This would provide for an additional critique of the licensee's investigation results, as described in its written response to the NRC, to better determine whether the licensee's evaluation was sufficiently comprehensive and whether any additional NRC follow-up action is warranted.

Senior Executive Review Panel Findings

The licensee's response did not sufficiently address all aspects of the concern and the staff's review of the licensee's response to the referral did not challenge the scope of the licensee's evaluation.

The Panel agrees with the PBLLRT that the guidance in MD 8.8 was not followed for the evaluation of the licensee's response. The review could have benefited from an NRC independent verification of the licensee's response.

Actions to Address Findings

a. Develop a checklist for structured review of a licensee response to a referred allegation. The Branch Chief level should conduct the review. The ARB should review the closure of allegations referred to the licensee, as appropriate. (OE)

b. Include in the checklist guidance for determining if the NRC needs to conduct independent inspection activities due to an inadequate licensee response. (OE)

**B. Communications/Interactions with Concerned Individual(s)**

1. PBLLRT Recommendation

NRC Region I, and from a more generic programmatic perspective, OE, should evaluate its allegation program, procedures, and practices to determine whether there needs to be more flexibility in honoring requests from a CI that they not be contacted. As noted in Observation A.1, notwithstanding the CI's request not to be contacted, in hindsight, additional contact with the alleger (via telephone or mail) would not have compromised the CI's identity and may have resulted in the NRC obtaining more specific information to support additional NRC action in this matter. In addition, contact with the CI to provide the results of the allegation review, including the NRC conclusion that it was unable to substantiate the CI's concerns, may have resulted in additional information being provided by the CI.

Senior Executive Review Panel Findings

The concerned individual (CI) should have been contacted to:

1) advise the CI of the intended referral to the licensee,
2) attempt to obtain additional information, and
3) inform the CI of the close-out of the March 2007 allegation as "unable to substantiate."

Actions for Items 1 and 3 did not meet the guidance of MD 8.8 in this case. The staff honored a request by the CI not to be contacted.

Actions to Address Findings

a. Refer to actions stated previously in A.1. (OE)

b. Clarify the program guidance/procedures to indicate that a CI should be contacted when an issue is closed, even if the CI requested no further contact. (OE)

c. Revise the program guidance/procedures to address cases where a CI cannot be contacted or a decision is made to not contact the CI upon closure of the allegation. The basis for the decision to not contact the CI will be documented in the closure memorandum. (OE)

2. PBLLRT Recommendation

The NRC regional offices, in coordination with OE, should evaluate their respective procedures and practices to determine whether the closure memorandum and closure letter, for concerns forwarded to the licensee, should be structured to address the following four categories of information: (1) Concern; (2) Licensee Evaluation of, and Response to the Concern; (3) Adequacy of the Licensee Response to the Concern; and, (4) NRC Assessment of the Concern.

Senior Executive Review Panel Findings

The staff's review of the licensee's response was not documented to address the items listed by the PBLLRT. MD 8.8 does not currently specify that level of detail for closure documentation.

The Panel agrees with the PBLLRT that this structured review would provide an additional tool to help ensure a thorough review of the licensee's evaluation.

Actions to Address Findings

a. Modify the guidance/procedures for documenting closure of allegations to require that closure documentation include sections on how the licensee followed-up on forwarded concerns, the NRC evaluation of the adequacy of the licensee follow-up, and the NRC assessment of the concern. (OE)

b. Meet with stakeholders to obtain feedback on the best way to share the basis for closure of an allegation with others who may have the same concern. (OE)

**C. Inspection Process for Detecting Inattentiveness and Inspector Awareness of Allegations**

1. PBLLRT Recommendation

Given that licensees may elect to implement additional surveillance methods for inattentiveness in response to Bulletin 2007-01, "Security Officer Attentiveness," (e.g., closed circuit cameras in BREs and ready rooms), the NRC's program Office of Nuclear Security and Incident Response (NSIR) should consider evaluating the information provided by these surveillance methods in the future, when appropriate.

Senior Executive Review Panel Findings

The Panel agrees with the PBLLRT that it can be difficult to detect and prove inattentiveness in certain locations.

Current routine inspection procedures do not address identification of inattentive security officers as an objective.

Actions to Address Findings

a. Modify the NRC inspection guidance/procedures for all program areas (reactor, materials, waste) to include specific guidance on techniques for maximizing methods to detect security officer inattentiveness. Factor licensee responses to Bulletin 2007-01 into this guidance. (NSIR)

b. Discuss these actions at an internal workshop for information and feedback. (NSIR)

c. Follow-up with the Industry on the actions being taken to address security officer inattentiveness to ensure that the issue is being properly addressed. (NSIR)

2. PBLLRT Recommendation

The NRC regional offices should evaluate their respective procedures and practices to determine whether region-based inspectors should be apprised of pertinent open allegations pertaining to the licensee of a facility they are scheduled to inspect. Currently, in the course of preparing for such inspections, region-based inspectors are only informed of allegations they were assigned to review by an ARB.

Senior Executive Review Panel Findings

There was no structured process to make visiting inspectors aware of an allegation that could be included as part of the inspection. This is not addressed in MD 8.8.

Actions to Address Findings

a. Expand the inspection procedures for all program areas (reactor, materials, waste) to include guidance for review of all open allegations or past allegation trends pertaining to areas to be inspected during inspection preparation. (FSME, NMSS, NRR, NSIR)

b. Improve the Allegation Management System database so it can be used more efficiently to identify allegations related to an area targeted for inspection. (OE)

c. Discuss these actions at an internal workshop for information and feedback.

3. PBLLRT Recommendation

The NRC regional offices should evaluate their respective procedures and practices to determine whether resident inspectors are informed of all allegation concerns specific to their assigned site, and the actions resulting from an ARB, so they are sensitive to the concerns in the course of their routine inspections, maximizing the opportunity to validate those concerns.

Senior Executive Review Panel Findings

The resident inspector staff may not always be aware of allegations that they could help evaluate with a prompt onsite observation.

Actions to Address Findings

a. Modify the allegation review process to include a structured method to inform NRC resident inspectors of all allegations and ARB assigned actions for their assigned site. (OE)

b. Discuss these actions at an internal workshop for information and feedback.

## Additional Findings / Actions Identified by the SERP

The Senior Executive Review Panel identified the following findings and additional actions during this review.

1. The existing policy of referring allegations to a licensee for follow-up does not need to be changed. The actions identified in the report will improve the implementation of the policy.

2. The guidance for the Office of Investigations to assist in obtaining sufficient information to make a decision when wrongdoing is suspected should be better defined. (OI)

3. The different response by the NRC to the March 2007 and September 2007 allegations regarding security officer inattentiveness reflected different amounts of evidence. In March, the NRC had limited information and the follow-up was insufficient. In September, the NRC had corroborating evidence to the allegation.

4. NRC and licensee management should reinforce the importance of the conduct of jobs such as those performed by security officers while at the licensee facilities. (OEDO)

5. Training should be conducted for Regional and Program Office staff on the changes to the guidance/procedures. (FSME, NMSS, NRR, NSIR, OE, RI, RII, RIII, RIV)

6. The regulatory response to an inadequate licensee follow-up of a referred allegation is not well defined. (OE)

7. The actions identified in this report should be applied to inspection and allegation follow-up in all cases and not just for security officer inattentiveness. (FSME, NMSS, NRR, NSIR, OE, RI, RII, RIII, RIV)