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OPEN SESSION

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Office of Enforcement

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UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

OFFICE OF ENFORCEMENT

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In the Matter of: :

MANAGEMENT MEETING :

WITH DUKE POWER COMPANY :

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OPEN SESSION

Catawba Nuclear Station

Catawba Branch of the National

Academy of Nuclear Training

Classroom No. 4

Clover, South Carolina

Wednesday, January 31, 1990

The above-entitled matter commenced at 10:58 o'clock a.m., pursuant to notice.

PARTICIPANTS:

JAMES LIEBERMAN, NRC/Office of Enforcement

STEWART D. EBNETER, NRC/Regional Administrator

RICHARD P. ROSANO, NRC/Office of Enforcement

GEORGE R. JENKINS, NRC/Enforcement and Investment Coordination Staff, Region II

CHARLES HEHL, NRC/Deputy Director Projects

KAHTAN N. JABBOUR, NRC/Catawba Project Manager

HAL B. TUCKER, Duke Power Company

ROBERT L. GILL, Duke Power Company

TONY B. OWEN, Duke Power Company

MICHAEL TUCKMAN, Duke Power Company

PROCEEDINGS

[10:58 a.m.]

MR. LIEBERMAN: Good morning. This meeting is being held today at the request of Duke Power Company by a letter dated January 10th, 1990. They requested the meeting to discuss two enforcement cases, EA-89-151 and EA-89-178. Both of these are proposed civil penalty cases.

Since we've already put the proposed cases in the public record, it's appropriate in accordance with our practice to transcribe this meeting so that if there's information that's relevant to making the final enforcement decision on the cases, we'll have a record of that.

In due course, we'll put the transcript in the Public Document Room after we've reviewed them to make sure there's no safeguards information. So with that, Mr. Tucker, we look forward to hearing your concerns.

MR. TUCKER: Thank you.

I'm Hal Tucker, vice president of Nuclear Production for Duke Power Company. Let me say, I appreciate your responding to our request by giving us the opportunity to discuss these two cases with you.

First I would like to address the incident involving the auxillary feedwater pump turbine at Catawba Nuclear Station. Really, I've got two objectives in this discussion. One is I want to clarify any misunderstandings that may exist

in your mind as to what transpired during the week in question relative to the auxillary feedwater pump turbine event to assist you when you evaluate my request that will be submitted in written form in which I will specifically request mitigation of the civil penalty.

We will submit a written response. It will have all the detailed information in it but I'd like to provide you some comments that kind of put that in perspective. It may not be quite that clear just reading the written report and that was the purpose of having this discussion. Then another point I would like to make beyond that is discuss what I see as a weakness in the enforcement policy in terms of practice, using the process of determining enforcement. So we will address that after we've talked about the specifics on this event. By the way, that particular point will be applicable to both of the issues that we're talking about.

Now in reading the notice of violation, there are several key issues that stand out which led me to believe that they are some misunderstandings relative to this event and I'm not sure how those misunderstandings came about but I would like to clear them up. First, it's implied that we placed the Unit II auxillary feedwater pump turbine in service while still having concerns as to its operability. That's a little bit more than implied. It's actually stated in the report. It's also implied that we took little action to ensure a thorough

understanding of this event and it's those two main issues that I want to clear up.

Let me begin by saying we in our written response, are not going to deny the violation. When we looked at the violation in its total context and we are not going to deny the violation but I think in putting it in perspective, we want to make some specific points relative to the violation.

First, in the beginning when this event initiated, it was associated with surveillance tests on the pump. In that process of going through the sequence of events we were outside our normal procedural manner of handling these things and that's understood, I think, by both of us in the beginning. We went through the process and as our report will reflect, there were three occasions in attempting to start the turbine that it did not run. It tripped out. Then the fourth time was successful.

Now, in the investigation and report and our previous discussions, it was pointed out that normally when we had a malfunction of something like that, we would use our work request process and our maintenance and we failed to do that and that was a part of our earlier discussions. The determination made by the individuals involved at that time, based on previous experience and information available to them at the time, they declared the pump operable when it successfully ran on the fourth attempt.

Between the third and fourth attempt and they did make the more complete inspection of the linkage and everything associated with it particularly looking for lubricant to make sure that it was lubricated because at that point, it was the opinion that the lubrication was our problem.

Now having relieved themselves of any question as to the connections of the linkage and things like that and plenty of lubricant available, then they attempted to run the pump the fourth time which it successfully ran. Then they declared it operable. Following that, we recognized the situation and went back into our normal process of dealing with a problem of that nature. There was a conscious review made of the event and looking beyond that, previous experience that we had had on both units with these turbines and it was concluded that if we had continued to test the turbine, then it probably would have run.

That was further substantiated later when we actually did the pre-maintenance tests and the work that we did later. The first time that we attempted to run the turbine, it tripped out. It went overspeed. It was restarted from control room and ran successfully. Our experience had indicated that we had something which at that time again was associated the best we could determine then with the lubrication. It's the lubrication with whatever else was involved -- at that point we did not know -- would create a drag on the stem such that it

would not respond as it should but once you exercised it, cleared it up, then it would respond.

That was the kind of thinking that entered into the decision following that fourth and successful start on the event -- the day that the event actually occurred. The next day in the conscious review not only by the people who were involved, by other members of the Catawba Management Team and people that are knowledgeable in that area, reviewed it and concluded that based on successful testing and previous history that we had experienced as well as what we knew about others, that that was a valid conclusion. It was operable immediately but recognized that because of this particular occasion, we really had a long-term problem that we had to deal with.

So they conscientiously went about designing a program that concluded the necessary tests, the involvement of all the details as to what you would measure, what you would analyze, to determine the root cause so that we could deal with it on a long-term basis. As is pointed out in our report, the sequence of events and I'd like to walk you through these and it's going to become evident to you as was indicated in the notice of violation, when we had completed this, we had gone a step up the learning curve and if we had known when we got into this situation what we know today, we would have taken a different approach but we did not know that at that time.

Let me walk you through these and kind of put it in

perspective for you. The same day that it actually happened, that's when they conducted the visual inspection of the components, the observations of the linkage, making sure it was free and so forth, manually exercising the linkage to ensure the freedom and then they had a successful start. That's when they concluded based on the completion of the monthly surveillance tests that the pump was operable.

The following day -- that occurred on July the 31st, 1989 -- and the following day, August the 1st, the event was discussed at the morning plant status meeting and that was the initiation of further evaluation which involved the maintenance engineering services engineer which is our maintenance support organization on-site, met with station management. The situation was evaluated to determine the steps that should be taken, again, looking at the event and what needs to be done relative to that event immediately or in the future. Past problems were reviewed in that discussion. At that point, nothing indicated that we had a stem corrosion problem. In fact, lubrication, as I indicated previously, seemed to be the major cause of the slow control valve response.

Nothing that we had in the equipment history led the station to believe the problem was stem corrosion and when we made our presentation down in Atlanta for the Region then we tried to make it clear with some of the information provided and slides used that lubrication of different components had

different effects and that was our attempt to show why we were involved with the lubrication question but apparently we didn't convey our message as completely there as I would like to have.

On that particular day, our attempt to contact the vendor was unsuccessful. We could not reach them. The operability of the auxillary feedwater pump turbine that was specifically discussed and a conscious decision was made that the pump was still operable. The second day, we brought the site inspectors in, briefed them on the status of the station efforts to that point to be sure that they were on board and understood what was going on. The turbine vendor was contacted, discussed with him -- with them and they recommended a dry film lubricant instead of the paste but the vendor also verified in that discussion that the control valve and linkage was of the latest design. We were questioning maybe they had changed that linkage.

Even after that discussion, lubrication continued to appear as the root cause of the slow valve stem response.

On the third day, after those discussions and reviewing with the vendor, as well as some other details within the station, then a follow-up meeting was held with the resident inspectors to discuss their concerns and alleviate what appeared to be some misunderstandings with them, still, and the decision was made to go ahead and pursue this, to resolve any questions on a long-term basis, in terms of

reliability of these pumps, because of course, both units were in question as long as this single pump was in question.

Work requests were written on that day to disassemble and clean the leakage and inspect the control valves for both units. The work was scheduled to begin August the 10th.

Now, we went ahead and inspected Unit 1. We visually inspected it to see that the lubrication there indicated any problem or if it was normal. The lubrication was considered to be a long-term problem and not an immediate operability concern, if that was really our problem.

But in looking at all of this and pursuing information with other utilities, searching NPRDS and trying to find whatever history we could use to help in pursuing this, then we decided to move the schedule up from August the 10th to August the 6th, to begin our process.

In discussing the details of what we were planning to do with the residents, they recommended a pre-maintenance operability test be conducted prior to going into the program we had outlined. The station concurred with that. In fact, we think that kind of exchange is beneficial, and that's what I alluded to earlier in our discussions today, that I think it is helpful and beneficial to have this kind of open communication, because we recognize the experience of the site inspectors as valuable to both of us.

With that discussion, we felt that the residents

understood the thorough and programmatic approach that was being taken, and that is spelled out in detail in our report. We felt that our approach was reasonable and appropriate and timely.

Now, the fourth day, which is August the 4th, procedure changes were made to perform the auxiliary feedwater pump turbine tests or starts with the speed control set on maximum, so that we could really test it, and plans were made to perform the pre-maintenance testing run prior to working on the linkage. We would not disturb the pump in any way before starting.

The people, the functional areas involved in all of this included operations, planning, performance, and maintenance engineering services personnel, to ensure that all groups understood the test and inspection process and that we had management agreement as to what we were going to do.

Then on the fifth day, August the 6th, the Unit 1 auxiliary feedwater pump turbine was successfully started. This kind of confirmed the station's assumption that lubrication was not a short-term operability issue.

The Unit 1 turbine control valve linkage was then disassembled, cleaned, lubricated, and reassembled. The turbine was retested and returned to service on August 7, 1989.

Now, one week after the initial test failures on the Number 2 unit, then we began the program. The first attempt to

start the Unit 2 auxiliary feedpump turbine, it tripped on electrical overspeed. It was reset from the control room and successfully ran on the second attempt.

Having done that, then the pump was secured and the linkage disassembled. The valve stem was noted to have excessive drag while in the valve assembly. The work scope expanded and stem corrosion was found to be present.

Now, corrective maintenance was performed, and the turbine successfully tested on August the 9th and returned to service.

Now, let me give you some of the conclusions that we came to after the first week.

Although Unit 2 pump turbine was proven to be operable on the July the 31st, there was a clear understanding to our folks that were involved that the condition of the pump did not meet our own standards of performance with regards to the long-term reliability, and that's the reason we began immediate actions, and those actions were taken right away, as I alluded to earlier, to review the event, including station management, and the scope of that review included our past problems, as well as some outside information we could get, and we concluded to go ahead and set up a test to determine the root cause.

As I said, work requests were written. We involved the site inspectors.

Now, the corrective actions that were taken after the actual root cause was determined -- let me mention some of those -- but this was a planned and a conscious effort to design a complete test program so that we could obtain any information necessary to determine the actual root cause of the problem.

The comprehensive testing program that we set up included force required to stroke the control valve and linkage, timed starts of the turbine, recorded and graphed the rpm, the speed versus time.

As I said, we continued our reviews of industry experience of similar phenomena, both in searching data and telephone conversations.

A station working group was formed to evaluate all aspects of the system operation: procedure reviews, including the maintenance procedures; startup characteristics of the system; material changes that had taken place -- the stem, the packing, lubricant, etc; industry problems factored into that, as they related to our experience; and the training available to the people involved.

All of that went into it.

Now, since then, bi-weekly pull tests have been conducted until the valve stem corrosion can be determined to be under control. We've done that on a biweekly basis, to determine the frequency of it. It is now performed on a

monthly basis.

MR. OWEN: Now, one addition to your comprehensive testing program proceeding from turbine operability was to include, as part of the testing process, the time for the CA pump turbine to develop head pressure. This was -- had been an annual test performed during refueling, but that test was added because we felt that whatever we did may, in fact, affect that parameter. So, that included in the testing process, as well.

Tony Owen, Station Manager, Catawba.

MR. LIEBERMAN: Now, I understand what you're saying is that on July 31, at that time, you had recognized that you didn't meet the standards for the long-term reliability that you desired.

Was that decision made independent of discussions with the NRC residents, or was the NRC residents involved in encouraging the long-term program?

MR. TUCKER: That cam about following our discussion at the plant status meeting the morning of August the 1st.

Now, Tony, you will have to address the involvement of the site inspectors, since I was not actually here. Can you clear that up for us?

MR. OWEN: The effort to look both broader and deeper at the problem began immediately, as Hal indicated -- immediately by a great number of personnel in our staff, as well as myself. Our inspectors were involved in the process,

in the communication flow, understanding the work that was being done relative to lubrication, and they not only were talking with our maintenance management, were talking with our engineers, as well.

Our mindset regarding the approach was somewhat driven by techniques employed earlier to help understand root cause problems associated with components, where the root cause was very difficult to find and pin down.

We knew, as Hal indicated, based on experience and work history of the component, that once we started the pump, tested it, and it was operating properly, as indicated that evening, when the problem first occurred, that that wasn't good enough.

If something occurred that would cause the pump to fail, without indication or perhaps between its normal surveillance times, anything like that may occur, we wanted to get to the bottom of it, and we were driven by the idea that we had to look hard and deep to solve the problem.

We agree that, in hindsight, we should have done some things differently, but our point here is we were doing a lot of things to try to understand the problem.

So, we didn't want to just be satisfied with the linkage manipulation in the testing that was done. We were looking to develop a program that would help us enhance reliability of that component for the long term, and that was

the process that we began that week.

MR. HEHL: I think Jim's question really focused more on the extensiveness of the programs identified or planned. Were those in place, already planned prior to the resident involvement?

MR. OWEN: The work that Hal mentioned was being developed throughout that week. The residents were in communication with a great number of our personnel throughout that week and I know there was a lot of discussion regarding lubrication. Whether or not the residents fully understood the total extent of the program test throughout that week, I can't say. It was our intent to understand what we were doing because our posture is one of being open and communicating.

MR. TUCKER: If I understand your question specifically comes down to and if I may paraphrase it, would we have done it had the site inspector not urged us to; is that your question?

MR. OWEN: Is that the question?

MR. HEHL: I think there are two perceptions. There's two sides of every question and answer and from a perspective -- from your perspective, I think based on your statement that it appears that you felt like you aggressively pursued and attacked resolution of this problem. From the other standpoint, I think as identified in our report, as I think discussed and I wasn't at the October 12th enforcement

conference that took place although I was involved during the evolution of this particular issue and my perception of what the residents relayed to us at that point in time was that -- two basic problems.

One, and it has to do with a philosophical problem with declaring something operable based on a successful surveillance test recognizing and I think you will agree that a surveillance test is only one parameter or indicator that goes into a determination of operability as defined, a capability of performing an intended safety function of the equipment and in that regard, that was one of the key concerns on the part of the residents initially.

The second concern was with the depth as they understood it of your evaluation and review. On the surface, it appeared that after three unsuccessful attempts at performing the surveillance test on this piece of equipment, some very minor adjustment or manipulation of the linkage occurred which resulted in a successful test which was then the basis for declaring this pump operable. That was an initial concern.

The second concern was if in fact there was continuing concern on the part of the plant management with regard to operability and root cause determination of the unsuccessful performance of this pump, then it was not evident in the timeliness evaluation of the known information with

regard to lubrication on the other unit at Catawba and subsequent testing of components.

So those are the issues at least as far as I understand that perhaps is a different perception of the data that you presented.

MR. OWEN: Given what we learned throughout the testing process and the root cause of this failure, we have I think recalibrated, if you will, as to what should have taken place at that point. We said out front there was an error in judgment. We said that we're not denying the violation because of that. There was -- what is at question here was whether or not we were taking sufficient corrective action to effect the -- your decision regarding civil penalty.

What we did based on our understanding and previous experience and work history, knowing that the issue was not as simple as the work with the linkage, we established "comp" measures to perform extensive maintenance on the test in a very -- in a short period of time, extensive maintenance on the pump in a short period of time. We agreed to a pre-maintenance test with very clear conscience that our thinking was appropriate and did not have concern for operability.

We established a program that week and to what extent it was communicated to the residents at all levels at all times, I can't answer but I know in passing conversation and in discussion with our staff, residents were involved. What we

were doing was patterned somewhat after the program we established to help understand the problems that we were having with our diesel.

We pulled together all of our resources, assigned different areas of research, if you will, for people to look deeply at different parts of the problem so we could bring this information, bring this research and study and judgment to bear on a test that we would run just as quickly as pulled this together and create a new beginning for understanding this problem and fix it once and for all and that's what was driving us.

Again, we admit error because we should have gone into the work request and torn it down and we would have learned about this problem which we hadn't seen before, this accelerated corrosion due to the interaction of the stem material, the leaking valve and the packing contamination -- grossly accelerated corrosion rate we experienced because of the combination of those three, but that effort appeared that we weren't -- apparently appeared, we weren't doing anything and we didn't care which is 180 degrees from our mind set.

MR. HEHL: I don't think that was --

MR. OWEN: That's what we read in the --

MR. TUCKER: The judgment exercised relative to the surveillance test was that that was a surveillance test. It's a little too early -- our experience has shown if you had any

dragging on that stem, once you exercised it a couple of times, within -- you repeat the test, it'll run. That was validated again just before we tore it down. First time it tripped, reset it, start it again and it ran. Still, the indication is lubrication.

Now the citation for violation specifically addressed the corrosion problem as if we knew that at the time. We did not know that but it expressly says, caused by corrosion of the stem circuits and then goes on to say, however the corrosion problem persisted and caused the valve stem to bind again. We did not know that at that time -- none of us, inspector or us -- that we had stem corrosion.

MR. HEHL: I don't think the words here or the intent or the words in the report that accompanied this action are intended or do relate a willfulness or a knowledge at that point in time on July 31st as to the root cause and that I think is the focus of this action is the fact that --

MR. TUCKER: You may not have meant that but that's -- I'm quoting you the words and it does not say anything about assumed problem with lubrication. It addresses the cause as being corrosion. When we did the test on July the 31st, 1989, now we learned that after we went through our test program but on July the 31st, 1989, we did not know we had a corrosion problem. There had been no indication of a corrosion problem with this type of turbine control anywhere we knew of at that

time in the industry so we had no indication or reason to conclude other than what our history showed us that we had lubrication problems particularly when you consider, you loosen it up and it works. Normally if you've got a severe problem with corrosion, it's going -- generally will present a more intermittent type operation than we experienced. That's been my personal experience and the reference that we make specifically in my appeal to remit the civil penalty, to emphasize the importance of aggressive problem resolution and conducting corrective actions within established programs and procedures have been authorized and so forth.

The reason given for imposing the civil penalty was failure to take prompt action and we're saying we went through a systematic timely evaluation to determine what kind of program was necessary to get to the root cause including the specific things I alluded to that we would perform. When we found the problem, then we dealt with it and we have some plans beyond that that right now as I said, we have a program implemented to assure us that that stem remains free.

Now we're going to replace the type of material. We're going to do some other things that we worked out to put a final conclusion to this. The point we want to make is, from our perspective, we were systematic and timely in our response and evaluation and taking corrective action and we changed our original schedule from August the 10th back to August the 6th

because we concluded what we needed to do in that time frame and went ahead and did it.

MR. LIEBERMAN: So, you were satisfied that when you made the decision, when it passed the fourth test, that that was an appropriate operability decision at that point in time.

MR. TUCKER: Based on what we knew then and our past record of performance on these tests.

And then, as I went on and said, during this time in which we were evaluating Number 2, we tested Number 1, and there was no problem there. We disassembled Number 1, and we didn't find the corrosion.

MR. HEHL: Our perception that, in fact, you did, in fact, schedule additional investigative efforts, scheduled with, I guess, a culmination of testing on August the 10th, it's my understanding that that schedule revision took place because of concerns that were identified and brought to your attention by the residents or concern with the operability of the other unit because of the, really, indeterminant route cause for this particular problem.

MR. OWEN: There were really three different dialogues taking place. The conversation that I personally had with the superintendent of maintenance dealt with expediting testing. The test was, I would say, in part, initiated by the residents being involved in this thing.

There was discussion with Bill and Mark, with our

maintenance management members, to move that test forward. They were a part of that discussion. That had input. I wasn't in that discussion at that time. I can't say who was driving it. But there was certainly agreement, as Hal indicated. Once we figured up what we needed to do, we moved that test back.

We wanted to know -- or we wanted to have a good plan going into the test, but we were agreeable to do the test prior to maintenance, because we think we could learn from that. We certainly agreed with that.

So, there was interest on our part; there was on the part of the residents, clearly, to move the test back.

Two other pieces of information that need to be brought to light here: Hal mentioned a number of things that we were doing with the pump itself.

As a part of the investigation, we learned that the steam-emission valves to the CA pump turbine were part of the problem. We put our design engineering people to work to find a replacement valve, which had been difficult for us to do. We actually sent people to Germany to help expedite purchase and procurement of valves, so that we could change those valves out in a reasonable timeframe.

In the research we did that week, we learned that the drain configuration for the governor valve packing housing was different than at McGuire, and we modified the packing housing drains on Units 1 and 2 here at Catawba, expeditiously.

We removed drain valve internals, as an interim measure, to complete in that modification so that we could improve the drain capability immediately.

These were other ongoing pieces of work in a very short timeframe to improve the reliability of that component.

MR. JABBOUR: When did you find out about the steam-emission valves, that they could be affecting the stem corrosion, and what day and what timeframe did you find out about those?

MR. OWEN: I can't tell you the exact date, but it was part of this overall process in looking at everything that would affect operability of that pump, in detail, again and again, those issues came up and we dealt with them.

MR. HEHL: I think that noting the absence of the residents, at least on our part and people that were directly involved in this, I really don't feel comfortable with us getting into too much of the detail of it. I think what we need to do is perhaps listen to your comments.

MR. EBNETER: Yes, I agree with that, but I would like to understand a little more.

Essentially, you are saying that we made the wrong call on prompt corrective action. That's what you're saying.

I just need to understand a little more.

July 31st is when you found the Unit 1 start. This was Unit 2. Is that right?

MR. TUCKER: That's correct.

MR. EBNETER: Unit 2 wouldn't start. So, you made three attempts, didn't start. The fourth attempt, it started.

MR. TUCKER: Well, between the third and fourth attempts --

MR. EBNETER: I know, you did some inspection.

MR. TUCKER: Right.

MR. EBNETER: I understand that.

That was July 31st. You made a comment that you started the Unit 1 pump. Was that the same day?

MR. TUCKER: No.

MR. EBNETER: I took another note before that you started Unit 1 pump on August the 5th.

MR. TUCKER: On August the 6th.

MR. EBNETER: All right. But I'm really interested in this timeframe between July 31 and August 4.

So, July 31st, you made three attempts, didn't work. You inspected it; you made another attempt. It started. Based on all visual inspections and whatever you could see at that point, you felt that a judgement call was operable.

Next morning, you discussed it at the plant meeting.

MR. TUCKER: Correct.

MR. EBNETER: It was decided, I guess, by you, Tony, that you needed some long-term action on that pump.

MR. OWEN: On that day --

MR. EBNETER: Well, let me go on. Do you agree with me or disagree with me?

MR. OWEN: It was not decided by me personally.

MR. EBNETER: Well, somebody.

MR. OWEN: I was in a meeting with Hal all day that day.

MR. EBNETER: But the comment that Hal made was -- August 1st, we discussed it at the plant status briefing.

MR. OWEN: That is correct.

MR. EBNETER: It was decided -- I don't know who decided this, but it was decided that we needed a long-term plan, and then some bullets under that I have marked down -- we did review past problems.

MR. TUCKER: That's correct.

MR. EBNETER: That's correct. And we did that by, what, looking at maintenance history on these pumps?

MR. OWEN: Equipment history.

MR. EBNETER: Equipment history.

MR. OWEN: That's correct.

MR. EBNETER: Based on that, there was no indication of a stem-corrosion problem, which sort of gave you more confidence -- my words, now -- that it was operable, there was no corrosion.

MR. TUCKER: That's correct. The equipment history review led us to that conclusion.

MR. EBNETER: Then, on that same day, apparently, at least, my note says under August 1st that you attempted to contact the vendor and you were unsuccessful.

MR. TUCKER: That's correct.

MR. EBNETER: And that was on August 1st.

MR. OWEN: A point about that, Stew, that ties those things together: The maintenance engineering staff, the engineers involved, and, I believe, our resident had discussions throughout the day on August the 1st regarding proper lubrication. Our manual was saying one thing about lubrication, and there was problems of note, other utilities, regarding lubrication, which was coming into play at this time.

So, there was discussion over lubrication, and folks were focusing in on whether or not lubrication was appropriately applied and in the right places, and that is why the vendor was contacted, to clarify whether or not --

MR. EBNETER: But you couldn't get him.

MR. OWEN: That's correct.

MR. EBNETER: So, that concludes the activities that I have on August 1st.

Still on August 1st, you made a conscious decision -- somebody on Duke's staff -- that it was still operable, but you were still going to pursue other avenues.

End of August 1st.

So, you did take some actions to follow that problem

on August 1st.

August 2nd, I noted that you briefed the residents on the issue and that you re-contacted the vendor, and the vendor verified that the linkage configuration was current. There had been no changes or redesign of the linkage mechanism.

MR. TUCKER: Right.

MR. EBNETER: And that he recommended to you to go to a dry lubricant.

MR. TUCKER: That was based, I believe, Tony, on our discussions with him of problems that we were experiencing.

MR. OWEN: That is correct, and that was one vendor contacted. We later contacted another vendor that had a different opinion.

MR. EBNETER: And was the resident involved on August 2nd with you at all in this linkage configuration, or did you inform him of anything? Do you know, just offhand?

MR. OWEN: Our residents were involved on August the 2nd in discussions with our MES personnel.

MR. EBNETER: Then on August 3rd, so far we've still got the one Unit 2 pump --

MR. TUCKER: I also said that we looked outside, began searching with industry history.

MR. EBNETER: Okay. I have that under August 3rd. Did that occur on August 2nd.

MR. TUCKER: We began that on the 2nd, didn't we,

Tony?

MR. EBNETER: The NPRDS searches.

MR. OWEN: We began the history search, according to these notes, on August the 1st.

MR. TUCKER: That's what I've got.

MR. OWEN: Equipment history searches.

MR. EBNETER: Internal equipment history.

MR. OWEN: That's correct.

MR. EBNETER: Okay. And I had on August 3rd, and it may be out of sequence now, but I had listed under August 3rd -- checked NPRDS and other utilities. Is that an accurate sequence? It doesn't make any difference, as long as I get them in the right timeframe is all.

MR. TUCKER: My notes indicate we actually began the process on the 2nd. It continued on into the 3rd.

MR. EBNETER: Okay.

MR. TUCKER: We were trying to ascertain what experience there might be outside of our own.

MR. EBNETER: What I'm trying to do is get this in a framework and see if can decide if those were reasonable corrective actions within that timeframe, and that's why I just wanted to make sure I understand it.

MR. TUCKER: Right. Okay.

MR. EBNETER: You started the process of a utility review?

MR. TUCKER: Right.

MR. OWEN: Still, on the morning of August 2nd, following our meeting, I met with all our maintenance people, compliance people, operations people. And we revisited the plan that our maintenance engineering services engineer had laid out the day before.

MR. EBNETER: We keep talking about this plan. Was that just a verbal direction?

MR. OWEN: It was a revisit of the work done to date and a summary to ensure that our efforts to bring this together would address all the different aspects of the problem.

MR. EBNETER: But was it similar to what we did today? We had some comments, and I told him to follow up on something of somebody else. Is that how you did it?

MR. OWEN: Verbal.

MR. EBNETER: Sort of a verbal direction?

MR. OWEN: It was a meeting specifically to discuss progress and understand directions.

MR. EBNETER: The resident wasn't at that meeting, I take it?

MR. OWEN: No, sir.

MR. EBNETER: Because see, on the August 3rd is the comment I have, where you wrote "work request." And I was trying to figure out the formality that you were going through here. And it may very well be reasonable that you did it that

way. But I want to understand exactly how the process works.

At any rate, August 3rd, you did have a follow-up meeting with the resident. That is what I have here.

MR. TUCKER: That is correct.

MR. EBNETER: And August 3rd, you wrote a work request, to disassemble and inspect the Unit 1 pump, the Unit 2 pump.

MR. TUCKER: At that time, it was scheduled for August 10.

MR. EBNETER: And it was scheduled for 8-18.

MR. TUCKER: Right.

MR. EBNETER: After you worked that, did you have the work order, work request written before you talked with the residents? Is that how you discussed it with him? Is this the work order we're working on? Because the next comment is that the resident recommended a pre-maintenance operability test.

MR. OWEN: I can't specifically answer your question whether we had the work request in hand at that time or not.

MR. EBNETER: But the resident specifically recommended that you do a pre-maintenance test to verify operability.

MR. TUCKER: Yes.

MR. EBNETER: Okay. And when you discussed that with the resident, was he aware you had moved the schedule up to 8-6, at that time?

MR. OWEN: At that time, it is my understanding that the schedule -- I wasn't in that meeting. But I understand that as a part of that discussion, the schedule was moved,, with input from the residents and input from our personnel.

MR. EBNETER: So you think the date was moved as a result of talking with the resident, or in conjunction?

MR. OWEN: I would say in conjunction. Because I think it was a concurrence that we now, that with what was developing that we could bring that test forward, and should move it forward.

MR. EBNETER: And then I had a final remark on August 3 that you were under the impression that the resident at that point understood your approach. Is that right?

MR. OWEN: Yes.

MR. TUCKMAN: Just a point of clarification. The next surveillance was probably not due for three months or so.

MR. TUCKER: Based on the frequency surveillance tests?

MR. EBNETER: But it wouldn't be due for approximately 20 days?

MR. TUCKER: It wouldn't be due until the end of the month.

MR. EBNETER: On August 4, then, you did do this pre-maintenance test before you started it, before you started maintenance on the linkage?

MR. TUCKER: Not on August 4. We made our plans, which included a pre-maintenance test run, prior to adjusting or working on the linkage. So we could run it as is, as final.

MR. EBNETER: So what did you do on August 4, then? I'm out of sequence.

MR. TUCKER: On August 4, that period of time from the 4th on was spent in developing the specifics of what we were going to be doing.

MR. EBNETER: Okay.

MR. TUCKER: In a comprehensive test and evaluation. Going through the process.

MR. OWEN: And preparing to do the Unit 1 test.

MR. TUCKER: Yes.

MR. EBNETER: August 5 you did the Unit 1 test.

MR. TUCKER: That is correct.

MR. OWEN: But we were prepared to do that test as well.

MR. EBNETER: And then one week later, which would have been what, August 12?

MR. TUCKER: August 7.

MR. EBNETER: August 7. One week from the original test on Unit 2.

MR. TUCKER: That's correct. Right.

On the 6th, we tore down the Number 1, cleaned it, did not find corrosion. The evidence we had on the Number 1

unit led us to believe that the assumption relative to lubrication was a valid assumption. So as soon as we got the Number 1 back in service, the next day, on August 7, then we took the Number 2.

MR. EBNETER: And you found no corrosion on Unit 1?

MR. TUCKER: That is correct.

MR. EBNETER: Just for completeness, on August 7, you made the attempt to start the Unit 2 pump, you did the pre-maintenance test. That is what you were calling, that test you were really doing was a pre-maintenance test.

You first attempted to start it, but then tripped on overspeed?

MR. TUCKER: That is correct.

MR. EBNETER: That was the second try from the control room?

MR. TUCKER: Control room reset it. Started it again. It ran.

MR. EBNETER: And it ran. And then you went into your work request and looked at it.

Okay. I guess I understand what you did.

MR. JENKINS: There is one other point while you are on this chronology, Steve. I know in our letter we talked about, at some point in time, and I don't know when it was, one of the motor-driven pumps was taken out of service.

Do you know when that was?

MR. TUCKER: That is, I think, mentioned in the report.

MR. OWEN: The motor-driven pump was taken out of service.

MR. TUCKER: August 1.

MR. OWEN: August 1.

MR. TUCKER: About 4:50 a.m. Repaired oil leak on the bearing housing drain plug.

MR. LIEBERMAN: I am trying to get a better understanding of this matter. You say you accept the violating. And there is a sentence in the Contrary 2 portion of the violation that says that the pump failed surveillance test, after the pump failed a surveillance test, the shift supervisor did not assure that the proper cause of action was taken to return the equipment to optical status.

Do you agree with that portion of the Citation 2?

MR. OWEN: Our shift supervisor, in discussion with the engineer, who was a backup person for our component engineer on this component, were collectively involved in making that decision and were saying that that decision was an error in judgment and that that is indeed a part of the violating.

MR. LIEBERMAN: Hindsight is obviously 20/20. You're saying that you're response to a contributing cause to this event was a failure to initiate a work request when the pump

tripped during surveillance tests of July 31.

If you had initiated a work request, would you have perceived your corrective actions to be different?

MR. OWEN: Yes.

MR. TUCKER: If we had disassembled that linkage, like we did on the Number 1, we would have found the corrosion problem.

MR. OWEN: If we had only disassembled the linkage, we would not have.

MR. TUCKER: Well, that's true, not just the linkage, we would not have.

MR. OWEN: Yes.

MR. TUCKER: We would have had to go into the valves.

MR. OWEN: And because the valve had been cycled at that point, and it moved freely once it was unlocked from the corrosion process, and without going into the governor valve itself, and tearing it down, then we may not have found the problem, even if we went into the work request.

We would like to think we would. But there is a strong possibility that just splitting the linkage and governor valve stem free, we would not have taken that step.

MR. HEHL: Can you expand on the error of judgment on the part of the shift supervisor; what in your opinion was the error in judgment, what he should have done differently?

MR. OWEN: In hindsight, in considering lessons

learned, even though we had previous experience to show that the problem was complicated and that it would take a strong involvement on a great number of people to bring together the resource to bear to fully understand the problem, even though we know that and that is still very true, we would immediately go into a work request process to see what information we could glean from that part of our program as well.

MR. EBNETER: That's paperwork.

MR. OWEN: No, that's a philosophy.

MR. HEHL: What you're saying then is the shift supervisor's error in judgment was that he did not promptly initiate the process that would have resulted in a more in-depth and complete evaluation of this event.

MR. OWEN: The error in judgment was that even though it successfully passed the operability test, we had not entered the work request program and done sufficient work to understand the maintenance problem so that operability could be counted on.

MR. EBNETER: You would not have accelerated the sequence of events other than initiate the work request on August 1st.

MR. OWEN: Had the work request taken us to the point of understanding that there was a problem which we had previously not foreseen with that valve stem, then we would have immediately gone in to tear down the pump and establish

compaction and whatever necessary based on lessons learned from that involvement.

MR. TUCKER: As a point of clarification, Stewart, the priority given the work request when it's initiated will really determine the timing of that and we've got the power to identify those that you would do immediately. It's Monday morning quarter backing to say what kind of priority we're to put on the work report.

MR. EBNETER: Corrective action always has two components to it, the remedial action which you thought was effective, the manipulation of the linkage for the short term and then the long-term corrective action which is the second component but was going to be handled through the work request process.

What I see is the residents saying that you did not do the longer term corrective action promptly and is questioning the judgment you made on the short-term operability but I am not sure you would have done that any differently even instituting the work request process but I'm just trying to understand what really is the problem.

MR. OWEN: There are two processes that could have occurred if we had entered the work request program immediately. One scenario would take us to an examination of the linkage, disassemble, clean, re-lubricate the linkage, manipulate the valve shaft which would have worked fine, shown

no indication of the type of corrosion we later found.

MR. EBNETER: But that would have only saved you two days. Is that significant on an issue like this? I mean the real issue he's questioning here is the operability of that pump. That's what he's questioning.

MR. OWEN: Unless we tore into the packing housing itself, then that action wouldn't have helped us.

MR. HEHL: Would that have been the appropriate thing to do?

MR. TUCKER: The point we're making is we looked at the situation and did a thorough evaluation to determine what really needed to be done.

MR. EBNETER: That's what I'm saying.

MR. TUCKER: If we had filled out a work request, I can't say precisely what we would have done or what results we would have gotten.

MR. EBNETER: I maintain you probably wouldn't have done it much differently. The only thing you would have done is gained two days on the problem. Now, is it unreasonable for you to delay two days to do the work request? I don't think you'd have done it much differently because there's not an awful lot you can do with it. The only thing you can do with a work request is go out and tear it down; right? You did some interim things to try to determine if you should speed it up. If you had found corrosion in your industry search or the NPRDS

or your equipment maintenance history, I guess it would be reasonable to assume that if you had found that, you would have accelerated the work request process but you had no other indications to do that.

That's my view any way. Jim, I don't know. What do you think? It's centering on reasonableness of the time frames we're working with and the actions you took in between. That's why I wanted to get the sequence straight.

MR. OWEN: I see our thoughts on timeliness changing. Recent activities associated with finding this screw in the contactors with the screw loosened in certain contactors in certain safety-related breakers. We begin a process which we follow around the clock until we looked at every breaker without stopping.

The situations we got into on the X breakers, we set up a problem resolution process that didn't stop. In this case, had we known the problem associated with the corrosion or if our past experience had not driven us to think that the pump was indeed operable and that manipulation of the linkage for the short term, the pump would be operable, then we would have worked on the sucker around the clock until we found the problem there. We were delayed or derailed from that thought process because the test which had gotten us there which we depended on so many times before for operability had given us short-term indications that the pump was indeed operable and we

believed that and we set about looking at a long-term correction.

Regardless of other pump operation or unit operation, if we felt that there was a problem with that pump, then we would have taken whatever action necessary to correct it.

MR. TUCKMAN: Another point that you brought up earlier about whether the resident know or did he lead or suggest or whatever. I guess my experience has been in dealing with resident inspectors the way Duke has been doing it is we get so involved so early that it's almost a joint thing. It's not like we come to a resolution and present it to him and say this is where we're going, do you see anything with it?

It's really an evolutionary process and they participate as much in the process as we do. So it's very difficult to --

MR. EBNETER: I think that's very valid but I think what I hear here is you think you had an agreement with the resident that this was an appropriate approach to this problem and then a few days later it turns out that it's not an appropriate problem.

MR. OWEN: I've had a number of discussions with Bill about this very point and it is clearly our responsibility to make the call. As Mike mentioned, I see us -- we're all in -- we all have the same interest. So we want to make sure that if someone feels that we're not proceeding in a proper direction,

we certainly want to have that understood.

MR. EBNETER: Yeah, but you didn't have that indication here and my staff has guidance and direction that if they feel there's a safety issue, they should not be -- they should tell you immediately that there is one and if you disagree with it, you should call me or Bill Hehl but the resident should not be saying, yes, I agree that this is the proper way to go and then three or four days or a week later say, well I disagree because it didn't turn out the way that you had anticipated it.

MR. JENKINS: Or make recommendations.

MR. EBNETER: If he felt back here on August 2nd that you had made the wrong call, he's obligated to tell you then and not agree with you, well, do this, this and this and then we'll see how it turns out. I just want to make that clear that he does have an obligation to tell you that.

MR. TUCKER: I concur with you that, now.

MR. HEHL: I think that communication took place. I think there was ongoing communication.

MR. OWEN: The evidence in my mind that indicates to me that we were together is that we agreed on the phone a time frame for a test and we agreed on a pre-maintenance test which was the resident's idea and we had no problems whatsoever in going forward with the test and if there was anything we could learn from a pre-maintenance test regardless of what it told us

about operability, then we would find that out and we were together. We ran the test. That was my perception.

MR. EBNETER: Okay, I've heard enough. I understand. I probably don't understand but I think I understand. Does anyone have any further questions on this?

MR. JENKINS: I would like to get a little clarification from Hal. In his response, he discusses the misunderstanding, lack of understanding on the part of the NRC on this issue and I guess I'm still not clear where you think -- I understand there's a disagreement on your part with our conclusions but I'm not sure where you say that we misunderstood.

I know you made a point about the wording of the letter which could be read as indicating that you knew up front what the cause of the problem was and that was never a misunderstanding. We may not have worded the letter in the best way but we never thought you knew that there was stem corrosion in the early stages.

So can you help me understand what the misunderstanding perception is?

MR. TUCKER: I can't pick that point specifically from the letter, the notice of violation. It clearly in the explanation of the violation talks about surveillance test failures on July the 31st, valve stem sticking caused by corrosion on the stem surface and following these failures we

needed corrective action relative to that. Again in that same paragraph, it makes reference to corrosion problems and that led me to believe that you were of the impression as expressed here in a public document that our problem was corrosion on July 31st implying that we knew that.

MR. HEHL: No, no. It says here that you failed to identify the ongoing corrosion problem. That to me says that -- and that is the thrust of this violation is that in fact, you know, you had an opportunity on July 31st at least in our opinion that if in fact your controls that are set in place for dealing with equipment failures were properly and aggressively implemented, then it is our contention that you would have identified the root cause of this component failure which turned out to be stem corrosion if you had aggressively pursued that issue.

MR. JENKINS: But at no time did we think that you knew up front that it was corrosion, nor was our action -- neither our severity level nor the civil penalty mitigation escalation considerations based on any such belief.

MR. WHEELER: In fact, on page 2, in the last sentence of the second paragraph you say, "Though it was initially thought that the problem was caused by using the wrong lubricant on the valve linkage, you failed to follow it up." Words are sometimes -- even the clearest words are sometimes subject to more than one view but it certainly wasn't

our intent.

MR. TUCKER: You're absolutely right, that point of disagreement but a part of that disagreement as we tried to explain here today, I think, was some misunderstanding collectively -- your part and ours. You questioned Stewart and Stewart tried to explain. In the discussions involving the site inspectors throughout this whole thing they were involved and we did not get the impression that the NRC's position was we had exercised inappropriate judgment and were not timely. We were under the impression that we had an understanding of what we were doing and I don't know whether anyone ever stated concurrence.

MR. HEHL: We have a difference, I guess, of opinion then.

MR. TUCKER: That's the area of misunderstanding.

MR. HEHL: I'm not sure how far we are off because I do think we do agree that we worked together and communicated on this issue. I think we will disagree at least based on my knowledge and discussions with the resident at that point in time during this event that in fact that they had communicated to you a concern with regard to the adequacy of the testing that was performed that night as far as manipulation of the linkage and that is an adequate corrective action and the fact that this was not included, incorporated into your work request system to facilitate extensive and effective corrective action,

that during the ensuing days of discussion that in fact lubrication concerns that you were aware of existed and were discussed with the residents, that based on concerns that they identified with the timeliness of corrective action to include looking at the other units' lubrication on linkage, that that in fact prompted the reduction or the change in schedule from August the 10th to August the 6th based on those discussions.

So I think there was an interaction and I'm not sure how much misconception there is, at least on our part of our participation in this activity. Well, that's enough.

MR. TUCKER: Let me make one further comment.

MR. HEHL: Let me make my last statement.

MR. TUCKER: Go ahead.

MR. HEHL: We're talking about the resident and what he knew or didn't know and he's not here and I don't want to get any further into that. I think I've got enough on that. You can make your last statement, Hal. The staff -- I think we've got enough.

MR. TUCKER: I want to make two statements, one about this, a point of clarification. Mike made a comment, when we get into these discussions, we don't necessarily say it's my idea or your idea. We work together to try to pursue resolution of identified problems.

Perhaps that's part of my concern a misunderstanding that we formed the wrong impressions of the process we went

through but in the report which I gave you a copy, we make the statement and it's underlined for emphasis.

Under no circumstances would any of Duke's stations declare a safety-related piece of equipment operable without a firm belief that their assessment of the situation was the correct one and the piece of equipment in question would function as necessary to fulfill its designed basis and I think our past history demonstrates that.

MR. EBNETER: I don't think we're questioning that at all, Hal. I do think there's several things in here that we need to look at from the NRC side and we'll certainly do it.

MR. TUCKER: Well, you heard our comments and our perspective relative to response timeliness and thoroughness. The other point that I wanted to make had to do with the enforcement process. Bill, you and Stewart both, more of you than that are aware, most of you around the table, we have made it a standing practice, we visit with you for enforcement discussions, my last request, if there's any question or misunderstanding or further questions or clarification, give us the opportunity to provide that clarification.

We have yet to be given that opportunity when we see the final result and from our perspective there may be some misunderstandings or some uncertainty that we could have provided additional information and I will propose to you that in the process when you are pursuing enforcement discussion

first, we will be glad to send a single senior knowledgeable person relative to that specific event to participate with you in your evaluation, not to try to influence you but to provide you with information that you may not have access to, to help clear it up.

Then when it comes to discussions between the regions and NRR, I think it is a mistake in that process to leave the licensee out of that discussion when serious decisions are made relative to violations of safety. I think the process should include the licensee and I'm not saying you're going to have an army there but you need a knowledgeable person associated with the event that can then speak to clarify questions and that would be the function, a point of clarification, not trying to specifically influence the direction but we would make a point of sending a person very knowledgeable that could address questions or perhaps clear up points that are developed during the discussions that are relative to our responsibility of safety.

That's my concern with the process.

MR. EBNETER: Hal, with regard to the process, that is the intent of holding the enforcement conference, is to get your side of the story at the conference.

Now, if you leave the conference and the staff feels they need more information, then it should be so stated in the enforcement conference, and then we can follow up on it.

I'll leave the rest of it to Mr. Lieberman, but agency policy is these are pre-decisional beyond that point.

Jim, you can adjust it, but there is no opportunity at that point, since it's draft and pre-decisional, for licensee input.

Is that right?

MR. LIEBERMAN: Well, that is correct. The process is you have the inspection, then the exit, and then we have the enforcement conference after the inspection reports have been written, to discuss the issues.

Some have suggested that we should issue the proposed enforcement action, and then have the enforcement conference after the proposed action, because then the issues are more joined, and you get the benefit of the licensee's views and discussions before we make the final decision.

Since it is a public process, I have always thought that it is more important to have that done before we go public on a proposed enforcement action and get that input on the front end.

I guess what you're saying is that you don't think that enforcement conference system is working effectively to get the exchange of views into the process.

When we look at an enforcement action at Office of Enforcement and discussions with NRR and discuss with the region, we think that we understand, and we are not aware that

there are misunderstandings.

If we are unclear on something, then we ask the inspector to go back and get some more information, or we have a dialogue, or we get the information, but we don't knowingly go forward with an enforcement action thinking that we have a misunderstanding.

So, it's hard to say we should be having more discussions to resolve misunderstandings if we are not aware we have a misunderstanding, and the only way to find out whether we have a misunderstanding is to really present our view and then see what type of reception you have.

MR. HEHL: As the process is right now, we conduct an inspection, document the issue in question. We send that to you in a report that identifies that we feel that this is an item that perhaps is proposed as a violation of requirements, that in fact, we are asking you to come in to discuss this issue in greater detail at an enforcement conference.

We within the region hold a pre-panel, where we discuss this issue, brief upper senior management on the issue, to include participation, in most cases, from NRR and some of the other offices. There are questions, areas for further clarification.

We hold the enforcement conference with you, after you have had an opportunity to be aware of the issues, and in most cases, I think you have been in possession of the report

which outlines our understanding of those issues.

After the enforcement conference, we hold an internal pre-panel within the region, again to discuss any additional areas of concern and evaluate the information that we've heard and the clarifications that we have gotten during the enforcement conference.

Now, on occasion, where there have been requests or misunderstandings, we have, in fact, then gone back through the resident inspector, in most cases, to ascertain and clarify details of a particular issue.

All those take place prior to this issuance of the proposed violation.

So, I understand what you're saying.

MR. TUCKER: My point is this: I don't disagree with your process of going through that prior to issuing a notice of violation with proposed civil penalties. In fact, I think that is the appropriate thing to do.

My point is -- and you have just made it -- we have an opportunity to make a presentation to you. People are assembled for that purpose. They are not always the decisionmakers. In fact, in most cases, they are not. They provide information to the decisionmakers, and we have no direct path, as it's presently practiced, to provide additional information directly, unless specifically requested.

You said you go back to the inspector. The inspector

is funnelled through someone within NRC to the decisionmakers.

We have one chance in direct discussion with the panel to present our position.

Any point of clarification thereafter is pursued through another process.

Again, we are depending on a "messenger" to convey our message.

I had rather present my own message to the decisionmaker, along with those people presenting the views, too, and when I say that, I'm using the term in expression of an individual knowledgeable.

MR. JENKINS: I think that opportunity exists, Hal, when you get the inspection report, which Bill talked about, with a letter that says this is under consideration for --

MR. EBNETER: That's not what Hal is saying. I know what he is saying. He is saying that I am not at the enforcement conference, or my deputy is not at the enforcement conference to hear the full story, that it gets processed through some junior-level managers and then funnelled up to me, and it's already -- the messenger's message may be colored by --

MR. JENKINS: But I think he also said that Tom Murley is not there.

MR. EBNETER: Tom Murley has very little to say about these enforcement actions. It's the region and Lieberman,

primarily, unless we really get into a real hassle. Right? It's almost always at my level and Jim Lieberman's.

MR. LIEBERMAN: That's right. And unfortunately, I do not go to all of the enforcement conferences. Frequently, I have someone from my staff go, or they listen in my telephone, but I hear what you're saying, and information is always filtered through the various steps, and I know when I look at these cases, I value the regional administrator's recommendations, and I value input from -- I do -- and I value NRR's input, and I look very carefully at the slides that the licensee has provided, to try to make sure we have the whole picture, because the last thing we want to do is go forward on an enforcement action without the right factual underpinnings. That serves no one's purpose.

Maybe we can give some consideration to getting to more of these conferences, and maybe transcribing the enforcement conferences so you get a better flavor of the discussion might be another way to do that, though I'm not perfectly sure that transcribing is necessarily the right way to go, because I think that may choke some of the interchange, so I probably don't really favor that.

But the point is, in some cases, and I asked the regions, which cases are the ones that we should really attend, that might be particularly controversial. Maybe we need to get to more of those type conferences.

But with the current process, we're not staffed nor set up to go to every one.

MR. TUCKER: Well, please understand, I am not pointing the finger at any individual. I've been through this process numerous times, and I think the process is what I'm talking about, not individuals.

MR. LIEBERMAN: I realize that.

MR. EBNETER: No. The individuals are involved in the process, though, because I may have been at the opening of this particular one, but I don't think I attended that full conference.

MR. JENKINS: You were there for part of the time.

MR. TUCKER: I understand that you were not there for the discussion of the turbine, and I wasn't there. I was out of the country at the time.

MR. EBNETER: I know, and your comment is probably correct. Perhaps too many decisions are made that are at the lower level and then get processed up, but I got the message, and I'll work on it, and I'm sure Jim will work on it. We'll look at that. There is some validity in your comment.

MR. TUCKER: I make the comment because I think we indicated previously that we take this extremely seriously. The $50,000 proposed civil penalty, in my budget, is not a drop in the bucket. I can't find it. It's not the money. We can afford to pay the bill, but it's what's behind the violation

and the principle associated with civil penalty. It's cost me a lot more than the $50,000 to get to this conference. So, that's not the question.

It's the principle and the sincerity associated with that.

MR. EBNETER: I agree with you. We'll have to work on the decisionmaking process, and I will look at it myself and make sure that I am more attuned to it and that Jim Milhoan, my deputy, is, if I am not there, and you need to help us, George. Sometimes it's the planning and the scheduling of these that gets us -- same as you Hal. If you're not available, after the fact sometimes -- once it gets settled, then it's very difficult to change.

MR. TUCKER: It is.

MR. EBNETER: But we will look at it.

MR. TUCKER: Thank you.

MR. LIEBERMAN: I realize we are talking about enforcement. But take the SALP process. That is another action that NRC take that has a great impact on the company. There it works somewhat similar. We have a proposal and there is input and then there is a final. Do you see differences between those two process?

MR. TUCKER: I don't think you want me to start discussing that.

[Laughter.]

MR. EBNETER: I don't think this is the appropriate place. Maybe we should skip to the next issue.

MR. OWEN: Could we go off the record for a moment?

MR. LIEBERMAN: Do you want to take a break for a few minutes?

MR. OWEN: If we could, please.

MR. LIEBERMAN: Certainly. Let's take a 10-minute break.

[Whereupon, at 12:30 p.m., the open portion of the meeting was concluded.]

REPORTER'S CERTIFICATE

This is to certify that the attached proceedings before the United States Nuclear Regulatory Commission

in the matter of:

NAME OF PROCEEDING: Management Meeting Duke Power

DOCKET NUMBER:

PLACE OF PROCEEDING: Clover, South Carolina

were held as herein appears, and that this is the original transcript thereof for the file of the United States Nuclear Regulatory Commission taken by me and thereafter reduced to typewriting by me or under the direction of the court reporting company, and that the transcript is a true and accurate record of the foregoing proceedings.

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CLOSED SESSION

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U.S. NUCLEAR REGULATORY COMMISSION

In the Matter of:]
]
MANAGEMENT MEETING]
WITH]
DUKE POWER COMPANY]

CLOSED SESSION

Catawba Nuclear Station
Catawba Branch of the
National Academy of
Nuclear Training
Classroom Number 4
Clover, South Carolina

Wednesday, January 31, 1990

The above-entitled meeting convened in closed session, pursuant to notice, at 1:00 o'clock p.m.

PARTICIPANTS:

JAMES LIEBERMAN, NRC/Office of Enforcement

STEWART D. EBNETER, NRC/Regional Administrator

RICHARD P. ROSANO, NRC/Office of Enforcement

GEORGE R. JENKINS, NRC/Enforcement and Investment Coordination Staff, Region II

CHARLES HEHL, NRC/Deputy Director Projects

KAHTAN N. JABBOUR, NRC/Catawba Project Manager

HAL B. TUCKER, Duke Power Company

ROBERT L. GILL, Duke Power Company

MICHAEL TUCKMAN, Duke Power Company

PROCEEDINGS

[1:00 p.m.]

MR. LIEBERMAN: Back on the record. Now we turn to the second enforcement action involving the safeguards issue. Would you like to continue?

MR. TUCKER: All right. I have some information here I want to give you. There are only four copies available that I have and if you'all can spread those out, I think they will be helpful. But I will be making reference to that as part of my discussion.

But in this particular case, we have a specific objective in mind, also, and that is to provide you with sufficient information to encourage you to reconsider the merits of this proposed enforcement action.

I take a little different position on this than I did the previous discussion and we will respond in writing. Specifically what we have, we have -- do they have copies?

MR. GILL: No, sir. I have six copies here.

MR. TUCKER: Now this is safeguards information. What we propose to do is to let you use it during our discussion and then we would take it back so you won't be burdened with the requirements of dealing with safeguards information. During our conference, you may have it for reference.

MR. EBNETER: Well, I may ask you to send me one.

MR. TUCKER: We will.

MR. GILL: They are in the mail today.

MR. EBNETER: All right.

MR. TUCKER: You will have exactly what we are handing you.

MR. EBNETER: Fine. I agree with you though. We should pick them up when we get done here.

MR. TUCKER: You can follow all of that and all of my comments and you can find then specifically in there. They are contained in there and what I say is based on that information. There are a few key points that I want to make.

In the Notice of Violation and proposed imposition of civil penalty reference is made to management involvement and actions and I want to show, I think, that actions have been taken by management that perhaps either were not known by NRC in consideration or not completely considered in the decision.

I think in looking at this particular area, functional area of operating a nuclear power plant in the security area, we see this from an enforcement point of view being handled a little bit differently than the other functional areas.

The people we deal with conduct their inspections and response to us relative to those inspections a little differently. We don't see quite as clear and reasonable standard of acceptance of performance on a continuous basis in

this area like we do in others and perhaps that is due to the specific documents used in terms of how you conduct the inspections and things that you conduct. I don't know.

But my point here is, we don't see it being the same level of two-way communication process in the security area that we do in other areas and I think there is a relative significance associated with this in terms of public health and safety that is different than the other functional areas.

My comments that I made in the previous discussion relative to the enforcement process, I would say, apply in this case, too, and that was more a generic comment that I just mentioned that as a part of this conference and won't pursue that particular point any further.

Now what we have done, we reviewed all of the events identified in your citation of violation. We looked back over the determination of causing those events, corrective actions taken. We viewed the history relative to that. We reviewed the past inspection history, the violations cited during the time we are talking about, inspector follow-up items and unresolved items that were identified in the process. We reviewed all of that.

As we look at it, we came to the conclusion that the inspection history does not support the decision to propose enforcement action as stated in the letter. We reviewed all of the security inspection reports for the period from October 19,

1987 through August 1989 which is the timeframe we are dealing with and in your letter of December 21, 1989 which is the Notice of Violation and Proposed Civil Penalty, it specifically identifies nine security violation areas that are cited in that.

I want to address those specifically as relates to all three sites. But then in the inspection review itself and, I believe, do they have this chart?

MR. GILL: There are three attachments, one for each station and near the end of each attachment, there is a chart. You might be able to pull those out. It is probably the last page or the next to last page. There should be a similar chart for each station and the first thing you will notice is that the areas are different at each site.

MR. TUCKER: We tried to put that in a form so that you could get in a picture the events we are talking about and timeframes relative to quarter of the year beginning with the fourth quarter of 1987 going through the third quarter of 1989. That is the timeframe which the citation deals with.

If you lay those out beside each other you will see, for example, Catawba, violations were previously cited in only four areas. Five areas had not previously had violations cited and we have a little bit of difficulty understanding when they were previously inspected with no citations, no violations cited.

At McGuire, for example, there were only four areas that were cited, five less than Catawba. Of these four, no violations were previously cited. At Oconee, there were only five violation areas were cited in this one and three of those areas, violations had not previously been cited.

So based on a review of the past inspection reports, we concluded that many of them in the security plan implementation were considered acceptable when we read those reports associated with the violations that had previously been cited.

Yet when read the one dated December 21st which covers this period of time, we don't detect the same acceptability and that is why I say that we need to have some clearly established reasonable standard of acceptance in this area more similarly to what we have in other areas.

Perhaps I can illustrate my point a little more clearly or it will become more clear if you look at the information given to you here and this is Catawba we are looking at here and Stewart, I want to use this to make my point I did this morning in the SALP meeting about we see it changing differently than declining as indicated in the SALP report.

If you take these reports, really to get the whole picture if you can kind of get them all out in front of you at one time, but what we tried to do is to take these different

areas and put them together so we can observe what is taking place with trend in time.

One is safeguards information control and this is the area where I see we have maintained a level of frequency of events that is unacceptable in my opinion. So that is the area, as you see we had two at Catawba, two in the fourth quarter of 1987 and none in the first quarter of 1988 and one in the second quarter of 1988 and none in the third and fourth quarters of 1988 or the first quarter of 1989 and then back up to the level of two in the second quarter and back up to the level of two in the fourth quarter of 1989.

I see that as being something that we have to deal with but in looking at that, I think a large part of our problem is our own plan when we identify information that is safeguards information that doesn't necessarily have to be declared safeguards information and by our plan and I had to deal with this myself, if I take a document that is declared safeguards information home with me, I have to keep it in my possession all the time. I can't leave it in my briefcase locked in the house while I go eat dinner at a restaurant. By our plan, I can't do that.

I think we have more flexibility in the regulations that we can exercise, one. Second, we can re-define our own program of what is safeguards information and eliminate a lot of that and we did this in some cases and took some of the

specific information, took it out of the safeguards category so I could use it without having to go through the process of locking everything up every time I wanted to leave my office or something. That is part of it.

But that as we have it defined now and as you look at us relative to that plan, that is a problem and we are going to deal with it.

Let's take tailgating, for example, at Catawba. It peaked in the first quarter of 1988 at four and we began taking some corrective action, got it down to a level, started back again, additional corrective action, and you see the last three quarters, zero. That is why, Bill, I say there is a trend, a positive trend that this shows and you have the information attached to that of the details associated with those.

You have one that has three categories on it, escorting, inadequate search, standby shutdown facility and these relate to the nine areas that you identified in there. I said certain ones were flat. The category of standby shutdown facility, the violations associated with that is what I call "flat." You are going between zero and one.

The inadequate search, only one date point in that entire time. It is kind of hard to say you have a negative trend with that and then escorting, again, between zero and one. Now you can argue about the frequency and we are going to address that and try to deal with it but my point is, it is

flat.

Then when we look at persons entering a protected area, again looking at mis-issued badge and failure to issue badge, mis-issued peaked again. Since then, the trend is definitely down, the last quarter, none, and we look at failure to issue, one in the fourth quarter of 1987 and zero since.

So when I put that in that perspective, I see it differently than indicated in your SALP report but these trends went this way as a result of management involvement relative to corrective actions.

You can see a different degree of effectiveness in some cases but in each case there was corrective action taken. Where we have a flat situation and the frequency continues, that says we have to do some more.

But the level we are talking about when I look at mis-issued badges, for example, and you will find in the written report, in the case of Oconee, for example, it was estimated during this period of time there were approximately one and a half million times badges were issued. Seventeen times totally both at PAP and inside containment mistakes were made. What is that? Four times 10 to the minus fourth or something like that?

MR. EBNETER: You were around 10 to the minus fifth errors and that is terrible!

[Laughter.]

MR. TUCKER: You got my point.

[Laughter.]

MR. EBNETER: The human error would be ten to the minus four when you put them in a PRA.

MR. LIEBERMAN: If you plotted this for the other two stations, would you get similar results?

MR. TUCKER: These, you can take that information that is on that and you can do the same thing with it.

MR. LIEBERMAN: Would you find a similar declining trend?

MR. TUCKER: You will find a little different trend. The point I want to make, all of them will show you corrective action was taken, we see a change. If it were to occur again, then we would depending on the individuals involved and the circumstances as to what kind of corrective action was taken but we would take corrective action.

MR. TUCKMAN: You also have to remember that at the beginning of this period, that is when we really started the logging process and all that, so that is when it really came out. It took a little while to get this program in place.

MR. EBNETER: Well, I agree. The logging thing was more or less of a historical look-back and they saw things over selected events without seeing all the other things. Right?

MR. GILL: The logs are done quarterly. The first quarter started October 1987 and were submitted thereafter. We

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will get into how we, in fact, looked at the results of the logs internally. I have quarterly summaries that we can go over.

MR. ROSANO: Let me understand before we go much farther. The numbers in the inspection reports which came from your logs don't really agree with the numbers that you have just presented in here.

MR. GILL: Sometimes there are errors there.

MR. ROSANO: Like by factors of two or three in some cases.

MR. GILL: For tailgating, they were tailgating into security access areas sometimes as opposed to vital areas and we have explained that in our violation response. Where there is a difference in numbers or dates, we have explained that in each one of the violation areas. Sometimes, it is just a matter of miscounting how many occurred. Sometimes, it is interpretation and that type of thing.

MR. ROSANO: For example, incorrect badge issues, from your logs from which the inspection report is written, I get 13 examples and that is over the course of time which was also augmented by yours.

MR. GILL: In some cases we have added events that occurred in the third and fourth quarter of 1989 which were not included in the citation. In some cases the citation added one and we couldn't find out which one it was. It depends on which

area it is.

We didn't try to argue too much about numbers. We point out where there is a factual difference but in some cases there were two events but the dates were different so we still responded on that but we do note that area.

In some cases like in tailgating, of the events you listed only eight really involved entry into the vital area access and even though the citation says 13 or 15 go into vital area access, others involved in the security area access, for example, where there is no vital equipment. So it is the attention to detail that we started looking at in going through this.

MR. HEHL: One of the key things, I guess, as identified in our transmittal, in our notice of proposed violation, was the, I guess, the acknowledgement that, in fact, you did take corrective action as events occurred but there was not the evidence of a program or aggressiveness in trending and, therefore, identifying perhaps more comprehensive corrective action to alleviate recurrence of these types of events.

MR. TUCKER: Let me address that.

MR. HEHL: Is what you are saying that, in fact, those efforts were underway at and during the time of the inspections that took place and that that was not adequately communicated?

MR. TUCKER: We evidently did not make that clear. We did not have a process to make a curve like this and kept it running together. Now what actually happened and in checking with our folks, the people responsible for the security area and in all cases those are Duke employees.

Now we have a contractor that provides the security service at the other two sites, here the entire security force is Duke Power Company, but the people that we hold responsible for making sure our security program is what it should be are Duke employees and they did keep the quarterly logs.

They would compare one with the previous and we have what we call functional area meetings. Periodically the three sites get together and they would compare that experience as it related.

MR. TUCKMAN: They are also even doing further than that. There is an organization of the southeast security managers and they were sharing information trying to see if are we in the right area or not in the right area. Do we have many more tailgating events than another station or vice-versa?

MR. LIEBERMAN: So what you are saying is though you might not have had a fancy graph with numbers on it, people were looking at the trends and taking action as appropriate to try to reduce the deficiencies noted.

MR. TUCKER: Right. Now we have underway in a larger sense utilization of computer technology to improve us in

getting the right information to the right people at the right times so they can make better decisions.

Now that program is very comprehensive. We are in the process of getting this information through Bob's group will be accumulating the information at all three sites, trending that with the information being available both to our corporate staff and to the stations so they can continuously monitor it on the computer with the trend process and make it much easier and much quicker. We just put the information in. So that is underway.

MR. HEHL: But back in July and August of 1989 and prior to that through 1988 and 1987 timeframe, there were mechanisms in place that were providing an oversight identification of these trends and aggressive action to reduce the occurrences.

MR. TUCKER: There was a very definite monitoring process and as Mike alluded to comparing with others and this is another point that is a part of my statement about acceptable level of performance.

We see from our perspective this particular case of citation an abrupt change in level of acceptance by NRC both from our experience and what we understand from taking to other utilities.

MR. EBNETER: What do you mean?

MR. TUCKER: We think this particular case and let me

give you some bases for that, the statement in there that the adjustment of civil penalty was considered due to the fact that Duke had not had any escalated enforcement action in the last two years, however this was not warranted because had the information in all the logs been known to NRC, the enforcement history at Duke Power sites might have been different.

Well, to begin with, the information was there. The reports were submitted. So all the logs and LERs were there. Now we have had specific cases and in that information you got we quote the times of the events and everything.

Let me quote you some of the inspection reports and information provided to us from NRC during this period of time that influence our thinking in this area. Oconee, inspection 87-46 dated 12/11/87, inspector J. Ennis stated on page two, number five, "Management effectiveness security program. No violations were identified in this area. The licensee had established a security management structure and chain of command to provide operational direction and control of security force actions. A management system had been established to provide for the development, revision, implementation and enforcement of physical protection procedures. The licensee plant management exhibited an interest in and a very favorable attitude towards physical protection requirements."

Again, at Oconee, inspection 89-10, May 23, 1989,

inspector A. Tillman stated on pages one and two, section A, "Management support. Review of security program functions and observation of security operational activities revealed that the program was effectively managed and that security resources were utilized in an efficient manner. The established management program provided for development, revision, implementation and enforcement of security plans and implementing procedures. Licensee management demonstrated an awareness of and supportive attitude towards physical protection requirements. The security organization consists of a proprietary security management function which included a security manager and two security specialists and a contract guard force with a total strength of approximately 130 personnel provided by Glove Security Company. Based on observations and discussions with Security personnel during the course of the inspection, it appeared that the security organization was adequately managed and that communication between station management and the contract guard force was sufficient to ensure the maintenance of good working relations, morale and motivation of the guard force."

I have some others I could quote but you see my point about the language used as you fed back to us, your perception of our managing this area during this period of time and then on December 21, we get this letter combining all three locations in a citation of a civil penalty and a level of

violation that we don't think was reflected in the degree of concern expressed and the relationship up to that point.

I do feel that you have a regulatory obligation as soon as you see a concern to inform us of that concern. It may be in the form of a violation, whatever form it may be, but my point is, up to this time we did not see that tone of concern in any of the written documents, inspections or review of our quarterly logs. It came very abruptly and we don't understand that.

MR. HEHL: I think we agree with you that there is a regulatory obligation and there is an obligation on our part to inform you of deficiencies that we identify or concerns that we have but I think our inspectors attempt to do that.

This particular case though, I think, deals not so much on the individual importance or consequence of the individual items that occurred looking at each one in an isolated instance.

The area of concern was really with the overall numbers and the effectiveness of your efforts in eliminating those occurrences and not attempting to make any excuses for our inspection staff, but I think that there is a period of time and perhaps pulling all this data together to look in the aggregate at these activities may not have occurred on an inspection-by-inspection basis.

MR. ROSANO: It is important to remember that, of

course, the logs are not reviewed on every site visit or every inspection effort and as you pointed out, these items were put into logs which constitutes an report and you will notice in the NOV, there was not a citation for reporting although there was some discussion about what level of reporting would have been appropriate for each of the events that were logged but that was not addressed in the NOV.

The inspectors review logs as often as resources permit and these items were not necessarily identified by an inspector during an earlier visit because he or she didn't look at the logs at that time.

MR. TUCKER: In some cases they were. They are mentioned in the violation cited for that we make reference to.

MR. ROSANO: There are some earlier citations that are referenced in the inspection report that were not necessarily included among these that were later found in addition to those earlier ones.

MR. GILL: Every one of these violations was, in fact, a logged event or a licensee event report.

MR. ROSANO: Right, but we are distinguishing between those that were earlier cited and those that were logged after that.

MR. GILL: And in some cases, some of the ones cited go back before a violation in which case you bring forward history that should have been corrected by the violation

response. There is one in particular at McGuire and let me see if I can recall the one.

That was the mis-issued badges and the citation occurred the first quarter of 1989. We felt that the corrective actions that we had taken at that time which would again have been reviewed by an inspector in May of 1989 effectively resolved that and yet the December letter goes back and picks up occurrences that occurred well before 1989.

MR. ROSANO: There were 41 examples of mis-issued badges across the three sites mentioned in the inspection reports as Bill pointed out. We are not attacking each particular violation but the fact that there seemed to have been a trend or a continuing problem that was not corrected in spite of the recurring nature of the problem.

MR. JENKINS: The issue here is not the different things. The issue or our perspective was you were finding them, you weren't fixing them and maybe that is subject to question but that basically our position.

MR. GILL: We felt that the inspectors had looked at those areas and frankly, I have looked at the inspection reports and there is no assessment. They have reviewed logs that say so many occurred and they, in fact, highlight that.

MR. EBNETER: I don't think that has anything to do with that, whether they found it in that time or anything else. I guess the way I view it and you did a good job on your

homework, Hal, however, you should have brought that in the office when you came to the enforcement office.

MR. TUCKER: Well, we presented it, not graphically.

MR. EBNETER: Not that way.

MR. TUCKER: Not that way.

MR. EBNETER: You see, the inspector when she did this and this was Orysia, I believe, I don't know all the details on it and I don't know who she talked with or whether she talked to your staff or whether she talked to the contractor staff.

MR. GILL: She talked to our staff.

MR. EBNETER: All right. They should have told her if they were tracking this and I went to part of this enforcement conference, George.

MR. JENKINS: Yes, sir. I think you were at all of it.

MR. EBNETER: I might have been there for all of it but, in fact, I specifically asked you how the three sites compared remember and you guys had that little chart you weren't going to show me until I asked and you put it up there.

MR. TUCKER: That was on the other area, wasn't it?

MR. EBNETER: No, it was security.

MR. TUCKER: All right.

MR. GILL: We did have 14 areas at that time.

MR. EBNETER: In looking at your analysis, it

certainly puts a different light on it but the primary problem the inspectors had or the inspector had was that they saw this repetitive pattern and you know as well as I do, they are looking at numbers and they don't put this in a probabilistic sense of well, this is only two out of a million or something. They just see it recurring month after month the same type of issue.

Now these certainly give you a much better view of what is happening and I would think that surely if your staff at each station is tracking something like this, that is what they should have presented to the inspector and that is what you should have presented to the regional enforcement conference.

Now I recognize that you did do some of that but it certainly wasn't as clear as the problem comes out in this analysis.

MR. TUCKER: I agree with you and that is part of my point when I said in the beginning, the two-way communication in this area is not as effective as it has been.

MR. EBNETER: I agree with that. I do agree with you also on what is an acceptable level of performance is not very well defined in the enforcement area and it does cause some difficulties not only in enforcement but in the SALP process, too. I will see what we can do with it.

MR. HEHL: But you look at some of this and when you

look back at when the inspection occurred and perhaps the data that was being reviewed at the time of the inspection, it is not quite so clear that there is a flattening of the line at this point, that probably she was looking at data that existed from the first quarter which showed a return to an increasing trend on this particular chart.

MR. TUCKER: It is also, Bill, like Stewart just said, how many opportunities for tailgating existed.

MR. EBNETER: That is part of the performance criteria and I do agree when we talk about personnel, a lot of these are probably personnel errors and I think there is an asymptotic line where you can't get below and we need to recognize that something at that level is not of any specific safety concern and that is part of this performance standard though. What is that?

MR. LIEBERMAN: Remember, the reg requires a high degree of assurance. The enforcement policy previously was very prescriptive on what is severity level three. Any access violation of vital area was essentially a severity level three if, I guess, two out of the three elements were missing and we had many more security violations. Then we have dropped that to be more general to try to focus on the bigger picture.

In doing that, we became more general and this is one of the situations of we don't want to be prescriptive because then we have too much detail. On the other hand, we want to be

general but when you are general, you leave more room for judgment and then we don't have enough detail and it is somewhere in between.

As other have already said today, the reason why we took this enforcement action is because it was our impression that these matters are being trended, I mean, were being recorded in logs and appropriate corrective action was not being taken.

MR. HEHL: Or the corrective action was isolated, appeared for the event and was not because of the repetitive nature of these things was by default not effective.

MR. LIEBERMAN: That is a better statement.

MR. TUCKMAN: I can only address one plant because that is all I was involved with at the time but my security manager came to me early one in this period that you are talking about and said that we on the basis of logable events, we are having a problem with tailgating, we are having a problem with mis-placed badges, that sort of thing and we started working out corrective actions.

With any corrective action, you do something and then it takes some period of time to wait and see how it does particularly on something this statistically small like this.

MR. EBNETER: It is statistically small. There is no question about that.

MR. TUCKMAN: It takes a while and we went out on

tremendous employee involvement campaigns and all sorts of things and after those campaigns were mounted, you could definitely over the next couple of quarters, you could see that drop off and continue to pay attention. So it is not like we were oblivious to what we were logging.

We were aware of what we were logging, the security manager identified, one, we have trends here, tried to compare us to the rest of the industry to see if we are at outlier, are we doing about what the industry is doing or where are you at because as you indicated, Stu, getting to zero events in security is an impossible task.

MR. EBNETER: It is difficult.

MR. LIEBERMAN: What was the result of your looking at the other facilities? Are you an outlier in some areas?

MR. TUCKMAN: In some areas we were and those were the ones we really paid some attention on.

MR. TUCKER: What we have done, you will notice, that went to zero. The process we have now to enter the plant has been changed so that we put another mechanical process in there that reduced the human element to get that human error down to another level. You can't get in the plant today the way you could during this period of time.

MR. TUCKMAN: And I will be the first to admit that the attention that the NRC put on this and I don't want to implicate myself but the attention to this helped get us more

focused in making those changes.

MR. ROSANO: This was one of the things we were looking for. We were looking for the process. We were looking for the trending. We were looking for the tools that not only identified the problems but focus your attention on certain areas and we looked at the events and the logs and over a two-year period we didn't see that because we saw that events that were reported in 1987 were still being recorded in 1989.

But, you are right, if you look at things like that, that can show you where there are weaknesses in the program and then you get the results that you might expect and it goes to zero but that is exactly the point in the package. That is what we were looking for.

MR. LIEBERMAN: Does your submittal demonstrate that over time you were taking actions? We obviously haven't read your submittal here.

MR. TUCKER: In each case, we identify that corrective action was taken and this information we gave you with these, the specific information about each of those points, what constituted the event that that point refers to, as you look at the total thing, then you have different people involved.

At one area you are talking about going inside containment where you give up your badge and coming back out and getting the wrong badge which is a different situation than

when you come into the protected area, a different process.

But they are mis-issued badges so you have different circumstances and the corrective action that we have now taken as Mike alluded to, he was very much aware that it was and he took about three different steps to try to get on top of it and then each proved to be less than totally acceptable to we would do something else.

That is clear in these things. You can read that in the document that we took corrective action. We have learned that the more we can put in a modification that is physical, either mechanical or electronic or something, then the greater we can reduce the probability of the human error.

There is a point where it begins to decrease and there is also a point in my opinion that it becomes an interference. We do not want the people to turn off their mind when they walk in the door.

MR. LIEBERMAN: There has to be a balance.

MR. TUCKER: You have to exercise some judgment there. We were dealing from the human aspect of it up to the point and then put the mechanical in at the PAP to stop.

MR. LIEBERMAN: Was your corporate security looking at the performance of the three plants and doing any studies or analyses of how the various plants were doing as a company as a whole?

MR. TUCKER: In terms of monitoring the trend and

data information on the reports as part of the functional area meeting I referred to earlier, the information all comes into our compliance group and Bob has an area there of monitoring for the total.

The one thing that did influence actions in this period of time, you made mention in your SALP, I believe, at both McGuire and Catawba, that we had reduced resources. One thing that we did in that timeframe, part of our conscious decision associated with the work activities review as we called it, that exercise, we re-assigned some of the responsibilities in most of the major functional areas and security was one of them.

So we re-assigned the general office function for that review, not the station, but the general office in that timeframe. So there was an interruption and introduction of transition from one group of people to another. I don't see any evidence that that influenced it but that is a fact.

MR. EBNETER: Let me clarify your answer a little bit and you can correct me if I am wrong.

MR. TUCKER: All right.

MR. EBNETER: Jim, in answer to your question, I don't believe there was a corporate oversight at this time. As you said, you had given this the site responsibility and this was one of the major concerns that sort of developed from this. Each station was doing it individually and each station had a

pattern and it didn't appear that there was some corporate oversight to look at those patterns. That is really how a lot of this came out.

MR. GILL: In the first part of this two-year period we are talking about, that is correct.

MR. LIEBERMAN: These functional meetings, when did they begin?

MR. GILL: We started our first one in January of 1989, about a month after the restructuring.

MR. TUCKER: But you had functional area meetings before then.

MR. TUCKMAN: The security managers from all three plants had been meeting together on some basis for several years.

MR. GILL: They had one person involved from the corporate office prior to that.

MR. TUCKER: Right. We now added that in there but the three sites getting together as Mike just alluded to, that has been our practice for several years.

MR. TUCKMAN: And not just in the security area either.

MR. LIEBERMAN: But in looking at problems, say in the logging of issues and is there a problem that we need to work together on and things of this sort which I presume is what the functional meetings area.

MR. TUCKMAN: Those meetings are among the security managers at all three stations plus the security representative from the general office would range in a full spectrum of things. "I am having this problem. Are you guys having this problem? How are you fixing it" and that sort of thing.

MR. EBNETER: Let me ask you something. What is Mr. Tuckman's role going to be? Is he going to have a bigger role in that since you are the general manager of nuclear support services? Is he going to be looking, say, maybe, instead of Bob, Bob, I guess, you are supposed to look at these logable events.

MR. GILL: The program we are developing will have my folks supporting you. I have a security specialist for each station under me.

MR. TUCKER: The answer to your question directly is yes. Mike in his responsibility is going to look at how we support and manage the technical areas of the station within our department and the support from other departments. We specifically had a recent discussion about all of the areas that were involved in our work activity review.

We have changed and you see evidence of it with the site engineering group we have, the division design engineering department. A number of changes have taken place in our corporation that involve different people and different relationships relative to this support and Mike is going to be

pulling that into focus including this kind of stuff, how we monitor all three sites.

It is a part of what I alluded to earlier, the broader scope of utilization of computerization so we can get the right information in and those programs are underway right now.

MR. TUCKMAN: As an example of an activity like that, we just started and had our first kickoff meeting on looking at reactivity management at those three plants.

MR. EBNETER: Does that mean how you react to us?

[Laughter.]

MR. TUCKMAN: No, no, no, no. Nuclear reactivity. We pull together the reactor engineers from all three sites, the general office design engineering, people who maintain our computers and all those sorts of activities and it was amazing to me that we had not incorporated all the lessons learned from one plant to another and that was one area that I wanted to start in. We intend to try to do much more on that.

MR. TUCKER: When you pull all of the information together on seven units and you find zero at one place and higher numbers in another place, then that raises some questions.

MR. EBNETER: So you have given me all of the statistics and they do tell a story. What is your bottom line here? Do you think we are way off base, I take it?

MR. TUCKER: I think the severity level is inappropriate and I certainly think the civil penalty is inappropriate for the circumstances evaluated across the board and as I mentioned to you in our original conversation, I have some concerns from my point of view the abnormality of it of bringing all three sites into one citation.

When I look at the review, there is a little bit of difference in the trend at each location. Well, we tried to point out, we were monitoring this not in the same sense that you see it presented there.

MR. EBNETER: I know, and that is my problem. I certainly think these set of statistics paint a different picture than the way we have seen it, you know, just by reading letters and things but I understand that. The abnormality of the approach here, I think, Jim Lieberman ought to tell you how that came about.

MR. LIEBERMAN: Yes, and it is unusual to consider the activities of more than one site in developing enforcement action. In looking at that and remembering that our basic concern was a lack of effective corrective action being taken in response to the various findings in the logs which may need to be re-evaluated in view of the information provided today but recognizing that we considered a separate enforcement action at each site.

We said to ourselves, "Well, maybe if you did that

and applied the enforcement policy, that would come up $150,000.00" and we thought that was not the appropriate amount of money for a case like this so we exercised some discretion and put it all together in one package at $50,000.00.

So that was the logic for putting together into one package. It is not the routine way of doing it. In most cases I wouldn't expect to see that but we thought it was the right way to package our concern.

MR. HEHL: But the enforcement policy does and correct me if I am wrong, Jim, does, in fact, address that events that occur at other units that are owned by the same utility are, in fact, issues that are perhaps pertinent to the enforcement process.

MR. EBNETER: I don't think it says that but I think, Jim, you ought to tell them how we arrived at this. You did go through the legal process with OGC.

MR. LIEBERMAN: That is true. Bill is right that the policy does allow us to consider activities at the other sites and we thought that there was a basis to take action at each site independent given the numbers.

So we thought we were on firm foundation to go with three separate actions but we combined it to get the amount of money that we thought was appropriate. That is how we got to where we got. Now what we have to do is to look at the information you have provided us to see if the basis that we

said in the letter is, in fact, valid and if we are wrong on the facts, we will have to re-group.

MR. TUCKER: Let me do this. Let me take a quick time-out and I will come back and we will respond to that. I had some other comments I wanted to make relative to why, I think, it is inappropriate if you will give me just a few minutes.

MR. LIEBERMAN: Sure. Off the record.

[Brief recess.]

MR. LIEBERMAN: Back on the record.

MR. TUCKER: Jim, let me respond to your comments in that we thought probably you did take such an approach in that decision and I realize the exposure both ways associated with that, but we didn't see that in any other functional area and again, I would say this area seems to be from our perspective treated a little bit differently.

One other point that I think I need to make and I alluded to in the very beginning but to put this in perspective in relative significance of safety of the plant, the badge mis-issue, nobody got in an area they were not authorized in terms of people that had badges and they were mis-issued. They were authorized to go into the areas they went in.

It was not a question of safety involved or some outsider getting in.

MR. EBNETER: I might agree that that is probably so

but did you actually verify that? You don't know where those people actually went.

MR. TUCKER: They had access to get into the areas they were authorized to go. Then when you get into a cad lock if you don't have your badge, you can't get in. So they were authorized to go into the protected area where they went.

MR. LIEBERMAN: But in none of these cases at the three plants had any situation where unauthorized persons obtained access to locations?

MR. TUCKER: In the case of badge mis-issue.

MR. LIEBERMAN: All right.

MR. TUCKER: In other words, I gave you your badge or I gave you the wrong badge. Now there was one case at McGuire where an area had not been and we changed the designation of it, one of the ladies associated with the Haymack Group, the Pinto group, who worked there all the time was recognized. Was that at Oconee?

MR. GILL: The cleaning woman who got into the protected area.

MR. TUCKER: Any way, she didn't have a badge and she got into an area that used to not be included protected and was changed but she was known to security people. My point is, I don't think there is any way you could take these events and create a situation where somebody could take that information and get into our plant and create any problem.

MR. ROSANO: I would like to point out that in security very often and I am sure it is true in the other areas, also, we are concerned mostly with vulnerabilities, not necessarily simply the event, and a procedure or system that would allow the wrong badge to be issued to a person sometimes it is just fortunate when it happens to be given to the wrong person who happens to be authorized so we are concerned about the vulnerability involved that would have given out the wrong badge. It may have been fortuitous that no unauthorized people actually went in.

MR. TUCKER: You have to realize also, there is a degree of familiarity. That is exercising your own security program.

MR. ROSANO: Yes, but in most sabotage scenarios, actual and those proposed, it is the recently terminated employee or it is another familiar individual who causes the biggest problem so we can't rely on that. We have to have physical authorization like a key card and a badge.

MR. TUCKER: I understand that.

MR. ROSANO: Those are important.

MR. TUCKER: I understand that but I am making a point. I understand the absolute aspect of it but I also raise a point as to the question of the need for absolutes. That is another element of security that is different from the rest of the functional area and an aspect of public health and safety.

In my review of this, I think that has to be a factor, how much at risk was public health and safety in this review.

MR. LIEBERMAN: The question is, do you believe that there is an insider and the insider may do some damage.

MR. TUCKER: If I have an insider, he is not going to make that kind of mistake. He will follow every rule and regulation to get to where he wants to go. He will sure he has the right badge. He will make sure I know he is in there.

MR. LIEBERMAN: I guess we really don't know what will happen in that situation. Hopefully, we will never have the situation to worry about.

MR. TUCKER: Again, this is getting into the philosophical area of it but the security aspect of the license part of a nuclear power plant is more militaristic, associated with military type, which I think is essential when you are dealing with a weapons facility or something like that.

But they are different situations and yet the security measures are patterned from my perspective after the military program rather than a commercial power plant and when you approach the reality of it --

MR. EBNETER: That is another when you need to recall the "Serenity Prayer."

[Laughter.]

MR. TUCKER: I will accept your advice and get off my

soapbox.

[Laughter.]

MR. TUCKER: But I am trying to put into perspective the public health and safety which I think is viewed differently in this area and it raises some questions in that respect.

I realize your comments about grouping the three together but I hope we have shown you that we did have in place some reviews, we did take some corrective actions and we have taken some more.

Each case we found or each violation that was pointed out in that sequence of time and in the inspection reports prompted our attention and, of course, this one heightened the attention the way it was expressed. But I honestly feel based on our review of the situation and the time covered by this inspection that the severity level and the civil penalty is inappropriate. I guess I rest my case.

MR. LIEBERMAN: We will give due consideration to your comments and your submittals and hopefully we will make the right decision.

MR. TUCKER: I trust you will.

MR. LIEBERMAN: I guess this meeting is over.

MR. TUCKER: Thank you.

[Whereupon, the above-entitled meeting was concluded at 2:10 o'clock p.m.]

REPORTER'S CERTIFICATE

This is to certify that the attached proceedings before the United States Nuclear Regulatory Commission

in the matter of:

NAME OF PROCEEDING: Management Meeting Duke Power

DOCKET NUMBER:

PLACE OF PROCEEDING: Clover, South Carolina

were held as herein appears, and that this is the original transcript thereof for the file of the United States Nuclear Regulatory Commission taken by me and thereafter reduced to typewriting by me or under the direction of the court reporting company, and that the transcript is a true and accurate record of the foregoing proceedings.

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