OFFICE OF INVESTIGATIONS

FY 2003
ANNUAL REPORT

FEBRUARY 2004

EXECUTIVE SUMMARY

This report provides the Commission with the results of cases completed by the NRC Office of Investigations (OI) (reference SRM COMJC-89-8, dated June 30, 1989). This is the 15th OI annual report and addresses fiscal year 2003 (FY 2003).

As stated in the NRC's Strategic Plan, the NRC's "Mission" is to license and regulate the Nation's civilian use of byproduct, source, and special nuclear materials to ensure adequate protection of public health and safety, promote the common defense and security, and protect the environment. The NRC's "Vision" is excellence in regulating the safe and secure use and management of radioactive materials for the public good. The "Mission" and "Vision" provide the framework for the agency's strategies and goals, which in turn guide the allocation of resources across the agency. OI aligns with the regulatory programs in ensuring the protection of public health and safety and the environment, and ensuring the secure use and management of radioactive materials.

OI conducts investigations of alleged wrongdoing by individuals or organizations who are NRC licensees or certificate holders, applicants for NRC licenses or certificates, or vendors or contractors to these entities. OI also provides assistance to the staff when requested. Assists to Staff are identified as cases having no indication of specific wrongdoing; however, the staff has requested OI's investigative expertise to support them in a matter of regulatory concern. Additionally, during the course of an investigation, OI may develop issues of potential safety significance that are not related to wrongdoing. This information is referred to the staff in a timely manner for whatever action they deem appropriate.

OI is composed of four regionally based Field Offices reporting to OI Headquarters. OI reports to the Deputy Executive Director for Reactor Programs and supports the reactor and materials programs. In FY 2003, there were, on average, 31 special agents and 8 operational support staff assigned nationwide. The average experience of an OI special agent in FY 2003 was approximately 16 years in Federal law enforcement.

There were 619 allegations of potential violations of NRC rules, regulations, or requirements received by the NRC during FY 2003. The 619 allegations represent a 7.6% decrease from the 670 received in FY 2002.

The total number of cases in the OI inventory during FY 2003 was 345, a 22.8% increase from FY 2002 (281 to 345). Of the 345 cases, 59 were Assists to Staff. OI closed 220 of these cases, or 63.8% of the total inventory. A statistical summary of cases opened and closed during FY 2003 is contained in the Appendix to this report.

In FY 2003, OI continued to focus on increasing its effectiveness, efficiency, and productivity in management, organizational, and process-related activities.

The following are significant achievements during FY 2003:

- Of the 166 investigations closed by OI, 160 (96%) were investigated to a conclusion by substantiating or not substantiating wrongdoing. This exceeded OI's performance goal of 90%.
- Of the 160 investigations closed as substantiated/unsubstantiated, 87.5% were closed in 10 months or less, exceeding the performance goal of 80%.

- During FY 2003, the NRC issued 109 escalated enforcement items,[1] which included Notices of Violation (NOV), civil penalties, and orders. OI investigative findings were considered in 48% of 107 proposed escalated actions:[2] 24 (or 34%) of the 70 NOVs; 19 (or 68%) of the 28 proposed civil penalties; and 8 (or 89%) of the 9 orders.
- OI processed 56 actions resulting from FOIA requests during FY 2003, a 31.7% decrease from FY 2002 (82 to 56).
- OI participated with various Department of Justice Anti-Terrorism Advisory Councils related to national security concerns and counterterrorism.
- OI participated in a multi-agency law enforcement initiative in support of NASA recovery efforts following the Space Shuttle Columbia disaster.

[1] An escalated enforcement item is defined as action involving Severity Level I, II, or III violations with White, Yellow, or Red Significant Determination Process findings; civil penalties; orders; and impositions.

[2] Note that an enforcement case or enforcement action issued to a licensee may include more than one individual escalated enforcement item. During FY 2003, this occurred in two cases.

CASES

Analysis of Case Inventory

Figure 1 shows the OI case inventory from FY 2001 through FY 2003. The total case inventory in FY 2003 was 345 cases, a combination of the 80 cases carried over from FY 2002 and an additional 265 cases opened in FY 2003. Included in the inventory are 59 Assists to Staff, 51 opened in FY 2003 and 8 carried over from FY 2002. Assists to Staff are identified as cases having no indication of specific wrongdoing; however, the staff has requested OI's investigative expertise to support them in a matter of regulatory concern. In FY 2003, OI closed 220 cases, 63.8% of the cases in the inventory.

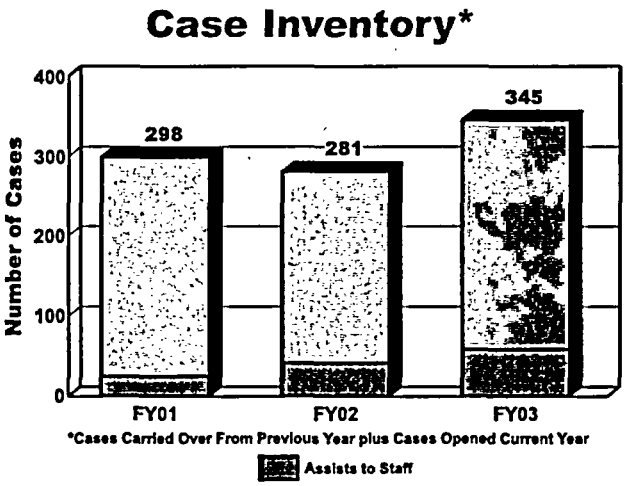

FIGURE 1

Analysis of Cases Opened

There were 619 allegations of potential violations of NRC rules, regulations, or requirements received by the NRC during FY 2003. The 619 allegations represent a 7.6% decrease from the 670 received in FY 2002 and a decrease of less than 1% from the 623 received in FY 2001.

The 265 cases opened by OI in FY 2003 are categorized as follows:

Material False Statements	58
Violations of Other NRC Regulatory Requirements	76
Discrimination	80
Assists to Staff	51

Figure 2 depicts the number of cases opened from FY 2001 through 2003. During this period, there was a 33.8% increase in cases (198 to 265). Discrimination cases continued to lead other categories of violations and increased by 23.1% between FY 2002 and FY 2003 (65 to 80). Cases involving suspected material false statements and other NRC regulatory requirements, as well as Assists to Staff, also increased during this period.

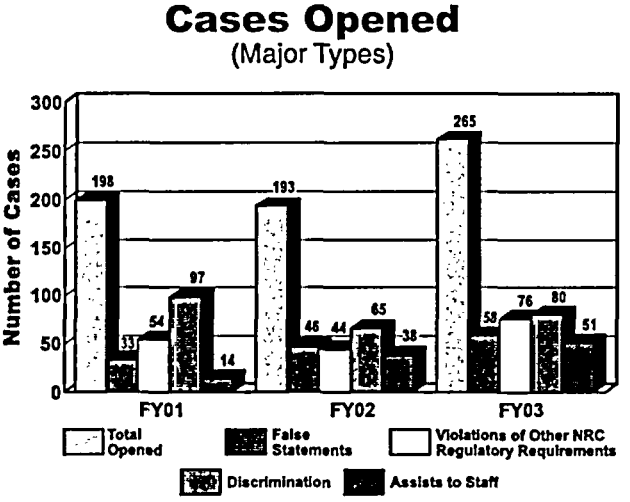

FIGURE 2

Figure 3 indicates the distribution of cases from FY 2001 through FY 2003 by percentage for the categories of cases opened. The FY 2003 distribution shows discrimination cases representing 30% of the cases opened, violations of other NRC regulatory requirements, 29%, material false statement cases, 22%, and Assists to Staff, 19%.

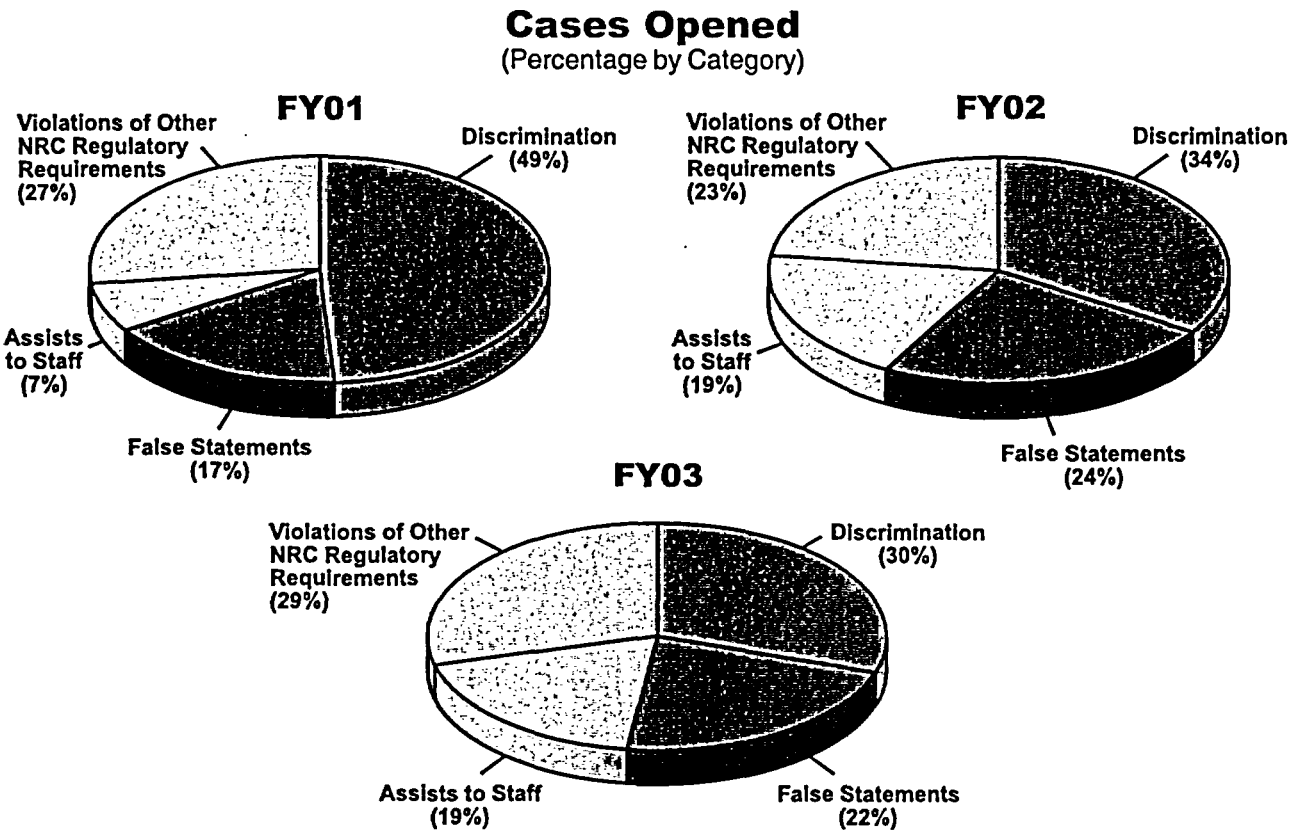

FIGURE 3

The graph at Figure 4 depicts the distribution of cases opened from FY 2001 through FY 2003 by the reactor and the materials program arenas. Reactor-related cases demonstrated an overall 33% increase (119 to 158), with a 12% increase (111 to 124) in reactor investigations and a 325% increase (8 to 34) in reactor Assists to Staff during the 3-year period. Materials-related cases demonstrated an overall 35% increase (79 to 107), with a 23% increase (73 to 90) in materials investigations and a 183% increase (6 to 17) in materials Assists to Staff for the same period.

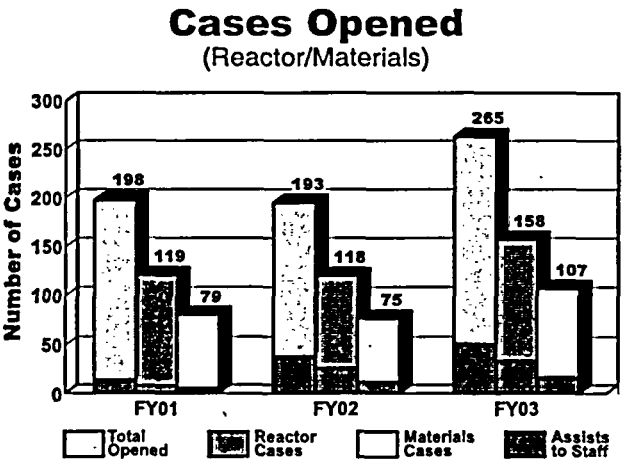

FIGURE 4

Analysis of Cases Closed

Figure 5 depicts the number of closed cases in FY 2003, categorizes them and compares them with FY 2001 and FY 2002. The 220 cases closed during FY 2003 represent a 9% increase from the number closed in FY 2002 (201 to 220) and a 5% increase from the number closed in FY 2001 (210 to 220). The cases are categorized as follows:

Material False Statements	48
Violations of Other NRC Regulatory Requirements	60
Discrimination	58
Assists to Staff	54

Cases Closed
(Major Types)

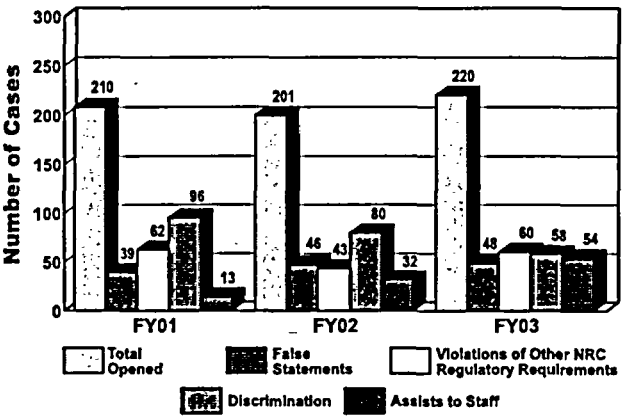

FIGURE 5

Figure 6 is a comparison, by category, of the percentages of cases closed from FY 2001 through FY 2003. Material false statement cases accounted for 22% of the closed cases in FY 2003, discrimination cases, 26%, cases involving other violations of NRC regulatory requirements, 27%, and Assists to Staff, 25%.

Cases Closed
(Percentage by Category)

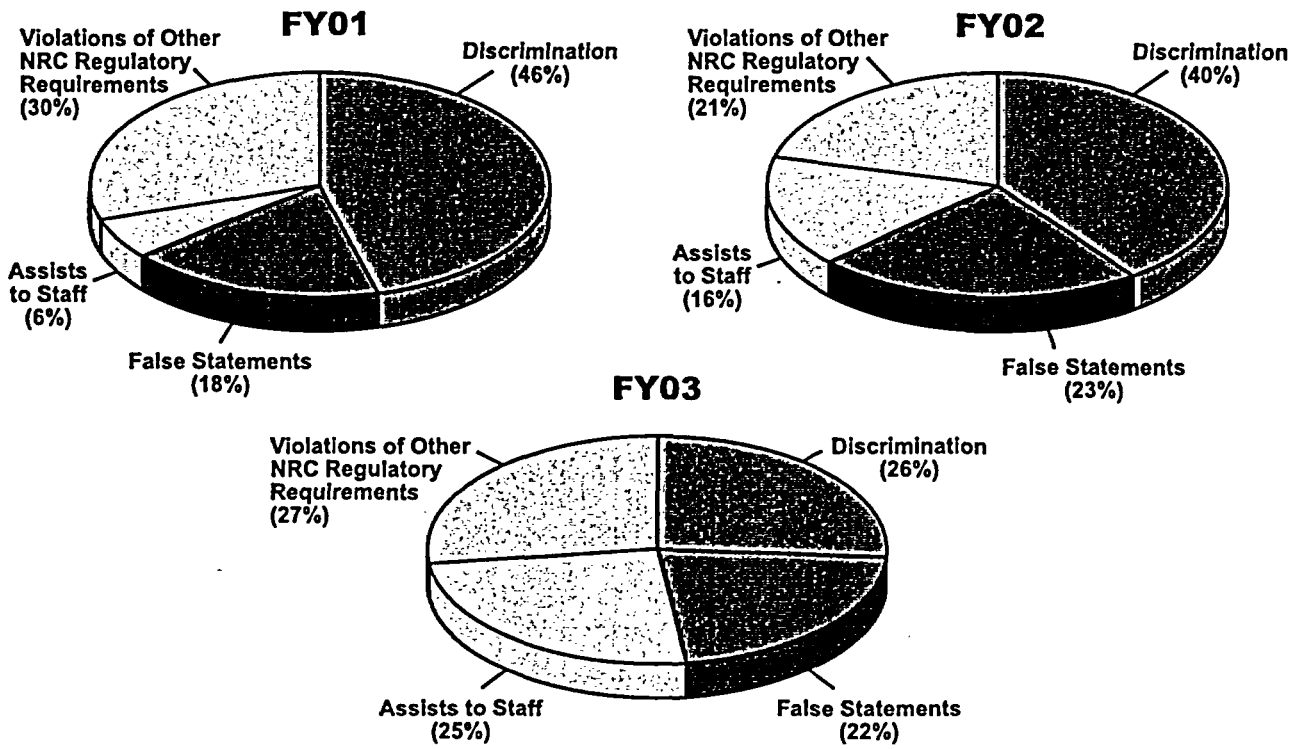

FIGURE 6

The graph at Figure 7 depicts the distribution of cases closed from FY 2001 through FY 2003 by the reactor and the materials program arenas. Reactor-related cases have decreased 20% (123 to 98), with a 363% increase (8 to 37) in reactor Assists to Staff. Materials-related cases have decreased 8% (74 to 68), with a 240% increase (5 to 17) in materials Assists to Staff.

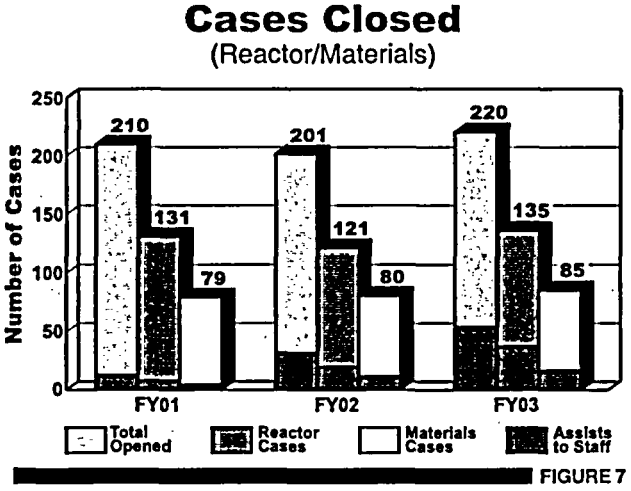

FIGURE 7

Of the 220 cases closed in FY 2003,

- 45 cases were closed after investigation substantiated one or more of the allegations of wrongdoing.
- 115 cases were closed after investigation did not substantiate wrongdoing.
- 5 cases were closed after the evidence developed did not warrant further expenditure of OI resources.
- 1 case was closed for administrative reasons.
- 54 cases were closed Assists to Staff.

Figure 8 illustrates the breakdown by category of closure with substantiated and unsubstantiated investigations combined.

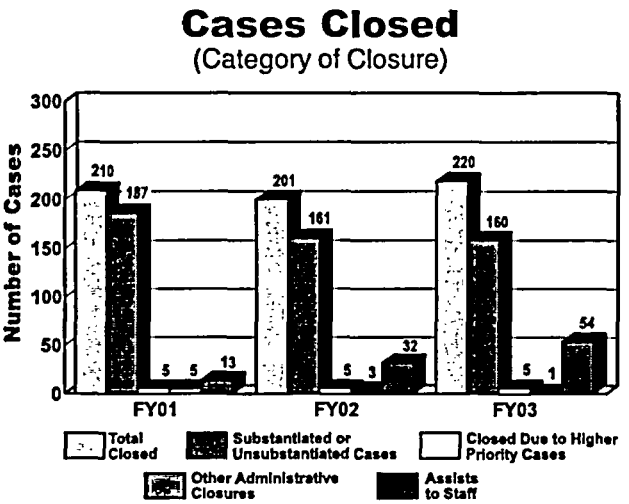

FIGURE 8

OI's effectiveness in aligning its activities with the NRC's regulatory mission is measured by those investigations that it conducts to a conclusion on the merits of the case by either substantiating an allegation of wrongdoing or not. It is the substantive information developed during these investigations upon which the technical, legal, and enforcement staffs can base enforcement and other regulatory decisions. Additionally, if the investigation substantiates wrongdoing, it is referred to the Department of Justice for prosecutorial review. OI's performance goals are 1) 90% of investigations closed will be brought to a conclusion on the merits as either substantiated or unsubstantiated, and 2) 80% of those investigations closed on the merits as either substantiated or unsubstantiated will be completed in 10 months or less.

Figure 9 is a depiction of the disposition of investigations closed for FY 2001 through FY 2003. The percentage of investigations brought to conclusion on the merits as either substantiated or unsubstantiated in FY 2003 was 96%, exceeding the OI performance goal of 90%.

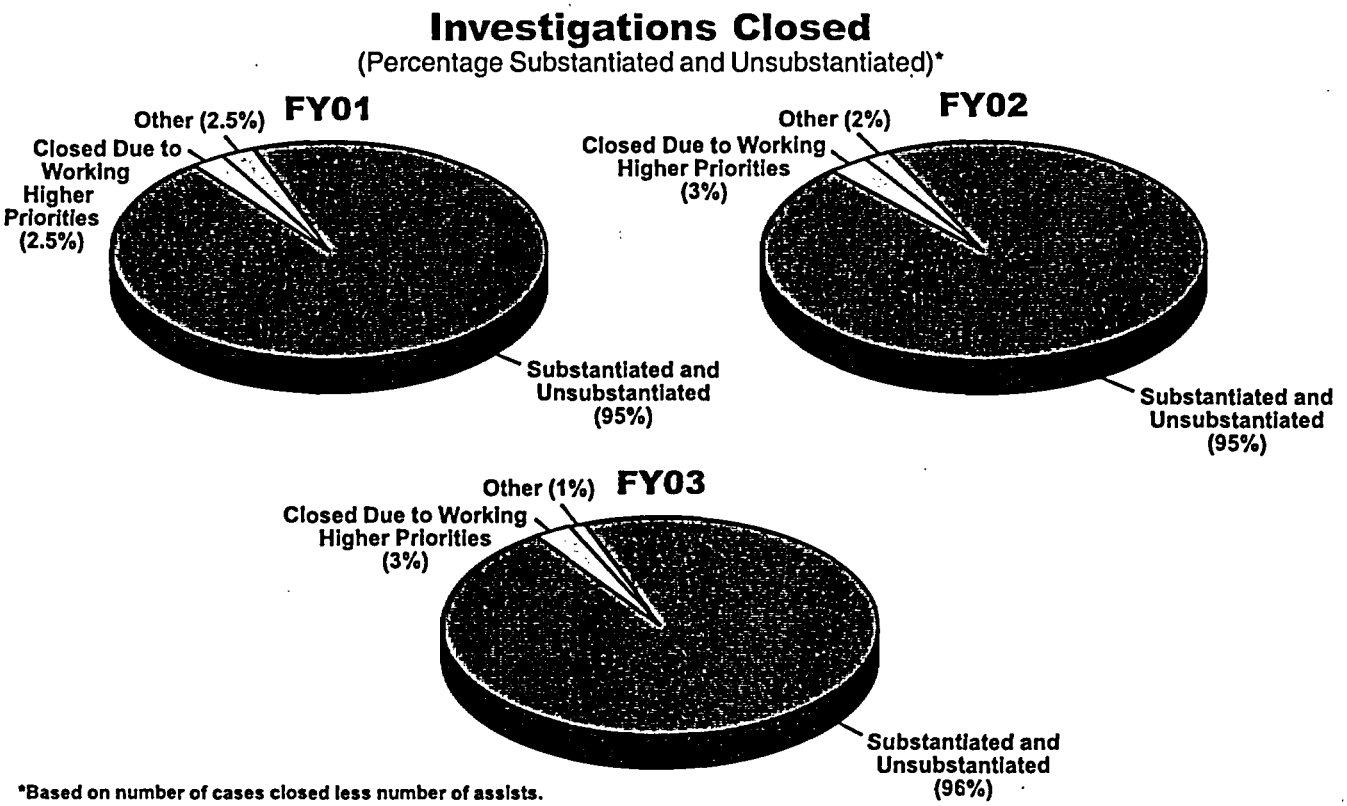

FIGURE 9

Figure 10 depicts the percentage of investigations closed as either substantiated or unsubstantiated that were brought to a conclusion in 10 months or less. In FY 2003, 87.5% were brought to a conclusion in 10 months or less, exceeding the OI performance goal of 80%.

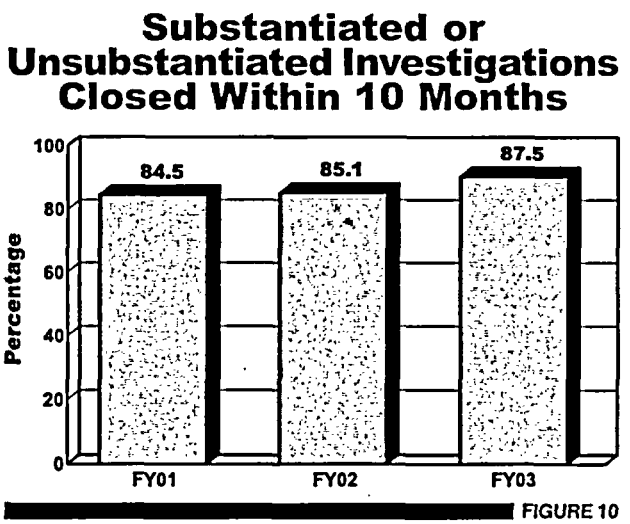

FIGURE 10

Figure 11 depicts the number of cases referred to the Department of Justice (DOJ) from FY 2001 through FY 2003.

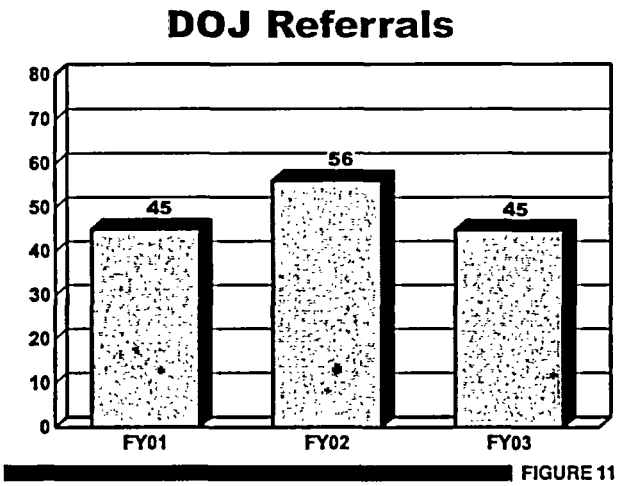

FIGURE 11

Management of Cases

Case-specific staff hours are shown in Figure 12, indicating a 13% decrease from FY 2001 through FY 2003 (46,000 down to 40,000 investigative hours). The FY 2003 ratio of investigative activities (field work and case-related travel) to administrative activities (allegation review process, report writing, management review of the case, etc.) is approximately 64:36. This compares favorably with OI's general standard of 60:40.

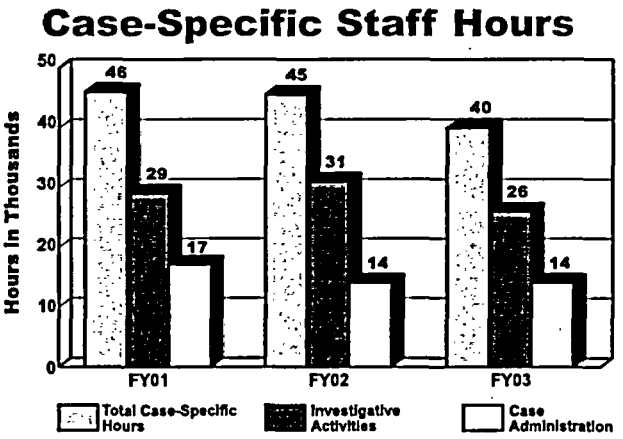

FIGURE 12

In addition to closing 220 cases, OI completed 56 FOIA actions, a 31.7% decrease from FY 2002 (82 to 56).

SIGNIFICANT INVESTIGATIONS

University of Puerto Rico

This OI investigation revealed that the University of Puerto Rico's Radiation Safety Officer (RSO) and the Director of Nuclear Medicine deliberately failed to conduct daily surveys of radiopharmaceuticals, a nuclear medicine technician willfully failed to notify the RSO of the discovery of contamination in the "hot laboratory," and a radiological imaging technician at Carolina Hospital, Puerto Rico, willfully failed to maintain records of dosimetry usage. On February 7, 2003, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $9,000 was issued to the licensee for three Severity Level III willful violations involving 1) the failure to perform daily radiation safety surveys of areas where radiopharmaceuticals are routinely administered to patients, 2) the failure of the RSO to calibrate contamination survey instruments annually, and 3) the failure to notify the RSO immediately after unexpectedly high radiation levels were found.

Engineering and Inspections, Unlimited, Inc.

This OI investigation determined that Engineering and Inspections, Unlimited, Inc. (E&I), conducted radiographic activities under materials licensee Testing Technologies, Inc. (TTI), in Kapolei, Hawaii, and deliberately violated NRC regulatory requirements related to the qualification of radiographers and the wearing of personnel dosimetry during radiographic operations. Investigative activities determined that non-certified assistant radiographers were conducting radiographic operations without wearing personnel dosimetry. OI concluded that TTI managers were aware of the regulatory requirements pertaining to radiographic activities, were aware that continuation of their radiographic operations would place TTI in violation of NRC requirements, but chose to continue the radiographic activities in deliberate violation of NRC regulatory requirements. On January 22, 2003, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $9,600 was issued to the licensee for deliberate Severity Level II violations involving 1) the performance of radiographic operations at temporary job sites by radiographer's assistants who were not accompanied by at least one qualified radiographer, 2) the performance of radiographic operations by individuals who had not met the training requirements, and 3) the failure to wear a combination of a direct reading pocket dosimeter, an alarming ratemeter, and either a film badge or TLD. Additionally, Notices of Violation were issued to E&I managers for misconduct related to participating in radiographic operations at multiple temporary job sites with knowledge that the operations did not conform to NRC requirements and for knowingly dispatching individuals who had not satisfied the training requirements in deliberate violation of NRC requirements.

NTH Consultants, Ltd.

On November 2, 2001, NTH Consultants, Ltd. (NTH), Farmington Hills, Michigan, reported that a moisture density gauge, Troxler Model 3411B, was discovered missing during a company inventory. A subsequent licensee investigation determined that the gauge may have been stolen by a former employee. Local police were notified regarding the alleged theft and contacted the former employee regarding the gauge. On November 3, 2001, the former employee gave the undamaged gauge to an NTH employee. An OI investigation was initiated to determine the circumstances surrounding the improper transfer and unlicensed possession of the nuclear gauge by the former employee. OI determined that an NTH former employee acquired and possessed, without authorization, the moisture density gauge containing NRC-licensed material in two sealed sources, which had been stolen and subsequently recovered. OI concluded that the former employee

deliberately acquired and possessed byproduct material in sealed sources, housed in a Troxler moisture density gauge, without the knowledge of the owner in violation of 10 CFR 30.3. Based on the facts developed in the OI investigation, on December 12, 2002, NRC issued an order prohibiting the former employee of NTH from involvement in NRC-licensed activities for a period of 5 years.

Dresden

This OI investigation was initiated to determine whether incomplete or inaccurate statements by Dresden officials concerning a scrammed reactor and a damaged high pressure coolant injection (HPCI) pipe support at Dresden, which occurred on July 5, 2001, were deliberately made. The OI investigation revealed that the licensee, Exelon Generation Company, Warrenville, Illinois, willfully provided false information to the NRC when it concealed the condition of another damaged HPCI pipe support. Dresden management denied that the support M1187D-83 (#83) was damaged and denied that a hydraulic water transient (water hammer) occurred during the scram. On September 28, 2001, during a subsequent NRC walk down of the system, NRC inspectors verified that support #83 was in fact damaged, although they had been informed 1 day prior during a conference call with the licensee that no other evidence of a water hammer had been observed. The OI investigation concluded that the licensee knew of damage to support #83 but did not disclose that information to the NRC. Based on the information developed during the NRC inspection and an OI investigation, NRC determined that the failure of the licensee to inform NRC of the known (damaged) condition of HPCI pipe support #83 during the telephone conference call was a willful violation of NRC requirements. On June 23, 2003, NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $60,000 for the Severity Level III violation.

American Radiolabeled Chemicals, Inc.

The OI investigation determined that employees of American Radiolabeled Chemicals, Inc. (ARC), a manufacturer of medical research chemicals in St. Louis, Missouri, deliberately failed to 1) make radiation surveys as required by 10 CFR 20.1301, which limits the dose to the public, 2) perform required weekly removable contamination surveys in restricted and unrestricted areas, and 3) accurately record the results of required weekly fume hood face velocity measurements. OI found that this poor performance resulted from inadequate oversight by ARC management and the Radiation Safety Officer (RSO) to ensure radiological safety and compliance with the NRC regulations. The individual involved in the violations was removed from radiation safety duties and eventually terminated by the company. On April 17, 2003, the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $12,000 for a willful Severity Level III violation.

Magna Chek, Inc.

The OI investigation determined that an employee of Magna Chek, Inc., a radiography company in Madison Heights, Michigan, deliberately performed radiographic operations at the licensee's permanent and temporary job sites without being certified through a recognized radiographer certification program. The investigation also revealed that the Radiation Safety Officer (RSO) willfully allowed this individual to perform radiographic operations without being certified. OI found that the uncertified individual independently performed radiography between August 1999 and February 2002 without the presence of a certified radiographer, even though another certified radiographer was available to perform that work. OI concluded that the individual knew that he was not certified, but continued to perform

radiographic activities. As a result of the OI investigation and NRC regulatory actions, the licensee agreed to dispose of all of its licensed material, surrender its license, and permanently eliminate its radiography department. On January 29, 2003, NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $6,000 for a willful Severity Level III violation. The radiographer who was not certified and the RSO were also cited.

Prairie Island

The OI investigation determined that information provided to NRC regarding Prairie Island's request for Notice of Enforcement Discretion (NOED) was inaccurate and incomplete. The information related to the Prairie Island engineering personnel's knowledge of a potential root cause for an April 9, 2001, failure of a diesel generator and the potential for that root cause to be a common mode failure to a redundant diesel generator. Additionally, an OI review of the circumstances surrounding the removal of a document from a group of documents requested by NRC staff determined that while the document had been removed initially, it was subsequently submitted to NRC within the requested timeframe. On December 13, 2002, NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $60,000 for a Severity Level III violation to the Nuclear Management Company, LLC, for failing to provide the NRC with complete and accurate information during the NOED telephone conferences and in letters to the NRC. Additionally, the NRC issued a violation to the individual who initially removed the document.

Yale New Haven Hospital/ Federal Express Courier

A Federal Express (FedEx) courier admitted to OI that he forged the signature of a Yale New Haven Hospital (YNHH), New Haven, Connecticut, employee signifying that the employee received delivery of a package containing two drums of iridium-192 seeds. The FedEx courier then left the package unattended outside the YNHH's "hot laboratory," in an area with unrestricted access by the public. The OI investigation determined that the courier was "exempt" from NRC regulations and Department of Transportation (DOT) Hazardous Material regulations. While it was determined that the courier's actions did not specifically violate either NRC or DOT regulations/requirements, the NRC has initiated actions to address this apparent deficiency in its regulations.

Pacific Radiopharmacy, Ltd.

An OI investigation determined that Pacific Radiopharmacy, Ltd., Honolulu, Hawaii, willfully failed to comply with the terms and condition of its license related to limiting the occupational dose to an individual adult to the shallow dose equivalent of 0.5 Sievert to any extremity and failed to make surveys that are necessary to comply with regulations. OI concluded that the licensee's employees displayed a careless disregard for the requirements 1) to wear monitoring devices in areas where radioactive materials are used and stored, and 2) to wear finger badges while eluting, preparing, assaying, or dispensing millicurie quantities of radioactive materials. On March 27, 2003, NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $9,000 for Severity Level I and III violations involving multiple examples (some that were willful) of failures to comply with license requirements.

Radiographic Operations in Offshore Federal Waters

On August 19, 2002, an unannounced inspection was conducted in offshore Federal waters in the Gulf of Mexico. An NRC inspector discovered that a radiographic exposure device, containing licensed material, had been left unsecured and uncontrolled in an unrestricted area on a platform while a radiographer and the radiographer's assistant slept on a separate platform. These individuals were employees of Global X-Ray & Testing Corporation, a State of Louisiana licensee. An OI investigation determined that the radiographer deliberately violated NRC regulations by failing to maintain control and constant surveillance of licensed materials, not in storage, in an unrestricted area. On May 22, 2003, a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $6,000 was issued to the company for a Severity Level III violation involving the radiographer's failure to control and maintain constant surveillance over an industrial radiographic exposure device in an unrestricted area.

On August 30, 2002, an unannounced NRC inspection was conducted in offshore Federal waters in the Gulf of Mexico. An NRC inspector discovered that a radiographic exposure device, containing licensed material, had been left unsecured and uncontrolled in an unrestricted area on a platform while a radiographer and the radiographer's assistant, employees of Nondestructive & Visual Inspection, Inc. (NVI), a State of Louisiana licensee, were eating lunch. An OI investigation determined that the radiographer engaged in deliberate misconduct by not maintaining surveillance over the radiographic exposure device. On June 16, 2003, NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $6,000 to NVI for a Severity Level III violation involving 1) failure to secure from unauthorized removal or limit access to licensed material located on a platform in Federal waters in the Gulf of Mexico (an unrestricted area), and 2) failure to control and maintain constant surveillance over an industrial radiographic exposure device in an unrestricted area.

Assistance Provided to Other Law Enforcement Agencies

National Aeronautics and Space Administration (NASA)

On February 1, 2003, the Space Shuttle Columbia exploded over the skies of Texas as it re-entered the Earth's atmosphere. NASA undertook a massive recovery effort to locate and preserve physical evidence which was spread over the East Texas landscape. NASA requested immediate support from OI in the recovery endeavor. In cooperation and coordination with NASA and numerous Federal, State, and local law enforcement agencies, OI agents responded to the designated East Texas location where they participated in debris recovery, evidence chain of custody and control, and special security details.

State of Maryland Office of the Attorney General

Following an OI investigation and concurrent with NRC enforcement action being taken against United Evaluation Services, Inc. (UES), formerly doing business as Accurate Technologies, Inc., the State of Maryland, Office of the Attorney General (OAG), indicted UES and its vice-president in September 2002 on four counts each of violations of the State's radiation control regulations. At the request of the OAG Environmental Crimes Unit, Baltimore, OI provided background information and documentation in support of the OAG investigation. As a result of the OAG investigation, both the corporation and its vice-president pleaded guilty and received 5 years' probation and fines in the amount of $20,000.

Department of Justice Anti-Terrorism Advisory Councils

The Attorney General announced on September 24, 2003, the name change of Anti-terrorism Task Forces (ATTF) to Anti-terrorism Advisory Councils (ATAC). This name change did not alter the substantive duties and responsibilities of the ATTFs, and the ATACs continue to co-exist and cooperate with the Joint Terrorism Task Forces (JTTF) in each district. The core functions of each ATAC are 1) coordinating specific anti-terrorism initiatives, 2) initiating training programs, and 3) facilitating information sharing. JTTFs retain primary operational responsibility for terrorism investigations, while the ATACs will continue to take the lead where they are better equipped to manage particular projects either because of other pressing JTTF priorities or limited JTTF resources. Also, the ATACs continue to serve in a supporting role to ensure all ATAC members receive timely information from the JTTF and the Federal Bureau of Investigation.

During FY 2003, NRC OI continued to cooperatively participate in a number of ATACs in various judicial districts, including making presentations to the ATACs regarding OI's role in the NRC.

Interaction with the Department of Justice

In FY 2003, 45 cases were referred to the Department of Justice for prosecutorial review.

APPENDIX
SUMMARY REPORT

OFFICE OF INVESTIGATIONS MANAGEMENT INFORMATION SYSTEM

Caseload Summary for the Period 10/01/2002 to 09/30/2003

Cases Open at Start of this Period	80
Cases Opened this Period	265
Cases Closed this Period*	220
Substantiated	45
Unsubstantiated	115
Higher Priority	5
Other	1
Assistance to Staff	54
Total Cases Open at End of this Period	125
Criminal Referrals	45

*** *Source:***
Alleger/Whistleblower/Intervenor – 116
NRC (Inspector/Technical Staff) – 51
Licensee/Licensee Employee Concern Program – 27
OI (Self-Initiated and Developed by OI) – 12
Other Government Agencies – 14