

# GOVERNMENT ACCOUNTABILITY PROJECT

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September 14, 1983

Honorable Nunzio Palladino, Chairman  
Honorable Victor Gilinsky  
Honorable James Asselstine  
Honorable Thomas Roberts  
Honorable Frederick Bernthal  
United States Nuclear Regulatory Commission  
Washington, D.C. 20555

Dear Commissioners:

On behalf of the Palmetto Alliance, the Government Accountability Project ("GAP") of the Institute for Policy Studies ("IPS") through its Citizens' Clinic requests that the Nuclear Regulatory Commission ("NRC") take immediate action to protect the future health and safety of the public in and around the Charlotte, North Carolina area through the following actions:

(1) Modify the construction permit (Catawba Units 1 and 2) to include a mandatory review by an independent contractor of the following:1/

(a) The actual "as-built" condition of the Catawba facility, done through a 100% reinspection of the safety-related areas of the plant;

(b) the design deficiencies and the breakdown in the design change control systems which render the design, as approved in the Final Safety Analysis Report, inaccurate and incomplete, and

(c) the quality assurance/quality control program which has existed with major weaknesses at the Catawba facility since the beginning of construction.

(2) A management audit of the Catawba upper and mid-level managers responsible for both design and implementation of the Catawba quality control/quality assurance program.

1/ GAP requests that the review be conducted by an independent contractor using criteria set forth in the 1981 letter from Chairman Palladino to Congressmen Dingell and Ottinger. Specifically, this criteria sets forth the independence and competence criteria as follows: (1) technical competence of the company and the individual companies and assurance that (2) the contractor had no previous activities at the plant, (3) that the contractor had no previous employment with the licensee, (4) that no individual employee had been employed previously by the licensee, (5) that neither the company nor employees owned or controlled licensee stock, and (6) that members of the present households of the employees were not employed by the licensee.

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ATTACHMENT 2

Further, GAP requests that the Commissioners direct the Office of Investigations (OI) to conduct a complete and thorough investigation into the deliberate mishandling by Duke Power Company (DPC) management of certain serious complaints by Catawba welding inspectors (*infra*, 41) to determine possible violations of 10 C.F.R. Part 21, 10 C.F.R. Part 19, and the Department of Labor provisions 29 C.F.R. Part 24 § 210 which prohibits licensees from harassing, intimidating, or in any other way discriminating against nuclear employees for revealing construction problems which they believe may lead to safety concerns.

Finally, GAP requests that the Commission review the on-going internal investigation by the Office of Inspector and Auditor (OIA) to insure that the scope of that investigation includes conduct by Regional officials, including the Region II administrator, which is directly contrary to NRC rules and regulations.

#### Background

The Government Accountability Project is a project of the Institute for Policy Studies, Washington, D.C. The purpose of the program is to broaden the understanding of the vital role of the public employee, private citizen, and nuclear worker in preventing health and safety dangers, corruption, fraud, waste and other abuses. GAP offers legal and strategic counsel to whistleblowers, provides a unique legal education for law student interns, brings meaningful and significant reform to the government workplace, and exposes government actions that are repressive, wasteful or illegal, or that pose a threat to the health and safety of the American public. Presently, the Project provides a program of multi-level assistance for government employees, citizens and corporate employees who report illegal, improper, or wasteful actions. GAP also regularly monitors governmental reforms, offers expertise to Executive Branch offices and agencies and state and local government bodies, and responds to requests by Congress and state legislatures for analysis of legislation to make government more accountable. The Citizens Clinic for Accountable Government of GAP responds directly to requests for assistance from community groups, local government bodies, and individuals who are facing difficult struggles against the federal government, large corporations, or other entities that seek to repress or intimidate the individual struggles for fairness and equity.

The Project is not an "anti-nuclear" organization. Our involvement with nuclear power plants began at the William H. Zimmer Power Station in Ohio. At Zimmer the information provided to GAP, and through GAP to the NRC, led in part to a stop-work order being issued by the Commission on November 12, 1982. This information was compiled over a period of two years by GAP investigators from dozens of workers within the utility and within the contractor.

Other cases that GAP has been involved in within the nuclear industry include the Midland Nuclear Power Plant in Midland, Michigan; the LaSalle Nuclear Generating Station in Illinois; and more recently the crippled reactor at Three Mile Island. Other requests for our assistance have come from whistleblowers across the nation and citizens concerned about the safety of the nuclear plants being built in their communities.

In March 1983 the Palmetto Alliance, [REDACTED], Esq., and [REDACTED], a former Catawba worker whose experiences with the applicant and the NRC staff is well-known to the Catawba Licensing Board, brought the apparent problems at Catawba to our attention. They had questions about "whistleblowing," quality assurance issues, the lessons GAP had learned at the Zimmer plant, and our other nuclear industry experiences. [REDACTED] detailed the status of the intervention proceeding in the Catawba case. At our request he provided us with background information about Catawba. Two staff attorneys and the Citizens' Clinic Director and staff associates initially reviewed the case information.

Based on the information that we had already reviewed as well as documents that surfaced late in discovery to [REDACTED] we determined that (1) there had been a significant breakdown in the quality assurance/quality control ("QA/QC") program implementation at the Catawba plant, and (2) the Nuclear Regulatory Commission Regional Inspection and Enforcement ("I&E") staff failed to take appropriate action to determine the extent of the quality assurance breakdown at the Catawba facility.

On April 21, 1983 our organization requested that the Office of Investigations ("OI") conduct an investigation into the handling of the complaints of harassment and intimidation of welding QC inspectors at the Catawba site. The complaints were brought to our attention through the information provided to the Palmetto Alliance during discovery. We also announced publicly that we were conducting an independent investigation of the Catawba facility.

GAP has now concluded a preliminary review of the Catawba plant. The analysis included a review of the documents on the public record, a review of testimony presented in discovery depositions of NRC and DPC personnel (including a DPC former corporate quality assurance manager, on temporary assignment to the Institute for Nuclear Power Operations (INPO)), and information received from DPC Catawba employees.

GAP will continue its independent investigation, concentrating on the concerns of DPC workers about quality control/quality assurance procedural breakdowns; as well as continue to monitor NRC staff efforts at resolving the issues we have raised.

## II. LEGAL BASIS

### A. Legal Requirements

The law gives the Commission broad discretion to revoke, suspend, or modify the construction permit of an NRC licensee. 42 U.S.C. § 2236 states that:

A license or construction permit may be revoked, suspended or modified in whole or in part, for any material false statement in the application for license or in the supplemental or other statement of fact required by the applicant; or because of conditions revealed by the application for license or statement of fact or any report, record, inspection, or other means which would warrant the Commission to refuse to grant a license on an original application; or for failure to construct or operate a facility in accordance with the terms of the construction permit of license or the technical specifications in the application; or for the violation of or failure to observe any of the terms and provisions of this chapter or of any regulation of the Commission.

Part 50. 100 of Title 10 of the Code of Federal Regulations states the same criteria for the revocation, suspension or modification of a construction permit.

The NRC has a mandatory duty to exercise this authority when necessary. According to the decision in Natural Resources Defense Council vs. U.S. Nuclear Regulatory Commission, 528 F.2d 166 (2d Cir. 1978), under the Atomic Energy Act of 1954, the NRC is required to determine that there will be adequate protection of the health and safety of the public. The issue of safety must be resolved before the Commission issues a construction permit. (Porter City Ch. of Izaak Walton League vs. Atomic Energy Commission, 515 F.2d 513, 524 (7th Cir. 1975).)

### B. Criteria to Exercise Discretion

According to 10 C.F.R. § 2.202, the NRC "may institute a proceeding to modify, suspend or revoke a license or for such other action as may be proper by serving of the licensee an order to show cause which will: (1) allege the violations with which the licensee is charged, or the potentially hazardous conditions or other facts

deemed to be sufficient grounds for the proposed action." As interpreted by the Proposed General Statement of Policy and Procedure for Enforcement Action, published in the Federal Register, 44 Fed. Reg. 66754, Oct. 7, 1980 (10 C.F.R. § 2.202, 2.204), suspending orders can be used to remove a threat to the public health and safety, to the common defense and to the security of the environment. More specifically, suspension orders can be issued to stop facility construction when further work would preclude or significantly hinder the identification and correction of an improperly constructed safety-related system or component; or if the licensee's quality assurance program implementation is not adequate and effective to provide confidence that construction activities are being properly carried out. Moreover, orders can be issued when the licensee has not responded adequately to other enforcement action or when the licensee interferes with the conduct of an inspection or investigation or for any reason not mentioned above for which the license revocation is legally authorized. In order to help determine the significance of violations within this list, the Commission established "severity categories" ranging from the most serious structural flaws (Severity I, to minor technicalities (Severity VI). 44 Fed. Reg. at 66758-59.

### III. SPECIFIC BASIS FOR SUSPENSION - QUALITY CONTROL BREAKDOWN

The Commission clearly has both the duty and the discretion to modify the Catawba Construction Permit or to take whatever other actions are deemed necessary to insure that Catawba is constructed in accordance with 10 C.F.R. requirements.

As discussed below the results of our preliminary analysis reveal that the current regulatory program does not confront the causes, the extent, or the continuing nature of the QA breakdown at Catawba.<sup>2/</sup>

#### A. Failure to Ensure that the As-Built Condition of the Plant Reflects the Final Version of an Acceptable Design

##### Criterion III - Design Control

A basic requirement of 10 C.F.R. 50, Appendix B, Criterion III -- Design Control, is that construction must reflect the final, approved design. Measures shall be established to: (1) assure that appropriate regulatory quality standards are specified in design documents and deviations from such standards are controlled; (2) select and review, for suitability of application, essential (safety-related) materials, parts, equipment and processes, (3) identify and control design interfaces and coordinate among participating design organizations; (4) verify or check the adequacy of design.

<sup>2/</sup> The evidence presented in the petition is illustrative, not comprehensive.

Design changes, including field changes, shall be subject to design control measures commensurate with those applied to the original design and be approved by the organization that performed the original design unless the applicant designates another responsible organization.

Catawba design documentation does not reflect the plant as designed, and it is unclear whether it reflects the plant as-built. Substantial documentation from Duke Power itself, and confirmation from workers leaves no doubt that Catawba's design and field engineers built this plant "by the seat of their pants," not by the book.

An audit, or a "self-initiated" evaluation using INPO methodology, was conducted from September to October 1982. It is attached and incorporated in its entirety as Attachment # 1.

The following recommendations emerge from Section B, "Improvements Were Recommended in a Number of Areas: The Following are the Most Important:"

- (DC.1) 1. Procedure for the responsibility, issuance, and control of Design input needs to be formalized. (supra, p. 2a)
- (DC.2) 2. Coordination on Design changes between the design disciplines should be improved. (p. 2a)
- (DC.4) 3. Formal program is needed to review design documents to assure constructability, maintainability, and operability. (p.2a)

These recommendations result from the following findings:

- (DC.1-1) No requirement exists for identifying, tracking, and assuring that commitments identified in the PSAR are met. Design information should be clearly defined and controlled. (supra, p.7)
- (DC.1-2) No control program for defining responsibility for providing Design input could be found. Input is usually provided on a request basis. (p. 7)
- (DC.1-3) Design input information is not always provided in a controlled manner. Memoranda serve as the primary vehicle for documenting Design input. (p. 7)
- (DC.1-4) System descriptions and flow diagrams do not always agree as to the current requirements. Several system descriptions were observed to lag revisions of system flow diagrams. (p.7)
- (DC. 1-5) No documented program was found for assuring correct application of seismic response spectra. (p.7)

According to the methodology, the findings above are based on observations. The INPO report devotes 18 pages of observations on design control deficiencies to support the findings. Although these observations do not provide sufficient detail for either the NRC or GAP to determine the full extent of the problems in design input and control, there can be no question that work at Catawba has largely proceeded on the basis of informal drawings and procedures instead of design changes approved by the project engineers. The INPO report underscores that conclusion:

1. From interviews, literature searches, and document reviews ... no requirement could be determined to exist for identifying and tracking PSAR commitments. (supra, p. 8)
2. ... no control program for defining responsibility for providing design input could be determined to exist. (supra, p. 8)
4. Interviews, literature searches, and document revisions in the Civil Environmental Division showed design input is provided through memoranda, specifications, intra and inter-disciplinary discussions and meetings. (emphasis added) (supra, p. 8)
7. ... no program requirement for conducting constructability, maintainability, or operability reviews was found to exist, .... (supra, p. 8)
13. ... no program for providing and controlling design input exists. (supra, p. 9)

As a result of construction personnel and field engineers making modifications on an undocumented, informal and ad-hoc basis, it is not surprising that further investigation by the INPO team discovered that system descriptions and diagrams did not agree for the following systems:

- (1) Mechanical/Nuclear Division
- (2) Mechanical/Electrical System (RHR)
- (3) Electrical Division (AFW and RHR) (supra, p. 8)
- (4) AFW electrical system in disagreement with the elementary electrical diagrams and the mechanical system description.
- (5) Review of the RHR system description and flow diagram revealed discrepancy between the requirements of the two documents concerning emergency power train assignments for the isolation valves between the RCS and the RHR system. (p. 16)

Design interfaces were also found to be lacking in that "the process for controlling design input documents does not require timely updating of system descriptions." (supra, p. 11)

Design process weaknesses detailed records not being filed in a timely manner, changes to design drawings receiving inadequate review, and calculations not being maintained in a controlled enough manner to support issued design documents. (supra, p. 15)

These are not theoretical problems. Findings DC. 3-3 plainly states:

Design documents relating to the design of the RHR System are in disagreement creating a potential for error in the design. This is also true for the AFW system. (supra, p. 15)

On page 21 of this section the following related observation is made:

The Auxillary Feedwater Electrical system description was last revised on October 10, 1980. There have been several revisions of the Electrical elementary diagrams and a complete revision of the Auxillary Feedwater Mechanical system description since the last revision of the Electrical system description.

However, the most telling comment about the extent of design control problems is "tucked" into this section on page 19. Unfortunately the credibility of the report is brought up seriously short by the lack of attention given to the following observation:

Finding 4-3. System descriptions are used to provide system control information. They do not reflect current system design. (emphasis added)

Further evidence from the INPO report that is merely cumulative is excluded. The evidence that follows is sufficient, however, to illustrate a comprehensive breakdown that requires an extraordinary NRC monitored review program.

DPC has had ample opportunity to respond appropriately to findings and observations in this evaluation. Clearly this "self-initiated evaluation" and DPC's lack of an appropriate response is the best argument in support of GAP's request for an independent design and construction verification program (IDCVP).

The following statements by DPC construction management are particularly illustrative of our doubts about DPC's ability to heal itself:



Responsible engineers and first-line supervisors do not feel keeping system descriptions current with design drawings is important. (item 15, p. 17)

and,

Interviews with personnel of the Electrical Division showed a lack of concern for the system description not being current with design drawings. (item 11, p. 9)

Even more revealing than the statements of the Catawba employees above is the denial, rationalization and insufficient response of the INPO Findings by DPC Management. Pages 100-121 of the INPO report detail those responses. Although DPC has committed itself in the future to some procedural modifications, the licensee has responded by explaining away the problem. None of the responses to areas of weakness in design includes a "backward look" to determine the extent of the problems. Only a few new programs or alleged program reviews are promised for the spring of 1983, and a few specific changes are promised in response to specific findings. This is entirely inadequate for the generic implications of the INPO findings.

DPC and Catawba management should not have been surprised by the INPO report. Conscientious Catawba employees have been raising complaints about problems in design control for years.

Former Quality Control Inspector [REDACTED], for example, a known critic of construction weaknesses on the site, recently was deposed by DPC attorneys in connection with the ASLB operating licensing proceedings. (Selected pages of his deposition are included as Attchmt.2). [REDACTED] sworn deposition confirms that the INPO findings were not isolated discoveries. As [REDACTED] explains:

Okay, one thing I did fail to mention was the fact that blueprints were changed to reflect construction errors. (pg. 37, 9-10)

On certain occasions we would go to inspect the cable tray supports, cable tray hangers, on all the cable supports or I should say most of them, were seismically braced. We found several instances in which seismic bracing was not run in the direction the print called for it to be run. (Id., Ln. 14-17).

We would, usually on this, our procedure was to talk to the technical support engineers, and generally the resolution would revise the blue print to reflect the change in the direction of the seismic bracing. (Id., Ln. 19- 21).

██████████ describes his concerns about this backward procedure on page 41:

Well, I wasn't fully satisfied. In other words, I was not comfortable with the fact that a print was being changed because a craft worker made a mistake and braced something the wrong way. (P. 41, Ln. 1-4).

I was still concerned about the fact that it was changed to reflect a construction foul up. (Ln. 18-19).

██████████ fears were well founded. His experiences with a totally backward approach to design control gives only one small glance at the "quick and dirty approach" used by DPC management to build Catawba.

A review of all the Design Drawing and Specification Variation Procedures used for design control affirms the worst fears of Catawba's critics.

Variation Notices (VN) have been used from the beginning of construction as the method of controlling field variations from Design Engineering drawings and specifications. Although initially controlled by Project Engineering, that function was transferred to Project Manager in September 1976. (Attachment 3.)

Prior to that transfer, no meaningful QA/QC review of design changes evidently occurred until May 1, 1974 when the Project Senior Quality Assurance Engineer became responsible for approving the QA aspects of variation notices and for specifying inspection if needed. (Attachment 4.)

Design control procedures remained inadequate throughout the decade. In Revision 7, June 27, 1975 the Project Engineer was restricted from using even the variation notice unless it became necessary. (Attachment 5.)

Prior to approval the (Project Engineer) must verify that the use of the variation notice is essential to maintain work in progress or to maintain work which will soon begin. (p.1.)

In the November 1975 Revision the Variation Notice became not a record of engineer approved design/specification changes, but the equivalent of a memo of understanding between design engineers and construction. (Attachment 6.)

Variation Notices (Form R-3A) are not to be used to report work that already has been accomplished or to authorize the use of an unapproved or preliminary design but rather to document an agreement with Design Engineering to conduct work in variance with an approved Design Engineering drawing or specification. (emphasis added)

According to revision 8 that agreement could be transmitted "to the field verbally by telephone, in person or in writing." All the paperwork from engineering to QA could be done in the convenience of office -- as revision 8 further explains:

The Project Quality Assurance Staff shall then review the Variation Notice. If inspection is needed, the words 'Inspection Required' shall be written in the 'Action to be Taken' section. If inspection is not needed, the 'Waived' block shall be checked. Items which will receive adequate inspection and documentation through the normal function of the Quality Assurance Program need not have their inspection documented on the R-3A, and the waived block should be marked. Quality Assurance approval shall then be signed and dated. If required, the Project QA Staff shall mark the R-3A to indicate inspection assignment.

When [redacted] raised concerns about the quality of nuclear construction design changes by telephone he was informed not to worry about it, that it wasn't his concern. (Deposition of Ron McAfee, p. 40).

Yet it was not until Revision 13, January 11, 1982, that the use of variation notices even began to come into compliance with 10 C.F.R. 50 Appendix B Criterion III. (Attachment 7) Significantly, this revision includes DPC's first attempt at addressing 10 C.F.R. 50 Appendix B requirements by the inclusion of Paragraph 4.8 requiring that design non-conformances be evaluated for reportability under 10 C.F.R. 21 and/or 50/55(e), and 4.10 which gives Design Engineering the responsibility for performing trend analyses on Variation Notices "to assure that any unnecessary trends are not developing."

Unfortunately, the commitment to 10 C.F.R. was short-lived. By the time that Revision 17 was implemented, the reportability review only applied to a small percentage of the Variation Notices; excluded from review were VN's selector "Interference," "Implementation

Option," or "Missing Information." 3/ (Attachment 8).

Construction at Catawba is currently using Rev. 19, dated July 1, 1983. Unfortunately the weaknesses of the Variation Notice (Form R-3A) have only increased. There can be no reasonable assurance after a review of the design procedures, the INPO Findings, and the experiences of Catawba workers who have talked to GAP that the plant is built as designed, and that design changes have been accomplished according to NRC requirements under 10 C.F.R. 50, Appendix B Criterion III.

GAP's previous experiences at Zimmer and Midland have revealed frightening construction flaws at sites near completion. The Region III Director has often commented that the "real sin" at Zimmer was that it was in the ground, 97% complete, yet in an indeterminate state. A review of the procedures used to build Catawba reveal marked similarity in the lack of attention to quality assurance and quality control requirements. Hopefully the Commission will recognize the critical importance of taking a comprehensive look at Catawba now.

B. Failure to Maintain an Adequate Quality Assurance Program to Identify and Correct Construction Deficiencies

Criteria I and II -- Organization and Quality Assurance Program

Most of the criteria of 10 C.F.R. Part 50, Appendix B, stem from Criterion I - Organization, and Criteria II - Quality Assurance Program. The criteria require a carefully controlled and documented quality assurance program with necessary staffing and training. Criterion I also describes the premise that provides legitimacy to a licensee's QA program: "Such persons and organizations (performing quality assurance functions) shall have sufficient authority and organizational freedom to identify quality problems; to initiate, recommend, or provide solutions; and to verify implementation of solutions." At Catawba DPC policies dominated these premises, and in the process took the rest of the quality assurance program step-by-step.

3/ Interference - The inability of Construction to perform the work as shown on design documents because of physical obstruction.  
Implementation Option - Alternate methods to install items which simplifies the construction.  
Missing Information - The inability of Construction to perform the work required by design documents because of insufficient information.

The premise for quality assurance at Catawba was simple: if a problem is discovered - fix it first, fill in the paperwork later. The entirety of this petition demonstrates that violations of regulatory requirements were common. Moreover, the situation was accepted by even the quality assurance management as "the way things were done" at Catawba. Even in the face of continued low quality assurance/quality control ratings by the NRC 4 and a series of critical reports by consultants, DPC continued to maintain that the Catawba facility had been constructed in accordance with 10 C.F.R. Part 50 Appendix B.

~~\_\_\_\_\_~~ Chairman of the Board of Duke Power in his deposition of July 12, 1983 maintained that there is nothing that caused him to question whether or not the Catawba station was safely built. (Deposition of ~~\_\_\_\_\_~~, p. 75.)

Regardless of Mr. Lee's view there is a fatal flaw in the nuclear construction quality assurance program: it is not, and never has been, independent of construction. 5/

4/ a. NUREG-0834, NRC Licensee Assessments, August 1981 rated Catawba 1 and 2 below average for the period 9/1/79-8/31/80. Specifically, NUREG-0834 states: "Catawba received a relatively large number of items of non-compliance when compared with other power reactor facilities under construction. Most of these items of non-compliance were attributed to weakness in the licensee's quality assurance and management overview process."

b. Systematic Assessment of Licensee Performance (SALP) Duke Power Company - Catawba Nuclear Station, Units 1 and 2, May 18, 1983, Draft of the NRC input, rates Catawba "2" in Quality Assurance. (Attachment 9.)

5/ This issue was the subject of an Atomic Safety and Licensing Appeals Board (ALAB) order in the McGuire proceedings. The matters raised by the McGuire case are equally relevant to Catawba. In that case the question of adequate QA independence was raised by intervenors South Carolina Study Group, in both the ASLB proceeding and on appeal to the ALAB. The ALAB remanded the question back to the Board for clarification, directing the staff and DPC to furnish the following information:

(i) An unequivocal response as to whether the applicant's quality assurance organization conforms to Appendix B to 40 C.F.R. Part 50. 'Quality Assurance Criteria for Nuclear Power Plants.'

(ii) If the answer is in the affirmative, an explanation of the basis for its assurance that the quality assurance responsibilities assigned to the applicant's engineers in the areas of construction, testing and operation meet the independence objective of criterion I in Appendix B.

The record of the lack of independent quality control developed through the history of construction of Catawba lends significant weight to the original fears of the South Carolina Study Group in 1973 and the Palmetto Alliance in 1983.

The intervenors recognized that the intent, indeed the entire purpose, for requiring QA/QC to be independent from construction was to allow inspectors an unfettered ability to determine the quality of construction and to implement approved QA procedures.

██████████ current Chairman of the Board, who was then Senior Vice President of both Quality Assurance Program and Vice President for Engineering and Construction, saw the regulatory request as something much less than a realistic requirement.

The Palmetto Alliance, in its deposition of ██████████ in July 1983, questioned the development of the first "topical" QA program.

██████████ responded,

(Footnote 5/ continued from previous page)

(iii) If the answer is in the negative (or anything other than an unqualified affirmative), an explanation of the basis and authority for its conclusion as to the acceptability of the applicant's quality assurance organization.

b. The applicant is directed to respond to the following questions:

(i) Do any of the applicant's engineers who have been assigned quality assurance responsibilities in the areas of construction testing and operation also have other responsibilities which could adversely affect the performance of their quality assurance responsibilities from any standpoint, including independence as well as available time.

(ii) What is the precise nature of the responsibilities of the company officials, up to and including the Vice-President for Construction, who supervise the Principal Field Engineer and the job Superintendent. The answer should reflect considerable detail, to clarify any implication of conflict between different responsibilities of a given individual.

(iii) Does the quality assurance manual specify in writing that (1) the Principal Field Engineer has been directed to communicate directly with the Vice President for Construction on quality assurance matters; and (2) that quality assurance inspectors have the authority to stop work.

Supplemental Decision (ALAB-143), Sept. 6, 1973, in the matter of Duke Power Company, William B. McGuire Nuclear Station, Units 1 and 2, Docket Nos. 50-369, 50-370, p. 623-625.

A. Well, we wanted to have not only inside our company but in all different boards and organizations that were reviewing Quality Assurance, NRC, AEC, Staff Hearing Boards, Operating License Hearings going on, Construction Permit Hearings going on; and we wanted to have a uniform, throughout the company, nuclear program, a Quality Assurance Program and procedures that everyone understood.... (A)t Ocone and McGuire we were getting different reactions and different requests; and so we filed the document saying this is the way we are going to march, and we got the NRC to review that in its entirety and to approve it; and we said now apply that to Docket Number so and so and so and so; and that is all the nuclear plants, and that resolved such questions as you have cited here, lack of documentation as to where somebody reports. (See Attachment 9A for this and other selected passages of Mr. Lee's deposition.)

This topical approach may have eased the regulatory difficulties for DPC in the early 1970's, but it has made public acceptance of the safety of Catawba much more difficult in 1983.

Obviously, [redacted] neither respected nor implemented the NRC instructions to his company in 1974 to split up the QA/QC function from construction and engineering. In a blatant disregard for the laws established by Congress to govern commercial nuclear operation, [redacted] decided that the administrative inconvenience of scheduling employees' vacations took priority over complying with the law or the court, as demonstrated by the following remarks:

A. As we formed the Quality Assurance Department as a separate and independent entity, remember I was wearing two hats, Vice President of Engineering and Construction and the Corporate Quality Assurance guy. In order to get the technical aspects of Quality Assurance under way, I did not want at the outset to set up a separate payroll, separate vacation records and separate lines of administrative reporting and personnel record keeping and time sheets and whatnot, but I wanted functional authority, that is the procedures, the technical aspects, what was acceptable and not acceptable, came under my authority; but I wanted these people to stay for a time on the payroll of the line departments that were doing the work.

This was a management technique in order to get the independent route started, and it was after we had established the functional or technical or procedural aspects consistent with the topical report in Appendix B, that then I selected a Quality Assurance Manager and moved all the people under a new department and therefore both administrative and functional authority were vested in the Corporate Quality Assurance Manager, who reported for all purposes, to me.

But you have to start somewhere, and I elected the management technique of leaving administrative control and management under the existing line departments for starting out with functional control, so that my time was not spent deciding who could take vacations when, so much as here are the technical criteria we are going to put in place. See Attachment 9a.

██████████ plans for getting a separate QA program started are interesting. As Corporate QA Manager and Vice President of Construction/Engineering, he chose administrative convenience over regulatory requirements for nine years or nearly the entire construction period for McGuire and Catawba! The original organizational structure of DPC continued without accountability until 1981 when the welding inspectors finally "put their foot down" and refused to buckle to construction cost and scheduling pressure. (See infra, pp.42-45 of this petition.)

The DPC policy inherently defeated the key premise of Criterion I -- organizational independence and authority for QA personnel to do their jobs.

The welding inspectors who submitted documented complaints to DPC management (and eventually to the NRC) unilaterally complained of pressure from construction. Some of those complaints have been provided as attachments to this report as Attachment 10. (For a more comprehensive list of available documented complaints from the welding quality control inspectors, the Appendix to FOIA 83-200 is attached as Attachment 11.)

Concerns such as those below dominate the statements of over two dozen welders:

The biggest concern that I have as far as not being supported in implementing the QA program is the fact that at times resolutions and general gray areas have been watered down in order for craft to meet scheduling deadlines. A lot of these occasions have been exactly opposite of procedure requirements, yet the problems being brought up were to be ignored, because at this point quality didn't matter -- only deadlines. (Statement of ██████████, Attachment 10.)



, another welding inspector:

L.R.D. and C.R.B. have stated that it is part of their jobs to make decisions and judgments, ... when they do give verbal directions they do not always want to accept the responsibility for them:

L.R.D. notified the QC welding inspectors, at one time, that they were over-inspecting misc. steel welds, because they were holding the craft too close to design and QA procedures. If the welds were close to the requirements, they should be accepted. But, when the NRC came and found discrepancies, such as weld lengths too short (approx. 1/4") and weld sizes slightly under (approx. 1/32"), L.R.D. tried to place the full responsibility upon the inspectors and issue "A" violations to them. (Attachment 10.)

The subordination of QA to construction, in fact, has permeated the program from the beginning of construction.

Even outside consultants failed to convince DPC Management of the failure of its QA program. The Management Analysis Corporation (MAC), hired to handle the welding inspectors "problem" creatively divided the welding inspectors complaints into "technical and non-technical" areas. In this way the MAC task force resolved the specific technical complaints-weld by weld, but it failed to address the "non-technical" programmatic flaws that left the welders no choice but filing their massive complaints.

Essentially because the welders documented their specific concerns it is only their work that the public can be assured has been performed according to procedures and specifications.

Ironically, the Licensing Board seems to have missed that point and has narrowed the scope of the claims to allow intervenors to litigate only the welding concerns. Yet, it is just these welds, reviewed by those welding inspectors who "revolted" against the status quo, which are most likely to be adequate. Unfortunately for the public the procedural quality assurance breakdown revealed by the welding inspectors is site-wide and the programmatic weakness permeates the project.

The welding inspectors' information is now two years old. But other workers GAP has talked to confirm that the pressure continues.

A recent letter from a Catawba worker describes the current situation:

We have been under pressure for all this time to do what is/was necessary to make our work look good on paper. However, it is not the fault of the majority of the employees. We are constantly threatened with violations (A, B, or C) which can mean our jobs if we fail to do what we are told, whether it be right or wrong. (Attachment 26.)

Other QC inspectors have confirmed that procedures may have changed on paper recently, but in reality the construction force is given "carte blanche" to finish Catawba.

The INPO report also addresses the lack of independence under Section C, Pages 3 - 97, and Section D.3. (The INPO report should be reviewed by the Commission in its entirety, not simply the examples referenced for illustrative purposes.)

C. Failure to Maintain Adequate Controls to Process and Respond to Non-Conforming Conditions

Violation of 10 C.F.R. Appendix B, Criterion X and XVI

Nonconforming item reports ("NCI's") are the key safe award to assure routine identification and correction of QA violations. It does not matter if procedures are violated or if hardware is deficient. Nor does it matter if the violation involves 10 C.F.R., Appendix B, or DPC's own QA Manual. NCI's are sent to the NRC. Both NRC and utility officials study the reports to learn trends in particular QA deficiencies. The breakdown of the NCI reporting system at Catawba illustrates the breakdown of the entire QA program.

It is significant to note that the overwhelming majority of QA violations discussed throughout the INPO audit by QA/QC personnel, and by workers that GAP investigators have spoken with were identified on more informal substitute forms such as R-2As, M-4s, M-51s, VN's and frequently mere inter-office memoranda.<sup>6/</sup> The permanent non-conforming item (NCI) reporting system at Catawba has only identified a shadow of the QA violations. As a result, it circumvents normal oversight for the vast majority of necessary corrective action.

1. DPC Policy to Circumvent Non-Conforming Items (NCI)

In a May 1, 1974 revision to the Control of Non-Conforming Items, Procedure Q-1, the lines of construction authority over Quality:

<sup>6/</sup> M-4's detail procedures for visual and non destructive inspection of fieldwelds and M-51's for components supports, see page 74 of INPO audit.

Assurance were explained. (Attachment 12).

The Planning and Facilities Engineering (cost and scheduling) not QA/QC began the NCI process "by numbering the report, distributing appropriate copies, and retaining the original in the office pending file." (§ 4.2, Rev. 5).

Although QA was given limited input into the resolution of NCI's, the QA "hold point" was neither required nor binding. In fact as Para. 4.4 explains, the QA/QC inspector was only a glorified file clerk for the engineering staff:

After the resolution has been approved, the Non-conforming Item Report shall be returned to the Planning and Facilities Engineering Staff for processing. The Planning and Facilities Engineering Staff shall assign responsibility for corrective action to the appropriate personnel by checking the appropriate action assignment section on Form Q-1A. The Senior Quality Control Engineer or an engineer or inspector working for him shall verify the corrective action taken by completing the "action taken per resolution" section on the Q-1A report. The Project Quality Assurance Staff shall then file the completed form.

If QA/QC had even been given authority over the construction NCI files there might be a possibility that documentation could be retrieved, but that is not the case. As Paragraph 4.5 of Rev. 5 demonstrates there was no overall QA responsibility for maintaining the status on NCI's.

The Planning and Facilities Engineering Staff shall maintain a log of the status of all Nonconforming Item Report sheets. The status may be logged on Form Q-1C or a computer printout. If a printout is used, it should at least document the Nonconforming Item Report sheet serial number, a description of the nonconformance and the status of the resolution. Monthly, the Planning and Facilities Engineering Staff shall send a list to Design Engineering of unresolved nonconforming items for which they are responsible. He shall also distribute to the Construction Engineers a list of unresolved or incomplete nonconforming items for which they are responsible.

The last sentence of Paragraph 4.5 gives a particularly chilling insight into what DPC management considered the purpose of NCI trending lists:

These lists shall be used by Design Engineering and the Construction Engineers to expedite the completion of their responsibilities for resolving the nonconformance. (emphasis added)

## 2. In Process Inspections

In October 1982 NRC Region III inspectors/investigators conducted a comprehensive inspection of the Midland Nuclear Plant's diesel generator building. Among other things the inspectors discovered a procedural QA deficiency. That violation (excerpted below) is described in a February 8, 1983 letter from James G. Keppler, Regional Administrator, for ██████████, Vice-President of Consumers' Power Company.

QC Supervisors instructed QC inspectors to suspend an inspection if an excessive number of deficiencies was observed. Consequently, there was no assurance that a complete inspection was being performed after the reported deficiencies were corrected and we have found several instances in which final QC inspections were based on only the limited deficiencies reported during the initial inspection. In addition, this failure to report all identified deficiencies resulted in incorrect data being fed into your Trend Analysis Program, inhibiting your ability to determine the root cause of deficiencies and prevent their recurrence. (Attachment 13).

(Consumers Power was fined \$60,000 for this Severity Level III violation.)

The Nonconformance Procedure for Catawba, Revision 9, dated June 11, 1976, bears striking similarity to the situation discovered at Midland.

If a nonconformance is identified on material equipment, or activities in the course of installation or construction, the nonconforming activities or activities which affect the resolution of the nonconformance shall be stopped and not resumed until the resolution of the nonconformance is identified. Activities involving the material, equipment, or item which do not affect the resolution of the nonconformance may continue. The Project QA Staff shall be responsible for determining which activities may proceed. Where necessary, these activities shall be described in the statement of the nonconformance. (Attachment 14).

This procedure, a clear violation of Criterion X of 10 C.F.R. Appendix B remained in effect from 1976 through 1978. Then the violations of Criterion X and XVI increased.

By Revision 12, June 22, 1978, QC/QA inspectors were completely shackled to the Senior Engineer. They no longer had any authority to write NCI's without first getting approval. As 5.1(13) explained:

The Senior Engineer shall review the information recorded for clarity, completeness, and validity; have needed corrections or additions made by the originator; and sign and date to indicate his acceptance. If a report is determined to be nonvalid, this shall be explained in space 10. (Attachment 15)

Shortly, thereafter, Document Control began to issue sequential serial numbers only for approved NCI's.

It was approximately this same time period that the welding quality control inspectors on the Catawba site began to balk at the controls put on their quality judgment. For at least two quality control inspectors the '78 procedures represented a serious professional compromise.

Diaries, or logs, from the welding inspectors produced last May in the Catawba licensing proceedings reveal that some of the welding inspectors began keeping logs within months of the implementation of revision 12. (See Attachment 10 for welding inspectors concerns.)

Revision 14, pgs. 20 and 21, January 7, 1981 includes DPC's solution to "recurring" NCI's and QA/QC criticisms by both of the NRC and internal critics.

Welding inspectors have explained to us that this Revision 14 procedural change became the "turning point" for many welding inspectors. DPC put the "screws on" Catawba management to eliminate the NCI problems -- so Catawba management put the problem back on the quality control inspectors -- instructing them via Revision 14 to (1) get construction on design engineer management review before writing up the NCI and (2) explore all other alternatives to 'take care of the problem' by preventing recurrences. According to both documents and interviews, the "hoops" that quality control inspectors -- particularly welding inspectors -- were having to jump through to do their job became unbearable.

As the welding inspector's handwritten notes describe:

I do not feel that this direction is in accordance with the intent of QA procedure - Q-1, pg. 2, rev. B, para. 5-B. Procedure Q-1 requires that all Q-1As, initiated, to receive a serial number, although they still may be voided. L.R.D. and C.R.B. have not been following these QA requirements, for after reviewing a Q-1A, and they do not feel it should have been initiated, they discard the Q-1A without a serial number. Q-1, pg. 3, rev. 8, para. 5.1.4. (Attch 10)

Q-1A discarded without a serial number: A Q-1A was presented to L.R.D. for review and processing, involving welding with paint and foreign contaminants in the weld zone and the visual appearance of the root pass. Q-1A was not serialized or processed. L.R.D.'s explanation was that only a partial pene. weld is required and since a full penetration has been acquired, there is no problem. (Attch 10)

NCI was written because of piping material having two heat numbers on it. When called to take the NCI tags off of the pipe QC Welding found that there were three heat numbers on the pipe. When brought to the attention of Larry Davison I was informed that the resolutions on NCI's were of no concern of mine and to remove the Q1-B tags. This clearly violates M-4 and H4 and it is of my concern as a Duke Power employee and a resident of one of the surrounding towns. (Attch 10)

The technical review described above was procedurally rationalized with 5.1.2(b), Revision 15:

b. Review the information recorded for clarity, completeness, and validity, have needed corrections or additions made by the originator; and sign and date for 'Technical Review.' If a report is determined to be nonvalid, this shall be explained in the description of item space. If the nonconformance is such that some activities concerning the item may proceed, the activities which may proceed shall be stated. If no activities are stated, then no activities concerning the item are allowed. The report shall be forwarded to the Project QA Engineer for review. (Attachment 16)

The latest procedure available, Revision 17, still contains excessive weaknesses, but curiously it also contains the first requirement for a 10 C.F.R. 50, Appendix B Criteria XVI evaluation of each NCI. (Attachment 17)

The inclusion of 5.1.19 is far too little too late to provide meaningful answers to Criterion XVI questions about Catawba.<sup>7/</sup>

The procedural problems traced through a decade of Quality Control problems is not simply a paperwork breakdown. The INPO audit (Attachment 1) documents the results of a decade long nuclear construction program that had virtually no QA/QC check or balance.

The INPO findings should have come as no surprise to DPC/Catawba management officials, the welding inspectors have been warning them for years. Unfortunately the vindication of the welding inspectors comes too late to make much difference in the quality of the plant. A quality assurance program cannot be "retrofitted" into the plant.

#### INFERIOR SUBSTITUTES FOR NONCONFORMING ITEM REPORTS

There are a number of inferior substitutes to the NCI form being used to report nonconforming conditions. In particular, the R-2A (inspection discrepancy reports) governed by the R-2 procedures, is used on the bulk of nonconforming items. (See generally depositions of L. Davidson and C. Baldwin, June 29, 1983).

The R-2A is deficient from NCI's in at least seven respects:

- (1) NCI's identify the cause of the problem.
- (2) NCI's cannot be closed with an informal undocumented design change.
- (3) NCI's give inspectors the ability to stop work on a nonconforming item that needs to be isolated.
- (4) NCI's are sent to the NCI for review.
- (5) NCI's are trended in QA.

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<sup>7/</sup> An individual assigned in writing by the Project Manager or QA Manager shall perform a 10CFR50, Appendix B, Criteria XVI evaluation of the NCI. The following items shall be considered, as a minimum, in this evaluation: a) Are there possible Duke or industry generic implications? b) What is the root cause of the problem? c) What corrective action is required to prevent recurrence? d) Is this condition repetitive in nature to the extent corrective action should be implemented? e) Should this condition be investigated at other Duke sites? f) Is this condition significant?

- (6) NCI's have control numbers (once issued).
- (7) NCI's require written resolution.

The INPO reports the following about the R-2A's:

The performance of Construction corrective actions was reviewed. Responsibility for trend analysis of R-2A's (inspection discrepancy reports) recently was changed from QA to Construction. This review indicated the following areas of weakness:

- A. No trend analysis has been performed during the period 6-1-82 through 8-23-82.
- B. Construction has not performed any trend analysis of QA surveillance reports.
- C. Construction has not performed any trend analysis of nonconforming item reports.
- D. Statement of action on R-2A #5677 does not address all areas of concern. Piping system was pressurized prior to release by hydro group. R-2A did not address procedure violation nor safety implications.
- E. Action required on R-2A #M5350, although cleared by QA, has not been completed. (INPO Report, at 43).

The INPO report further observes the following in the section of corrective action:

- 1. Deficiencies were noted in Forms R-2A (Inspection Discrepancies) where the Quality Assurance group.
  - A. accepted the statement of action required when the action did not address the root cause of the problem or
  - B. approved clearance of the R-2A when corrective action had not yet been taken.

Specifics of the examples are discussed in Performance Evaluation Details for Objectives No. CC-6, Items 1.D and E.

In short, R-2A's have provided Catawba management with a paper-work resolution to hardware problems. In the past Catawba was criticized for having "too many NCI's" by the NRC.<sup>8/</sup> The solution has been to write R-2A's, or some other substitute like M-4's, or M-51's instead.<sup>9/</sup>

<sup>8/</sup>

SALP Report I, supra p.4.

<sup>9/</sup> Procedure M-51 requires the inspector to fill out an M-51C Form to identify discrepancies noted during hanger inspections. The forms are then returned to the craft for correction. Management is not made aware of problems noted, and no trending of these discrepancies is developed and analyzed to evaluate basic causes and address generic problems.



██████████ testified that there used to be twenty-five NCI's per week, now there are only two. (Charles Baldwin deposition, June 29, 1983, at p. 53. )

The legitimacy of the R-2A as a substitute for NCI's depends not so much on its procedural flaws, but on its implementation. Workers report to us that R-2A's are used liberally by both QA and construction to legitimize construction that pushes ahead of QA/QC inspections.

VOIDING THE NONCONFORMING ITEM REPORT

A particularly ominous method of cutting down NCI's at Catawba has been "voiding" or "verbally overriding" the NCI by management. It is as if it never existed. There is no record of it, nor any written record of the subject. ██████████ describes the process in his July deposition as follows:

- Q. Is there any form or documentation which you would document those instructions if your instructions were to the effect that the NCI was not a valid NCI, not valid to handle as an NCI?
- A. No, I did not document that.
- Q. What was the Inspector supposed to do with it, as you understood?
- A. Anything he would like. There wasn't any procedure requirement at that time. He could destroy it if he liked, keep it on file for his personal records if he likes.
- Q. Was there anyone other than the Inspector employed by Duke Power Company who was responsible for maintaining a file of those NCI's that were not pursued beyond that point?
- A. Ones that weren't approved?
- Q. Yes.
- A. No, not that I'm aware of.
- Q. Were copies of those unapproved NCI's filed with the Nuclear Regulatory Commission?
- A. No.
- Q. Did you maintain any records of circumstances where you determined that the proposed NCI was not a valid NCI?
- A. No.

(Deposition of ██████████, June 29, 1983, pp. 82-83.)

There can be no way to ever determine the number of NCI's that have been forgotten, discarded, voided, or destroyed. According to Mr. Baldwin there were "... numerous occasions" when the inspector did not write up an NCI report after talking to his supervisor. (Deposition p. 84.)

D. Failure to Maintain Adequate Material Traceability to Identify and Document the History of All Material, Parts, Components and Special Processes.

Criterion VIII -- Identifications and Control of Materials, Parts and Components

10 C.F.R. 50, Appendix B, Criterion VIII requires that identification and control measures be established to assure that each material, part or component "item is maintained by heat number, part number, serial number, or other appropriate means, either on the item or on records traceable to the item, as required throughout fabrication, erection, installation and use of the item." These measures "shall be designed to prevent the use of incorrect or defective materials, parts, and components". Similarly, Criterion IX requires control of special processes, including welding. To illustrate, the weld must be traceable back to a properly qualified welder using the proper procedure with the right filler material.

The full extent of material traceability deficiencies is unknown. But all indications are that the breakdown has occurred on a massive scale.

To illustrate, the INPO report concludes on page 32:

Finding (CC.3-1) Site receipt inspection does not ensure that material and equipment received on site are evaluated against the requirements of the procurement specifications. Examples of the problems identified may potentially result in delays, waste of materials, additional time spent on disposition of deviations from procured materials and work stoppage.

Finding (CC.3-2) A consistent method for material identification was not in effect in the warehouse. Several instances were noted where I.D. tags had fallen off, equipment was marked with ink; and when material was being sectionalized to start fabrication, a means for maintaining the identification was not being done.

Finding (CC.3-3) Proper protective measures were not taking place for environmentally sensitive equipment that was "robbed" for space parts. Some parts were being stored in an open door instrument cabinet.

Finding (CC.3-4) Procedure QFP-8.002 CNS, Rev 1A, does not indicate the disposition of unused filler material. Confusion appears to exist regarding handling of unused filler material and adherence to AWS code requirements could not be determined.

Finding (CC.3-5) Materials are not being maintained or stored effectively at work site locations. Several examples were noted which reflected improper control.

Finding (CC.3-6) Scheduled preventive maintenance activities on installed equipment are not always assured throughout the entire period of Construction Department control. Equipment was identified for which preventive maintenance had been canceled up to 21 months ago, and there was no evidence that compensatory requirements had been established.

There is also the question of the acceptance of material from other Duke sites for use at Catawba.

During a review of No. 10 cadweld operation in the Auxiliary Building, it was learned that the cadweld sleeves and powder had not been received by QC Receiving. These items were received from another site as non-quality items, and the QC inspector was not aware of the 16 51144 sleeves until notified by his supervisor. The work was stopped.(supra, )

E. Failure to Maintain an Adequate Quality Assurance Program for Vendors.

Criterion VII: Control of Purchased Material, Equipment and Services

10 C.F.R. Part 50, Appendix B, Criterion VII requires the applicant to establish measures that assure that purchased products "conform to the procurement documents" and provide "for source evaluation and selection, objective evidence of quality furnished by the contractor or subcontractor, inspection at the ... source, and examination of products on delivery". Documentary evidence of conformance to procurement requirements -- sufficiently identifying the specific codes, standards or specifications met by the purchased products -- must be available at the plant prior to installation or use, and retained at the plant afterwards. The applicant or its designee is also required to periodically assess the effectiveness of the control of quality by the source.

During the history of the Catawba construction, DPC has relied almost exclusively on itself for material, equipment and services. As a result DPC has not been plagued by the numerous problems that GAP has discovered at other facilities that relied exclusively on vendors for products and services. This autonomy has led to an impression that DPC has adequately controlled the products and services used in Catawba's construction. This impression however is not accurate.

The examples below illustrate that serious weaknesses exist in the vendor program.

To illustrate,

The following weaknesses were observed in control of HVAC contractor's welding program.

A. No welder knew the weld procedure under which he was working.

B. All welders knew required weld size and location, but did not know how they acquired that information.

C. No process control was available to specify the welding procedure for plenum erection (from Drawing CN-1684-VA-OOOH, Rev O).

D. Welder was making welds without removing galvanizing material.

E. HVAC support 2-H-VC-4999 had undercut in excess of that allowed by AWS D1.1 code.

F. Welder/supervisor picks welding procedure from all available welding procedures. Supervisor indicates welding procedure(s) used on a support after the support is complete.

and,

A review of the vendor audits of the HVAC contractor did not disclose any weaknesses in the program. Observations of HVAC support installation indicates the following weaknesses:

A. There is no traceability of weld procedures to the finished weld.

B. Procedures did not meet Code requirements.

#### IV. REQUEST FOR MONITORING OF OFFICE OF INSPECTOR AND AUDITOR (OIA) INVESTIGATION BY THE COMMISSION

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In April 1983 GAP requested an investigation by the Commission's Office of Investigations (OI). Our request, by letter dated April 21, 1983 was for an NRC investigation into unprecedented worker resistance to DPC violation of quality assurance criteria and professional code requirements. (Attachment 18). Subsequent to our request the investigation request was forwarded to the Office of Inspector and Auditor (OIA). In May 1983 OIA investigators began an investigation into the issues raised by our request. In May 1983 OIA investigators met with GAP officials to allegedly "review" documentation to establish the concerns our organization had about NRC Regional actions in connection with the "welding inspectors incident". (Infra, at 42.)

To date the NRC has not released any results regarding OIA's efforts. Our previous experiences with OIA however, leave little room for optimism for either comprehensive or timely results.

Unfortunately OIA's history has produced a dismal record of agency excuses for the misconduct of its employees. 10/

Since the misconduct of regional NRC employees in this case was such a serious breach of NRC policy regarding protection of workers' confidentiality, as well as other violations enumerated below, GAP is requesting the Commission to (1) monitor the ongoing OIA investigation for scope, comprehensiveness, and thoroughness, (2) review the implementation of internal NRC operation policies of the Regional Administrator, and (3) probe by the Executive Officer for Operations Support into the inconsistency of enforcement policies of Region II with the rest of the Regions.

A. Violation of NRC Policy and Regulations by NRC Personnel Regarding Protection of Witnesses and the Release of Draft Information to Utility

NRC policy regarding confidentiality of nuclear workers who give information to the NRC is, ironically, best explained in a speech given by Mr. James P. O'Reilly, Region II Administrator, to the Atomic Industrial Forum's 1983 Conference entitled "NRC's Response to Whistleblowers" (attached and incorporated as Attachment 19). 11/ That policy is reiterated in a June 27, 1983 letter from Mr. O'Reilly to GAP:

I reiterate that NRC policy is to grant confidentiality to the extent possible under law, to any allegor who requests confidentiality with respect to allegations which are considered by the allegor to be safety-related.

Mr. O'Reilly further explains his personal view of the successful implementation of this policy in Region II in his letter. (Attachment 20).

It is to be noted that I have scrupulously adhered to the policy in the past and will scrupulously adhere to it in the future.

10/ For a detailed account of GAP's direct experiences with OIA see testimony of [REDACTED] and [REDACTED] presented to the Oversight and Investigation Subcommittee of the Committee on Energy and the Environment, June 20, 1983.

11/ The text of the speech was provided to Palmetto Alliance in May 1983 as a response to its request for NRC policy regarding protection of whistleblowers, and also to GAP in a June 27, 1983 letter from Mr. O'Reilly on the same subject.

Unfortunately for the over two dozen welder inspectors at the Catawba construction site Mr. O'Reilly's view of reality is, at best, fanciful.

① To illustrate, in October 1980 two lead welding inspectors finally gave up on DPC to resolve their technical concerns or take care of the harassment and intimidation to which the inspectors were subjected. They went to see the resident inspector, at that time, a Mr. G. F. Maxwell. Mr. Maxwell unfortunately was obviously not aware of any NRC policy or of Mr. O'Reilly's policy regarding confidentiality of workers. His breach of their confidence is outrageous.

The details of this breach are best described in the deposition of ██████████ at Catawba. ██████████ has consistently been the prime target of workers' complaints regarding harassment, intimidation, falsification of records, and violations of QA/QC procedures. (Attachment 20) <sup>12/</sup> Mr. Davidson first described his NRC "notice" of the complaints of his workers in an interview with ██████████, a consultant hired by DPC. (The notes of that meeting are included as Attachment 21). The following excerpt from ██████████ note confirms that Mr. O'Reilly's "scrupulous adherence" to workers confidentiality excluded the Catawba welding inspectors.

In October 1980 -- NRC Inspector (Maxwell) informed Davidson that WI's are bringing problems to him ... inspectors keep books -- are encouraged to do.

██████████ further describes this meeting on pages 16-29 of his July 13 deposition. Of particular concern to us is Mr. Maxwell's apparent disclosure of the identities of those inspectors who came to him (pp. 21, 22) as well as his revelation to ██████████ that the welding inspectors were keeping "a black book list of items they were not happy with ...". (Deposition pg. 20).

Of course, if the workers had not requested confidentiality perhaps Mr. Maxwell's disclosure could be explained, though not excused. However it is the Regional Administrator's position that the contacts were under the request of confidentiality. In fact in an August 12, 1983 NRC Response to a Freedom of Information Request (FOIA) for "all agency records and information related to and/or generated in connection with an investigation at the

<sup>12/</sup> The deposition was taken July 12, 13, and 14, 1983 in the Matter of Duke Power Company, Docket 50-413, 50-414.

Catawba Nuclear Power Plant in South Carolina in "Concerns of Welding Inspectors" Mr. O'Reilly details the confidentiality of informants as the bases for withholding groups of records responsive to our request. (Exhibit 11) Throughout the letter -- Mr. J. M. Felton, Director Division of Rules and Records of the Office of Administration reiterates his statement:

The detailed names are of individuals who were confidential informants who provided information during an agency investigative effort.

Mr. Maxwell left the Catawba facility as NRC resident inspector in late summer 1980. He was replaced later by a Mr. P. K. VanDoorn was obviously not familiar with the "scrupulous" confidentiality policies of Mr. O'Reilly either.

② Unfortunately for the workers, Mr. P. K. Van Doorn not only failed to acknowledge the seriousness of the Catawba problems that he inherited, he compounded them. He learned of these concerns upon his arrival in February 1981 on the site. (See deposition of P.K. Van Doorn, pp. 98, 99, May 19, 1983).

② Not until a year later, in February 1982, did he react to the warnings from the welding inspectors of major QA problems, pressure from construction. Their allegations this time included falsification of documents, harassment, intimidation, and a systematic historical breakdown of the QA program. (See Memo to File, P. K. Van Doorn, March 15, 1982. (Attachment 21).

Surprisingly Mr. Van Doorn's reaction to the above allegations was entirely inconsistent with the hypothetical response to just such a situation described in Mr. O'Reilly's speech to the Atomic Industrial Forum. (Attachment 19).

Now, in accordance with your request, I will describe for you, with an example, the process by which the NRC responds to all allegations relating to nuclear activities. Please note that almost all allegations are unique. They involve different locations, different circumstances, and different individuals. Let's presume, for my example case, however, that an alleged informs an NRC Regional Office that certain specific welds at a nuclear power plant do not meet regulatory requirements.

The allegation may have been received by telephone, personal contact with NRC personnel, notes - either signed or anonymous, or from news media representatives. A prompt preliminary evaluation of the allegation by the NRC, whatever its source, will determine the initial NRC response and the Regional Office group assigned to address the issue. In this example on welding, a technical issue is involved which would be assigned to one of our technical inspection groups.

Other possible NRC reactions would be determined by whether or not the allegation involved misconduct or wrongdoing. In such a situation, the NRC Office of Investigations would become directly involved. The Office of Investigations is a staff office reporting directly to the Chairman of the NRC. It is staffed by professional investigators residing in both headquarters and regional offices. This group investigates allegations involving potential or alleged misconduct or wrongdoing and is available to support the Regional Office's technical inspectors' pursuit of issues which require significant interviewing of individuals. Similarly, should an investigation of alleged misconduct or wrongdoing involve issues where technical assistance is necessary to conduct the investigation, the technical staff would provide support to the Office of Investigations.

An example of how the Office of Investigation would become involved can be demonstrated in the welding example. Let us assume that the initial inspection of the defective welds reveals that certain records may have been falsified. At this point, the purely technical issue has expanded to include the possibility of wrongdoing. The Office of Investigations would then be called in for the specific purpose of investigating the issue of falsified records. In general, falsification of records required by the NRC, could constitute a material false statement and in certain cases, a criminal offense.

2 Yet, even in the light of the policy instructions which were presumably given to Mr. Van Doorn by Mr. O'Reilly no referral of the concerns of the welding inspectors was given to the Regional personnel responsible for investigating deliberate utility wrongdoing.

Instead, key Region II personnel reviewed and confirmed their previous decision of January 29, 1982 to allow a DPC Task Force to address the issues raised by the welding inspectors. (See R.C. Lewis' memo May 18, 1982, incorporated and attached as Attachment 22.) This action reveals a mentality that is equivalent to allowing the fox to inspect the fence around the chicken coop.



Finally, as the welding inspectors "were left slowly twisting in the wind" <sup>13/</sup> the NRC inspector they had turned to for help was busy insuring that DPC had all the information available. In a December 20, 1982 memo to file George Grier, DPC Corporate Manager, describes notes given to him that date by P. K. Van Doorn. "Attached are notes from Kim Van Doorn...Kim will be recommending that no further interviewing is necessary in regards to his matter."

(3,4) The resident inspector gave this memo to the utility on December 20, 1982. (Attachment 23). By doing so Mr. Van Doorn not only violated the confidence of workers who came to the NRC in good faith but he also violated the NRC's policy regarding release of draft information. <sup>14/</sup>

A January 7, 1983 IE Report (50-413/82-32 and 50-414/82-30) confirms that the inspection was ongoing. The report, included as Attachment 24, reveals that, as of January 7, 1983, the investigation/inspection was ongoing. An undated memo from P. K. Van Doorn to J.Y. Yorse, Chief Investigator in Region II (Attachment 25) removes any doubt that the Resident Inspector did not understand the seriousness of the welding inspectors allegations.

B. Violation of 10 C.F.R. § 1.64, Duties of  
the Inspection and Enforcement - Regional Directors

10 C.F.R. § 1.64 states that:

The Office of Inspection and Enforcement develops policies and administers programs for: Inspecting licensees to ascertain whether they are complying with NRC regulations, rules, orders, and license provisions, and to determine whether these licensees are taking appropriate actions to protect nuclear materials and facilitates, the environment, and the health and safety of the public; inspecting applicants for licenses, as a basis for recommending issuance or denial of a limited work authorization, construction permit, or an

<sup>13/</sup> This description was used by one of the welding inspectors to describe how they viewed the lack of NRC support.

<sup>14/</sup> NRC policy regarding release of draft inspection and/or investigation reports is stated in the NRC Inspection and Enforcement Manual, § 1005, and clarified in a March 8, 1983 letter from C. Nunzio Palladino to Congressman Edward S. Markey in response to a question regarding the policies regarding the release of draft inspection reports. The letter states, "current NRC policy prohibits the release of draft inspection reports without the express permission of the Executive Director for Operations".

operating license; inspecting suppliers of safety-related services, components, and equipment to determine whether they have established quality assurance programs that meet NRC criteria; investigating incidents, accidents, allegations, and unusual circumstances including those involving loss, theft, or diversion of special nuclear material; enforcing commission orders, regulations, rules, and license provisions; recommending changes in licenses and standards, based on the results of inspections, investigations, and enforcement actions; and notifying licensees regarding generic problems so as to achieve appropriate precautionary or corrective action ... NRC's five Regional offices are responsible for carrying out inspections and investigations.

Problems at the Catawba facility cannot be blamed entirely on the licensee. The Congress of the United States was very clear in its mandate to the early Atomic Energy Commission ("AEC") that monitoring civilian nuclear power projects was to be a major part of its task. At least part of the responsibility for the problems at Diablo Canyon, Zimmer, Midland, and Three Mile Island have rested with the regulators who "looked the other way" at utility misfeasance or lethargic implementation of regulatory requirements.

In this case, the Regional Administrator responsible to the Commission, and ultimately to the public for the safe construction and operation of Catawba has failed to detect generic problems with the QA/QC program, the design control deficiencies, and the subsequent hardware problems.

⑤ As pointed out in this report (supra, p.16 ) it was not until 1982 that DPC implemented its 1974 commitment to split the QA/QC function from Construction and Engineering. In this case DPC management has not just dragged its feet about bringing the Catawba construction project into compliance with 10 C.F.R. requirements -- it has refused to do so. The Commission must ask Mr. O'Reilly why he never requested even an explanation of that situation.

Further explanations are needed to explain why the Regional Administrator did not respond to the serious allegations of harassment, intimidation and falsification of records brought to his attention by the resident inspector in January 1981.

Finally, in light of the generic deficiencies revealed in the INPO report (Attachment 1), we request that OIA audit the regulatory program at Catawba in an attempt to determine or explain why DPC was allowed to build this plant according to the undocumented intuition of management, instead of to 10 C.F.R.

C. Violation of 10 C.F.R. § 1.64(b), Duties of the  
Executive Officer for Operations Support

10 C.F.R. § 1.64(b) states that the Executive Officer for Operations Support is responsible for, among other things, "developing requirements for enforcement and investigations; and "assuring consistency of the enforcement program among the various offices."

After a review of the documents on the public record it is clear that the implementation of the Commission's enforcement program has specific inconsistencies in relation to findings, violations, and programmatic deficiencies at the Catawba facility.<sup>15/</sup> We list four examples as illustrative of our observations. These examples are not intended to be comprehensive.

1. In Process Inspection Notices ("IPIN")

In Section III, C of this petition (supra, p. 18) we describe this practice, first as identified and acknowledged by Consumer Power Company (CPC) at its Midland Nuclear Power Plant (Units 1 and 2) in IE Inspection Report 83-01 (Docket Number 50-329/330) and then as described in Catawba's Quality Control procedure, Revision 9, "Control of Nonconforming Items."

We will exclude a detailed restatement of the evidence available to the Commission. A full record of desposition testimony as well as workers statements confirms that the practice of either construction or Technical supervisors halting QC inspections "in progress," and subsequently requiring either rework, reevaluation, or "voiding" of NCI's has been common practice at Catawba since at least late 1977.

The trending and documentation issues raised by this practice are the subject of another portion of this petition (supra, at 23) yet Region II's acceptance of this practice without recognition, violation notice, or enforcement action is unexplainable.

Consumers Power Company (CPC) was fined \$60,000 for the IPIN practice. Regional Administrator Keppler ordered a technical resolution which requires 100% reinspection of all inspections affected by this practice.

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<sup>15/</sup> Catawba is the first and only Region II nuclear plant under construction that we have had experience with. We have worked with Region I, III, IV and V on problems at other plants.

Although a few problems requiring corrective action were identified (i.e., four unacceptably installed pipe hangers), the majority of the NRC independent measurements did not disclose hardware problems. ... recognizing that significant construction deficiencies could have resulted from the quality assurance problems identified during this investigation, the NRC has required the establishment of a comprehensive quality confirmation program to determine the quality of plant systems important to nuclear safety. The NRC will confirm the adequacy of the program and may make additional independent verifications. Deficiencies identified by these programs will require resolution prior to issuance of an Operating License.

The results of this investigation and our review of your 10 CFR 50, Appendix B, noncompliance history reveal an additional matter which is of significant concern to us. This matter concerns inadequate corrective actions. The results of our normal inspection program for the construction and testing of Zimmer indicate you were found in noncompliance forty-four times since December 1979 with thirteen of the eighteen different criteria of Appendix B to 10 CFR 50. During our Systematic Assessment of Licensee Performance review on December 16, 1980, we expressed concern with your relatively poor performance in this area. This poor history of compliance with 10 CFR 50, Appendix B, when considered with the recent findings of the investigation indicates that your corrective actions only addressed individual problems and not underlying programmatic causal factors. Consequently we request that you review your history of noncompliance with 10 CFR 50, Appendix B, for the past two years and in your response to this letter provide those steps you have taken to address and correct the underlying programmatic causal factors related to the noncompliance.

Two years later at Midland a \$120,000 civil penalty was imposed following the discovery of a quality assurance breakdown. Midland was 87% complete. The February 8, 1983 states:

The results of the inspection indicate a breakdown in the implementation of your quality assurance program as evidenced by numerous examples of noncompliance with nine of the eighteen different criteria as set forth in 10 CFR 50, Appendix B. The breakdown was caused by personnel who failed to follow procedures, drawings, and specifications; by first line supervisors and field engineers who failed to identify and correct unacceptable work; by construction management who failed to call for quality control inspections in a timely manner, allowing a backlog of almost 16,000 inspections to develop; and by quality assurance personnel who failed to identify the problems and ensure that corrective actions were taken. As a result,

you failed to fulfill your primary responsibility under Criterion 1 of Appendix B to 10 CFR 50 to assure the execution of a quality assurance program. In addition, of particular concern to the NRC is the fact that quality control (QC) supervisors instructed QC inspectors to suspend inspections if excessive deficiencies were found during the performance of inspections. Consequently, not all observed deficiencies were reported, and complete inspections were not performed by all QC inspectors after the reported deficiencies were corrected.

The evidence that has been available to Region II about a quality assurance breakdown at Catawba is more comprehensive, better documented, and virtually undeniable. Yet Catawba has reached 84% complete with a clean bill of health.

10 CFR § 1.64(b) requires reasonable "consistency" among the regions. It is unreasonable that the public living near Catawba should accept a lesser standard of quality and safety than the public in Ohio or central Michigan.

We urge the Executive Office for Operations Support to compare the QA/QC record of Midland, Zimmer and Catawba. 17/

### 3. Control of Contract Welders and Welding Procedures

The October 1982 INPO report makes the following observations about welding and welding procedures of the HVAC contractor at Catawba:

No welder knew the weld procedure under which he was working.

Welder/supervisor picks welding procedure from all available welding procedures. Supervisor indicates welding procedure(s) used on a support after the support is complete. (Attachment 1, p 36)

The response promised by DPC was

A review with Bahnson personnel confirmed that the sign offs on the weld procedures constituted verification that the procedure meets the requirements of AWS D-1.1. A letter is forthcoming to verify this. (INPO, p. 147.)

17/ Of particular interest to us on this subject would be the analysis of Ms. Elinor Adamson Unit 4 Branch Chief of the Office of Nuclear Reactor Regulations (NRR). Ms. Adamson is Branch Chief over Unit 4 which includes both Midland and Catawba.

Similar situations at other plants have led to enforcement fines, ordered reinspections and rework for welding performed by unqualified or uncertified welders and/or welding done to unapproved procedures.

At Catawba no violation notices were issued for the welding deficiencies, no NRC review was conducted of the work of the unqualified/unverified welders, and no other enforcement action was taken by Region II. There has been no serious attempt made to determine the extent, or the cause of the HVAC welding problems. No questions have been raised to DPC and no explanation has been provided from them about (1) how many welders were unqualified, (2) what procedures were flawed, (3) what action has been taken to identify all the welding of those unqualified welders, (4) when was the last audit DPC performed on the HVAC contractor, (5) how long have the procedures been non-conforming, and (6) what changes have been made to prevent this from recurring.

#### 4. Harassment and Intimidation

This petition (infra, p. 41 to 45) has requested the Commission direct the Office of Investigations (OI) to perform an investigation into the improper handling of the welding inspectors' harassment and intimidation complaints by DPC management.

We also request under § 1.64(b) that the Commission's Operations Support Office review the entire record available on the welding inspectors charges of harassment and intimidation<sup>18</sup> / and compare the evidence with that used to support the \$50,000 harassment/intimidation civil penalty fine at Zimmer in 1981.

In that case the NRC found that contrary to both 10 CFR 50 and CG&E policies

QC Inspectors did not have sufficient freedom to identify problems and were not sufficiently independent from cost and schedule. The results of interviews indicate that some QC Inspectors were: (a) harassed by construction workers and supervisors; (b) not always supported by QC management; and (c) intimidated.

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<sup>18/</sup> This information can be obtained by a review of the documents listed in Attachment 11, Freedom of Information Act (FOIA) 83-200, and other relevant documents produced under discovery of "Contention Six - Quality Assurance" in the ASLB licensing proceedings. Docket 50-413, 50-414.

Examples of "insufficient freedom of QC inspectors, including insufficient freedom from cost and schedules: were listed as:

1. Five QC Inspectors interviewed executed signed sworn statements wherein they claimed they were doused with water (while engaged in the performance of inspection duties) by construction personnel. Two other QC Inspectors made similar statements.
2. A QC Inspection supervisor claimed that over his objections qualified QC Inspectors who were doing thorough jobs were reassigned by QC management because of complaints by construction personnel.
3. Two QC Inspectors executed signed sworn statements wherein they claimed they had been harassed by being searched for alcohol by security personnel at the request of construction supervisory personnel. One other QC Inspector made a similar statement.
4. A QC Inspector executed a signed sworn statement wherein he claimed the QA Manager had threatened to fire him after construction personnel complained he had used a magnifying glass to visually inspect a weld when in fact he was using a mirror and either device was an acceptable tool.
5. A QC Inspector executed a signed sworn statement wherein he claimed he was struck by a stream of water from a fire extinguisher while performing an inspection.
6. A QC Inspector executed a signed sworn statement wherein he claimed he was threatened with bodily harm by a construction person if he did not pass a weld.
7. A Lead QC Inspector executed a signed sworn statement wherein he claimed:
  - a. He was accused by the QA Manager for holding up a concrete pour when in fact the delay was caused by the concrete trucks being late.
  - b. Construction management frequently approached QC Inspectors and challenged their inspection findings and questioned their judgment.
  - c. The QA Manager said things like, 'our job here is to accept, not reject, and we are here to get this plant built.'

8. A Lead QC Inspector executed a signed sworn statement wherein he claimed he was relieved of his inspection duties because he continued to submit legitimate nonconformance reports over construction management objections for deficient welds on pipe support hangers. He also stated that QA management had previously told QC Inspectors to not write anything to make Kaiser look bad.

9. A QC Inspector executed a signed sworn statement wherein he claimed he was told by QA management to accept inspected items that were unacceptable.

We know of no other case except Catawba where so many inspectors (over two dozen) provided so much concrete evidence to support their claims of harassment, intimidation and lack of independence from cost and scheduling. (See documents listed in Attachment 11).

The actions of a mid-level manager who threatens "to throw someone off scaffolding" if an inspector writes another NCI or the brandishing of a shotgun to a QC inspector constitute the deliberate violations of 10 CFR Part 19, and 24 CFR Part 24, §210.

DPC has a duty to enforce those laws. The absence of DPC's willingness to confront the harassment and intimidation complaints of its employees, dismissing them as "non-technical concerns" are the equivalent of condoning these activities.

Information available on the public record does not explain why Region II did not take any enforcement action to insure that Duke's Catawba Management understood that 10 CFR Part 19 was applicable to them as well as all the other utilities.

Just as the public is entitled to equal protection from health and safety hazards that could result from poor nuclear construction, nuclear construction workers are entitled to equal protection under the Atomic Energy Reorganization Act.

#### V. Request for a directed OI investigation

By letter dated April 21, 1983 GAP requested the Office of Investigations (OI) to open an investigation into certain serious allegations -- including harassment, intimidation, falsification of records, and approval of non-conforming items -- brought to the attention of both Duke Power Company Management and the NRC throughout 1980, 1981, and 1982.

To date, no OI investigation has begun. It is our understanding



that our request was forwarded to the Office of Inspector and Auditor (OIA) in May of this year, and that the investigation is still ongoing. However, even a closed OIA report, regardless of the outcome, will not deal effectively with the question of deliberate utility violations of the Atomic Energy Reorganization Act.

We believe that it is critical that OI begin their investigation immediately, therefore we request that the Commission exercise its authority and request the investigation.

Our own review of the voluminous amount of information regarding the entire episode, referred to as the "welding inspectors incident" indicates that both the NRC staff and the utility misjudged and mishandled the warnings of QA/QC inspectors.<sup>19/</sup> Only a complete, thorough investigation by the appropriate branches of the agency can resolve whether the mishandling and misjudgment was deliberate.

The chronology of events presented below clearly indicate the need for an investigation. Catawba workers that GAP investigators have talked to confirm our own findings and conclusions. More important, they confirm that QA/QC procedural flaws, harassment/intimidation of quality control inspectors and hardware problems continue on the site. (See Attachment 26 , affidavit of [REDACTED])

Unfortunately, the workers have nowhere to go with their problems -- all roads lead back to Duke. Even our organization has determined that there is inadequate independence of the Regional NRC office from Duke Power Company. In the current regulatory vacuum we cannot, in good faith, provide the NRC with workers' affidavits -- we have no confidence that the workers' confidentiality or information (thus their identity) will be protected (see Attachment 19, June 27, 1983 letter from Mr. James P. O'Reilly to [REDACTED] regarding confidentiality), and we have no confidence that the workers' information we would provide will be adequately addressed.

#### Summary of Welding Inspector Incident

In late 1977 and early 1978 procedural changes in the Q-1, Non-conforming Item System, were implemented at the Catawba construction site. These changes took authority from the Quality Control Inspectors and placed it with technical supervisors. The Technical supervisors worked directly under and closely with construction/engineering.

<sup>19/</sup> See Attachment 27 , "Groups Voice Catawba Plant Safety Questions," Charlotte Observer, June 26, 1983.

In 1978 [redacted] began to document problems that he, as lead welding inspector, had identified as in non-compliance with the approved procedures. Soon after, other welding inspectors also began to write down, in logs or diaries, items which they were told to "not write up" as a non-compliance ("NCI") or incidents in which they were told to "sign off" on items which they did not approve. In most of these incidents the welding inspectors objected to the instructions, and documented their objection and any resulting arguments. This continued throughout 1978 and 1979. Relations between the welding inspectors and the technical supervisors and QA/QC management continued to deteriorate.

In the summer of 1980 two of the welding inspectors decided that the situation of construction and QA/QC supervision overriding NCI's had gotten out of hand. They went to talk to the resident NRC inspector. Within days, the resident inspector had reported the complaints of the inspectors back to the main target of their complaints, he also informed DPC of the fact that the welding inspectors were keeping logs of the changed NCI's. The resident inspector left Catawba in late summer 1980.

In January 1981 DPC management and the NRC met to discuss the "welding inspectors concerns." In February 1981 the new resident inspector arrived, Mr. P.K. VanDoorn. During this same time period the Systematic Assessment of Licensing Performance (SALP) was released and a special team inspection was conducted at Catawba -- both revealed quality assurance/quality control problems. During the same time period a large number of specific quality assurance-related deficiencies, violations, and discrepancies appeared in IE reports. (See IE reports 1977 through 1981.)

In June/July 1981 Duke Power Company decided to "downgrade the pay" of the welding inspectors. The inspectors complained that the downgrading was a direct result of their continued implementation of QA/QC procedures on the site. They began the official complaint procedure through Duke Power Company's employee recourse process. In December 1981 their complaints were reviewed by the Chairman of the Board, [redacted]. He rejected their complaints. However, he initiated a task force to deal with their concerns.

Three weeks later the task force finished its report, dismissing the problems. This was reported at a meeting with the NRC in January 1982. The welding inspectors, however, again went to the NRC and reported that the task force was a "whitewash." These complaints were transmitted back to Duke Power Company. Duke then initiated a second task force and hired the Management Analysis Corporation (MAC) to conduct a review of the problem with "skilled interviewers."

MAC's contract with DPC included a provision that MAC be prepared to testify for DPC in the operating license hearings, if necessary.

On March 24, 1982 W.J. Tobin, Regional Investigator provided C.E. Alderson the Director of EIS with the initial summary of Case No. 2G022. He attached two memos from VanDoorn which "Jack Bryant suggests we date as March 15, 1982." The memo stated among other things:

I am impressed with the magnitude and specificity of these concerns, as I am with the fact that we are dealing with \_\_\_\_\_ employees, versus an isolated former employee, who are apparently presenting their concerns to the Duke task force reviewing welding problems at the Catawba site. (Attachment 28)

In May 1982 the Duke Power Company management made a presentation to Region II personnel, including the Regional Administrator. Their conclusions are included in a two-volume report available in the Public Document Room, entitled, Welding Inspectors Task Force. Essentially the MAC task force and subsequent corrective action dealt with the problems by (1) talking to all the welding inspectors, (2) identifying all of their concerns, (3) dividing up their concerns into "technical and non-technical" (4) having all of the technical complaints either repaired, re-evaluated, or re-worked until the complaining inspectors were convinced that all of their specific problems were solved, (5) recommending to Duke a strengthened communication program between the inspectors and construction personnel. The task force did not address the question of harassment, intimidation, or procedural QA/QC flaws.

In late August 1982 another meeting took place between the NRC and DPC about the welding inspector concerns. Soon after, the resident inspector went to see DPC employee Bradley to "scan" the files of the information contained in the MAC report, and to notify DPC that he was about to begin his investigation of the welding inspectors' concerns, and would notify them of his findings.

On December 22, 1982 P.K. Van Doorn met with \_\_\_\_\_ to discuss his findings during his investigation. He also gave \_\_\_\_\_ Manager, a copy of his notes--which included a summary of the concerns of Catawba welding inspectors. On January 7, 1983 an IE report was issued which contained a partial resolution on the case, but which held open NRC review of the corrective action

In February 1983 the "case chronology records" of Region II report that the case was closed. In March 1983 the case is reported closed in an IE report.

In March 1983 the Palmetto Alliance was granted discovery of Contention Six and Seven regarding Quality Control/Quality Assurance issues in the ASLB operating licensing proceedings. In response to interrogatories about "disputes between management and workers" the information about the welding inspector complaints was revealed by Duke Power Company.

In June 1983 [REDACTED] filed a second employee recourse complaint to protest the low ( a "2" on a scale of "5") performance rating that he received. It was the first rating he had ever received that was not outstanding. He protested that the low rating was a direct result of the complaints he had raised about QA/QC violations and harassment. He also complained that the new supervisor, [REDACTED] had been brought in to build a negative record on his performance.

By July 1, 1983 [REDACTED] had been removed as his supervisor. [REDACTED], and [REDACTED] had been counselled about the fact that the Intervenors would be putting the "worst face possible" on words like "harassment, intimidation, and falsification of records."

In August 1983 welding inspectors continued to file employee recourse complaints about harassment and intimidation by their supervisors.

(All of the documentation detailing the above record is available by a review of the documentation provided in discovery in the Catawba licensing proceeding. In the event that the Commission would like GAP to present a detailed documented chronology of the welding inspectors experience at Catawba, we will do so.)

#### Conclusion-

The laws governing the construction of nuclear power plants were not written to be applied differently in five areas of the country. Nor was Criterion B of 10 C.F.R Part 50 written as a guide for the utilities to implement at their leisure. Yet Duke Power Company management decided that QA/QC independence was an option at Catawba, not a requirement.

It was not an accident that Catawba was rated below average in the first SALP report. It deserved that rating. Unfortunately for the residents that surround the Catawba plant and for the municipalities that have purchased the plants' power Catawba is still below average.

All the other plants in the original "below average" category have since undergone major reinspections. These reinspections have discovered major hardware problems that have required years to identify, repair, and rework. It is an illusion to think that Catawba does not also need to be scrutinized because it was built by Duke Power Company. There is no footnote in the law that excludes Duke from it, and there are no inspection standards which exempt a plant from the stringent quality control requirements that Congress has placed in the law.

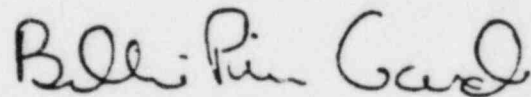
It has taken, as it always seems to take, a group of quality control inspectors who were willing to risk their jobs and their careers with Duke Power to demand that QC be implemented at the Catawba site. They were successful.

If the Commission fails to intervene on behalf of the QC inspectors, however, they will have all raised their complaints in vain. The Regional Director has decided that this was Duke's problem, and he let Duke handle it in their own way. But just as the utilities are not exempted from the consequences of isolated incidents which come to the attention of the NRC, the Regional Administrator cannot be exempted from establishing a regulatory atmosphere that does not tolerate any harassment or intimidation of nuclear workers.

Mr. O'Reilly has placed the burden of standing up to licensee management squarely on the back of the workers to insure that Catawba is built according to 10 C.F.R. That is the responsibility of this Commission.

We look forward to your response to this Petition in the near future.

Sincerely,



Billie Pirner Garde  
Director  
Citizens Clinic

cc/w enclosures

Service List, ASLB

H. Denton, NRR  
D. Eisenhut, NRR  
T. Rehm, EDO  
V. Stello, IE  
B. Hayes, OI  
J. Cummings, OIA  
W. Dircks, EDO  
J. O'Reilly, IE, RII

cc/wo enclosures

P. McKenna, OIA  
E. Adamson, NRR

U.S. NUCLEAR REGULATORY COMMISSION  
Office of Inspector and Auditor

Date of transcription February 24, 1984

Report of Interview

George F. Maxwell, Senior Resident Inspector, U.S. Nuclear Regulatory Commission (NRC), Shearon-Harris Nuclear Power Plant, Wake County, North Carolina, was interviewed concerning his knowledge of NRC's handling of various allegations raised by welding inspectors employed by the DPC Power Company (DPC) at the Catawba Nuclear Station (NS), Rock Hill, South Carolina. During the interview, Maxwell provided the following information in elaboration of the testimony he provided to the Atomic Safety and Licensing Board Panel concerning Catawba NS:

On February 11, 1980, Maxwell was transferred to the Catawba NS to be the Resident Inspector (RI), and was the Catawba NS Resident Inspector until July 18, 1980, when he was transferred to the Shearon-Harris Nuclear Power Plant. On June 17 and 18, 1980, while he was conducting a routine RI inspection, Maxwell noticed welding inspectors using black personal notebooks to record their observations while they conducted routine, in-progress surveillances of structural welding activities covered by the American Welding Society (AWS) standard. These welding inspectors were not complying with DPC's Q-1 procedure which required welding inspectors record deficiencies noted during surveillances of AWS welding activities on an M-19F form or another appropriate Quality Assurance form. Maxwell questioned the welding inspectors about their practice of noting observations in personal notebooks and learned that the welding inspectors were, in fact, keeping a record of things they observed during AWS surveillances in their notebooks. Some of the information being recorded in the notebooks was the name of the welder and the particular rejects observed by the welding inspector.

The welding inspectors maintained a personal record on welders until sufficient deficiencies were observed to result in the preparation of a nonconformance report (NCR). Maxwell did not ask the welding inspectors if he could review the contents of the notebooks nor did he recall asking the welding inspectors why they were not following the DPC Q-1 procedural requirement for documenting deficiencies. Maxwell disagreed with the practice of documenting deficiencies on personal notebooks; therefore, he telephoned Mr. Nick Economos of NRC Region II Headquarters for guidance. Economos advised there was no black and white law that Region II could enforce against this policy. Maxwell then asked Economos to have Region II look into the practice because Maxwell believed that DPC management needed to know what the welding inspectors were finding during their surveillances. Plans were then made for Peter K. Van Doorn, a Region II inspector, to travel to Catawba during the first part of July 1980 to look into welding activities at the site. Van Doorn was selected for this review because of his expertise in the welding area. When Van Doorn came to Catawba during the first part of

Investigation on January 31, 1984 at Catawba Nuclear Station File # 83-52

by George A. Mulley Jr. Date dictated February 24, 1984

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July 1980, he reviewed the records maintained by the welding inspector supervisors. Van Doorn discovered that for several months, welding inspectors had not been documenting welding surveillance inspections on the appropriate forms. Instead, the welding inspectors were documenting their surveillances in personal notebooks. From the supervisor's records, Van Doorn determined that the surveillances were, in fact, being done; however, they were not being properly documented. As a result of this inspection, DPC was assessed a low-level category violation for surveillances not being properly documented. The violation was documented in Inspection Report 80-15, dated July 1, 1980, as item 3. Sometime during June-July 1980, Maxwell discussed the problem of welding inspectors not properly documenting surveillance findings with [REDACTED]. [REDACTED] was in charge of all welding inspectors. Maxwell informed [REDACTED] that welding inspectors (unnamed) were not properly documenting surveillances of structural welding and expressed his concern that DPC management would not be able to properly track welding deficiencies identified during surveillances. [REDACTED] told Maxwell that he would look into the problem. On July 18, 1980, when Maxwell departed Catawba for Shearon-Harris, DPC had not yet responded to the violation in Inspection Report 80-15.

During October 6 through October 10, 1980, Maxwell returned to Catawba to conduct a routine resident inspection (Inspection Report 80-31). Maxwell was directed to conduct this inspection because as of that date no resident inspector had been assigned to Catawba. During the inspection, Maxwell performed a follow-up inspection of previously identified items, inspected the installation of electrical supports and cables, and inspected equipment storage. Maxwell's follow up inspection required that he contact both electrical and welding inspectors. On October 7, 1980, while Maxwell was walking through the site to check on the progress of various activities, he came across some welding inspectors and welders who were working in the same area. The welding inspectors were talking very loudly and claiming they were dissatisfied with Catawba and that the project was all messed up. One of the welding inspectors claimed he was carrying a black book for "CYA" purposes. Maxwell asked why the inspectors thought the job was all messed up and one of the welding inspectors stated all the discrepancies were written in his black book. When Maxwell asked the inspectors about the black book he was told the inspector was documenting his observations in the book. Since this practice seemed to be a repeat of the documentation violation discovered in June 1980, Maxwell was concerned that the book contained specific nonconformances identified by the inspectors which had not been written on the appropriate DPC quality assurance forms. Maxwell did not ask to look at the black book of the welding inspectors. Since Maxwell considered the use of a personal notebook by the welding inspector as a recurrence of the documentation problem identified in June 1980, he concluded that DPC had not corrected the earlier violation. Maxwell told the welding inspectors that he would get back to them to discuss their problems.

On the morning of October 8, 1980, Maxwell called Charles Murphy, Branch Chief, Construction Inspection Personnel, and Jack Bryant, Project Section Chief, Region II, NRC, and informed them of his observations of October 7, 1980, in regards to the welding inspectors. Maxwell asked that investigators from the Region II, NRC Office of Investigations (OI) talk to the welding inspectors and conduct an inquiry into their concerns. Maxwell believed there were two issues: 1) use of a personal notebook to record deficiencies, and

2) the statement that Catawba project was all messed up. Maxwell thought an OI investigation was appropriate due to the general nature of the welding inspector comments and because any resulting inquiry would probably be lengthy. Maxwell thought that OI could initiate the inquiry, then, if necessary, other regional technical sections could be called to assist OI.

Murphy replied to Maxwell's request by stating that Maxwell did not have enough information to determine if the welding inspectors could identify any specific safety related problems. Murphy instructed Maxwell to talk to the welding inspectors and ask them for specific information.

On October 9, 1980, in response to a telephone call from Maxwell, the welding inspectors elected to come to the NRC resident inspector office to discuss their statements with Maxwell. The welding inspectors also provided Maxwell with three, general, non-safety related concerns, namely 1) non-safety forms were not signed by quality assurance; 2) weld wire stubs were not controlled in a non-safety related building; and 3) disposition of an NCR concerning a non-safety item in a non-safety building. They also expressed one concern of possible safety significance: the disposition to "use as is" of nonconformance reports. The inspectors thought those Nonconforming Items (NCI) which were dispositioned to "use as is" should be looked into to determine if the technical staff at Catawba had provided the correct disposition. The inspectors provided no specific NCI numbers to Maxwell; however, in general the NCIs did relate to safety-related systems. Maxwell asked the welding inspectors if they were using a notebook to record observed deficiencies. The welding inspectors denied having black books and told Maxwell they were just kidding when they made the comment about a black book. Maxwell took this reply to mean the welding inspectors had changed their minds about telling Maxwell about the information they were documenting in their personal notebooks. The welding inspectors told Maxwell they did not want to discuss their concerns with OI investigators or to become involved with investigators. The welding inspectors did not want to be identified in regard to their concerns because they were afraid their jobs might be jeopardized. Even though Maxwell informed the inspectors that the law prevented the inspectors from losing their jobs for cooperating with NRC, the inspectors did not want to talk to OI investigators. During the interview, the welding inspectors never indicated to Maxwell that they were being intimidated or harassed during the performance of inspections. On October 14, 1980, Maxwell prepared a letter to J.C. Bryant, Section Chief, Region II, which documented the interview. The letter was sent to Bryant for his and Region use. There was one general concern that Maxwell thought should be followed up on. That was the disposition of "use-as-is" NCRs.

Between October 9-10, 1980, Maxwell discussed the concerns of the welding inspectors with numerous other inspectors on site. He questioned them concerning documentation, processing, and final disposition of NCRs. Maxwell did not discover any information to indicate inspectors were using non-approved methods to document nonconforming conditions. Maxwell's inquiry did reveal that several mechanical and welding inspectors did not completely understand the processing of NCRs. Additionally, Maxwell reviewed 24 NCIs which he selected from the NCI log book to determine if there were repetitive nonconformances in various inspection disciplines. The 24 NCIs were selected based on interviews and indications of repetitiveness in the NCI log book, i.e., if the nonconformance conditions occurred more than twice. Maxwell then



examined the disposition of the NCIs to determine why the condition repeated itself. Some of the NCIs reviewed were safety related while others were not. As a result of the review, Maxwell located one welding nonconforming condition that required further review. The information developed during Maxwell's inquiry was relayed to a Region II inspector, Bob McFarland, for follow up during an up-coming inspection. Between October 20-22, 1980, during a follow-up inspection of Inspection Finding 70-05-01, titled "Engineers Disposition of NCI's," McFarland looked into the specific NCR that Maxwell had questioned during his inquiry.

On October 10, 1980, prior to the exit conference between Maxwell and DPC management, Maxwell had a meeting with [REDACTED] who was, at that time, the [REDACTED] at Catawba. During the conference with [REDACTED], Maxwell discussed the areas he had inspected during the past week and asked for any input that Davison might be able to provide. During the meeting, Maxwell discussed previous open items he looked into and his observations during the inspections. Maxwell made general comments to [REDACTED] that "some of his people" were still using improper methods for documenting deficiencies and that he needed to refresh "some of his people" on the proper use of nonconformance forms, i.e., the Q-1 form. Maxwell did not further identify any of these people to Davison and never told [REDACTED] that he was talking about welding inspectors. Maxwell did not make an issue of the possible documentation problem because he had nothing concrete with which to substantiate violations of procedures. Maxwell just relaxed his impressions to [REDACTED]. Additionally, Maxwell had not seen [REDACTED] response to Van Doorn's inspection finding, 80-15-03, from his July 1980 inspection. Therefore, Maxwell was not aware of any commitments made by DPC as a result of the finding. Consequently, Maxwell was not prepared for a confrontation with [REDACTED] over the matter of proper documentation of deficiencies. Maxwell emphasized he never identified to [REDACTED] any of the inspectors he had talked to Maxwell did not even limit his complaints to welding inspectors because he had talked to welding inspectors, electrical inspectors and non-destructive examination (NDE) personnel during his inspection. Maxwell told [REDACTED] that his people need refresher training on proper documentation of deficiencies, and NRC had previously identified this problem as an inspection item and would continue to review documentation and processing of NCRs in future inspections.

Maxwell opined that because the previous inspection finding concerning documentation of deficiencies involved welding inspectors, [REDACTED] may have assumed that they were the individuals who Maxwell was directing his complaints at.

In response to questions, Maxwell emphasized that when welding inspectors came to his office on October 9, 1980, it was in response to his telephone request. These welding inspectors never indicated to Maxwell that they had ever been harassed or intimidated and, in fact, from what Maxwell had observed the inspectors were very outspoken. The inspectors provided no specific information relating to safety concerns at Catawba. When Maxwell suggested the welding inspectors talk to OI investigators, the welding inspectors refused. They stated they did not want to talk to investigators and did not want to get involved. Maxwell got the impression that the welding inspectors did not want to get any pressure from DPC management. Even when Maxwell told the welding inspectors they would not be identified and nothing could happen to them, they would not provide any specific information and would not talk to

investigators. Other than in this context, the issue of confidentiality was never discussed. Maxwell also asserted he never used the term "black book" when discussing this situation with [REDACTED]. Maxwell told [REDACTED] that some of his people were not using the proper forms to document deficiencies and consequently were not making management aware of problems and that there was confusion concerning the requirements for processing and dispositioning of nonconformance reports. Maxwell informed [REDACTED] that this item would be followed up on because it had been previously identified as an unresolved item.

APPENDIX A

NOTICE OF VIOLATION

50-15-e3

Duke Power Company  
Catawba 1 and 2

License Nos. CPPR-116  
CPPR-117

Based on the NRC inspection June 30 - July 3, 1980, certain of your activities were apparently not conducted in full compliance with NRC requirements as indicated below. These items have been categorized as described in correspondence to you dated December 31, 1974.

As required by Criterion XVII of Appendix B to 10CFR50, as implemented by the DPC Topical Report "Duke 1-A", Paragraph 17.1.17, sufficient records shall be maintained to furnish evidence of activities affecting quality and these records shall include results of monitoring of work performance. Duke QA Procedure M19, Rev. 14 requires QC surveillance of welding parameters for containment welding to be performed randomly and documented on Form M19F.

Contrary to the above, on July 2, 1980 M19F documentation forms were not available dated after January 22, 1979. Interviews with site personnel indicated that the surveillances were performed.

This is a deficiency.

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that the surface inspection is only required to verify defect removal. The Duke interpretation does not consider that the intent of the required inspection may be also to verify whether the material has been damaged by the defect removal. Since this paragraph is subject to interpretation, the inspector considers that Duke must obtain ASME agreement with its interpretation and provide further technical evaluation of repairs made to date as necessary. This is unresolved item 50-413, 414/80-15-02, NDE of repair excavations for containment welds.

- d. On July 2, 1980, the inspector attempted to review records of QC welding surveillances for Unit 2 containment welding. Duke procedure M19, Rev. 14 requires QC surveillance of welding parameters for containment welding to be performed randomly and documented on Form M-19F. The last Form M-19F on file was dated Jan. 22, 1979. Interviews with site personnel indicated that surveillances were being performed but not documented. This is in noncompliance with 10 CFR 50, Appendix B, Criterion XVII which requires sufficient records to be maintained to furnish evidence of activities affecting quality and requires these records to include results of monitoring of work performance. This is deficiency 50-413, 414/80-15-03, Failure to document QC welding surveillance.

No items of noncompliance or deviations, except as described in paragraph 7.d., were identified.

8. Safety-Related Piping (Welding) - Observation of Work and Work Activities (Units 1 and 2)

The applicable code for welding of piping is the ASME Boiler and Pressure Vessel Code, Section III, 1974 Edition plus Addenda through Summer 1974. The inspector observed selected field welds at various stages of completion for conformance to code and procedure requirements. Areas reviewed included, as applicable: weld identification/location, joint preparation and alignment, evidence of QC verification, use of specified procedure, appearance of weld, welder identification and qualification, use of specified weld material, control of preheat and interpass, use of specified purge, preparation of weld, periodic checks of welding variables and control of filler metal. The following welds were observed:

<u>Weld No.</u>	<u>Unit</u>	<u>Stage of Completion</u>
1RN144-39	1	Fitup
1KD-18-12	1	Fitup
2ND-3-3	1	Fitup
2NV-154-2	2	Intermediate welding
2NV-154-3	2	Intermediate welding
2KC-155-2	2	Intermediate welding

No items of noncompliance or deviations were identified.

## DETAILS

### 1. Licensee Employees

#### Persons Contacted

D. G. Beam, Project Manager  
\*D. L. Freeze, Project Engineer  
\*R. A. Morgan, Senior QA Engineer  
R. G. Rouse, QA Technician  
\*J. C. Shropshire, QA Engineer (QAE) Mechanical, Welding  
\*S. W. Dressler, Senior Construction Engineer  
\*L. R. Davison, Senior QC Engineer  
H. L. Atkins, QA

Other licensee employees contacted included ten construction craftsmen, three technicians, and four engineers.

#### Other Organizations

Hartford Steam Boiler Inspection and Insurance Company

C. F. Toegel, Authorized Nuclear Inspector (ANI)  
\*J. W. Kosko, ANI  
\*B. Wood, ANI

### 2. Exit Interview

The inspection scope and findings were summarized on September 5, 1980 with those persons indicated in Paragraph 1 above. The inspector identified the areas inspected and discussed in detail the items of noncompliance and the unresolved items. No dissenting comments were received from the licensee.

### 3. Licensee Action on Previous Inspection Findings

(Closed) Deficiency 413, 414/80-15-03 "Failure to Document QC Welding Surveillance", Duke Power Company letter of response dated August 19, 1980 has been reviewed and determined to be acceptable by Region II. The inspector held discussions with the Project Engineer and examined the corrective actions as stated in the letter of response. The inspector concluded that Duke Power Company had determined the full extent of the subject noncompliance, performed the necessary survey and follow-up actions to correct the present conditions and developed the necessary corrective actions to preclude recurrence of similar circumstances. The corrective actions identified in the letter of response have been implemented.

### 4. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve noncompliance or deviations. New unresolved items identified during this inspection are discussed in paragraph 5e and 5f.

U.S. NUCLEAR REGULATORY COMMISSION  
Office of Inspector and Auditor

Date of transcription February 16, 1984

Report of Interview

██████████ Manager, for the Duke Power Company (DPC) at Catawba Nuclear Station, Rock Hill, South Carolina, was interviewed concerning the Quality Assurance/Quality Control (QA/QC) program at Catawba and an October 1980 meeting he had with George F. Maxwell, the U.S. Nuclear Regulatory Senior Resident Inspector at Catawba. During the interview, ██████████ provided the following information.

██████████ assumed the position of Project QA Manager at Catawba in February 1981. Prior to that date, ██████████ was the ██████████. ██████████ explained that as ██████████, he received administrative support from the Project Engineer at Catawba; however, he was under the functional control of the Senior QA Engineer at Catawba. ██████████ received all his operational direction and guidance concerning implementation of the QA/QC program from the Senior QA Engineer. To ensure independence of the QA program from any construction influence, the Senior QA Engineer reported directly to the QA Manager for Construction who was located off site in Charlotte, North Carolina. The QA Manager for Construction reported to the Corporate QA Manager who worked directly for the Senior Vice President for Construction and Design. The Corporate QA Manager was on an equal level with the Vice President for Construction who also reported to the Senior Vice President for Construction and Design. ██████████ stated that the independent functional line of control for QA ensured that Catawba QC personnel were able to independently evaluate the implementation of the QA program at Catawba. If ██████████ had any problems with construction personnel, he was able to report directly to his functional supervisor the Senior QA Engineer.

During the first of 1981, DPC restructured the QA organization at Catawba. ██████████ was appointed Project QA Manager, and now both the Senior QA Engineer and QC Inspection Supervisor report directly to him for both administrative and functional purposes. ██████████ reports to the QA Manager for Construction.

On October 10, 1980, George Maxwell came to ██████████ office to discuss an NRC inspection that Maxwell had just completed at Catawba. During the meeting, Maxwell reviewed some items from previous inspections that were still open. In this context, Maxwell made some general comments to the effect that some of the QC inspectors were still improperly documenting their observations in personnel notebooks. ██████████ was not certain about how the term "black book" was coined; however, he noted that the notebooks provided QC inspectors by DPC were, in fact, black in color. Maxwell also told ██████████ that some inspectors had brought problems to him that DPC management should be aware of and resolve. These problems were not within the jurisdiction of NRC; therefore,

Investigation on February 2, 1984 at Catawba Nuclear Station File # 83-52

by George A. Mulley

Date dictated February 16, 1984

Maxwell could do nothing but make DPC aware of them. During the meeting, Maxwell mentioned no names. He just stated "some inspectors" had approached him while he walked through the site. ██████████ inferred from Maxwell's comments that the information being documented in personal notebooks by the inspectors was observations, not deficiencies. ██████████ believed the inspectors were documenting actual deficiencies they observed on the appropriate forms. Additionally, although Maxwell did not mention any names or identify what group of inspectors had approached him, ██████████ assumed the inspectors were welding inspectors because Maxwell had indicated by his use of the word "still" that the problem was a recurrence of the one documented in the July 1980 NRC inspection. That violation involved welding inspectors. Additionally, Maxwell was most likely to encounter welding inspectors while he was walking through the plant on an inspection.

After the discussion with Maxwell, ██████████ wanted to remind the welding inspectors that although inspectors had the right to go to NRC at any time, DPC had established recourse procedures to solve problems. Before going to NRC, non-NRC problems as well as NRC problems should be first communicated to DPC to allow DPC management the opportunity to resolve either the technical or non-technical concern. ██████████ decided to have a meeting with the welding inspectors to discuss the DPC recourse procedure. ██████████ first discussed the matter with the welding inspectors supervisors, ██████████, a Technical Supervisor, and ██████████ a Supervisor Technician. During this meeting, ██████████ informed ██████████ and ██████████ about what he was going to tell the welding inspectors about the DPC recourse procedure. ██████████ and ██████████ told ██████████ that they would also make welding inspectors aware of the proper procedures to be followed when reporting problems. During ██████████ subsequent meeting with welding inspectors, none of the inspectors indicated they thought the DPC policy was unfair or bad.