



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W.  
ATLANTA, GEORGIA 30303

(17)

JUL 16 1984

MEMORANDUM FOR: File

FROM: J. J. Blake, Chief, Materials and Process Section  
Engineering Branch  
Division of Reactor Safety

B. Uryc, Investigative Coordinator

SUBJECT: TRIP REPORT - REVIEW OF DPC INVESTIGATION (JUNE 12-13, 1984)  
CASE NO. RII-84-A-0012

During the period June 12-13, 1984, the undersigned returned to the Catawba Nuclear Plant to review the status of the Duke Power Company (DPC) investigation into the allegation concerning the overheating of socket welds (commonly referred to as the Welder B issue). This was the third planned visit with the licensee on this matter. Previous trip reports were filed on May 23 and June 19, 1984. During this followup visit, the primary focus was on the status of DPC activity to date and DPC efforts to bring the investigation to a close.

Administrative Review of Investigative Process

Mr. Ray Hollins, the individual in charge of the DPC investigation made available those individuals who were responsible for the followup and evaluation of the major areas of concern. These individuals presented a summary of their actions to date and all except one gave the impression of being on top of their areas of assigned responsibility. The one individual who did not seem prepared was responsible for the issues involving vendor weld concerns, and he gave us the impression that he was not pursuing his area as aggressively as the other individuals responsible for key concerns. This was later discussed with Mr. Hollins, who agreed with our perceptions and assured us he would initiate appropriate action to ensure the vendor weld concerns were dealt with properly. The other individuals involved in resolving the concerns appeared to be totally involved in their effort. Their attitude and demeanor during their briefings was very professional. They responded well to our questions about their efforts and we were impressed with their in-depth knowledge of the concerns.

We discussed the proposed action regarding the employee relations concerns with Mr. Hollins. He advised that preliminary proposals would recommend removal of the General Foreman and foreman from their positions; counselling of welding superintendent for allowing an atmosphere of fear and hostility to exist among the welding craft; written letters of reprimand for three other foremen; a general meeting for supervisors regarding quality of work; publishing of articles in company newsletters regarding the DPC position on quality; implementation of a quality concern program similar to that developed by Georgia Power Company; and a mandate to employee relations to closely monitor craft to insure that concerns do not reoccur. Mr. Hollins stated that these proposals would be submitted to senior management officials at DPC for final consideration and implementation.

JUL 16 1984

An additional 105 affidavits were reviewed. These included results of followup interviews with workers and new interviews. They were well written and thorough in scope.

Technical Review of Concerns Identified During Interviews By DPC

During the investigative interviews conducted by DPC, there were 27 concerns identified for followup. Four of these categories were related to employee relations and the remaining 23 involved site hardware.

The four employee relations concerns were assigned to the corporate employee relations office for development and resolution. The 23 technical concerns were assigned to members of the DPC investigation team with construction, quality assurance, and engineering backgrounds.

At the time of this visit, the last few followup, in-depth interviews by the investigation team technical reviewers were being conducted. Discussions with team members were held to determine how thoroughly the areas of concern were being developed and what progress was being made toward resolution of the concerns.

The areas of employee concerns and status can be summarized as follows:

1. Violation of Interpass Temperature - This item coincides with NRC unresolved item No. 413/84-31-01. DPC and NRC consultants are preparing to do field evaluations of selected production welds during the week of June 18, 1984.
2. ARC Strikes Removed Without Proper Approval - This item coincides with NRC unresolved item No. 413/84-31-02. Additional followup will be discussed during the week of June 18, 1984. This is still under review by DPC.
3. Buddy Weld/Half Weld Sequence Technique - DPC has determined that none of the practices described in the concerns were a violation of the welding procedures provided that all welders were qualified and everything was properly documented.
4. Craft Workers Assigned to Watch For Inspectors - This is an employee relations item and is still being investigated.
5. The Quality of Work Has Suffered Due to Production Pressure - No physical examples were presented, therefore, DPC employee relations was assigned this area of concern to evaluate what constituted undue production pressure.
6. Work Performed Without Process Control in Hand - There seems to be some question as to how close to the work area the process control paperwork needs to be. The only real concern are cases where workers have been asked to start work before the process control paperwork arrives at the job site.
7. Inspector Performing Productions Work - Additional interviewing by DPC investigation team failed to develop this item beyond the original concern.

8. Work Performed on Material That Was Nonconformed - One example was developed in this area, NCI 5641 nonconformed some material in the spent fuel area. Records also show that NCI 5648 documented the fact that welders had worked on materials covered by NCI 5641.
9. Cold Spring of Pipe - This concern centered around an example of cold spring in the RN System of Unit 2. This item is still being developed and documented by DPC.
10. Work on Weld When Bevel Was Wrong - The only example cited was substantiated and involved a class "G" pipe weld which only requires welder inspection prior to welding. In this case, the welder refused and the supervisor did not insist.
11. Concern With Quality of Vendor Welds - This item is still being developed by DPC investigation team.
12. Concern That Employees Are "Out to Get" The Supervisor or Cause Trouble - This item is assigned to the employee relations office.
13. Employees Hesitant to Discuss Quality Concerns With Supervision - This is an area assigned to employee relations.
14. Procedural Concern With System Testing - Technical interviews determined that the area of concern involved the procedure that was used to flush the waste gas piping. The circumstances surrounding this flushing operation are being reviewed by DPC.
15. Less Than Acceptable Work Performed - This item involved instrumentation work in the turbine building, etc., this concern still being developed.
16. Concern About Proper Preheat - The materials discussed in this concern are not sensitive to preheat problems and the welding procedures were qualified without preheat.
17. Concern About Excessive Weave Width - This was expressed as an item, a worker remembered hearing. DPC Welding Engineers are working to evaluate the concern.
18. Copy of Test Given Prior to "Red Head" Certification Test - This item is still being developed and evaluated by DPC quality assurance engineers.
19. Concern That All Bolts Not In Structural Steel - The example cited was substantiated but design analysis has shown that the structural column in question is loaded in compression and the nut is not needed. (NRC Violation 413/84-17-01 cited a similar case.)
20. Concern That Holes Blown in Backing Rings - Two welds were specifically noted. One burn through was substantiated, one was not. Item still being resolved.

JUL 16 1981


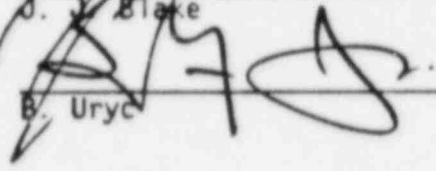
21. Employee Given Instructions to Deceive An Inspector - This item involved the checking of which anchor bolts were torqued with a craft torque wrench which was found to be out of calibration. There is no safety significance because in all cases, the bolts had been checked by inspectors using a different torque wrench.
22. Employee Asked to Stencil Weld He Did Not Make - This was substantiated - The welds involved were miscellaneous steel welds for electrical supports. The welders repaired any that looked bad prior to stencilling. Anyone who passed the new hire test to work at Catawba as a welder would have been qualified to do the original welding so there was no question about stencilling work done by unqualified people.
23. Improper Welding Technique on Teflon Seated Valves - Test welding being done to determine possible effects. So far, it has been determined that seat leakage could occur. A check of Unit 1 shows that of 2,000 valves, only nine leakers have been found, does not appear to be a major problem but still being evaluated.
24. Stainless Steel Filler Material in Carbon Steel Weld - A welder admitted that approximately six times, he had added a drop of stainless filler metal to seal off porosity. Welding engineering has had a mockup welded with one complete pass of stainless steel filler metal to test properties of suspect weld.
25. Violation of Hold Point Without Reprocessing Process Control - This involved a welder that passed a fit-up inspection hold point, realized his mistake and then ground out the root weld rather than admit the mistake. Technical evaluation showed that would have probably been the proper corrective action. Training need to properly document all work.
26. Concern Over Crack in Reactor Wall - During field trip with the concerned worker, the wall crack was found to be in the Auxiliary Building wall along the AA line between columns 50 and 51 from elevation 594 to 611. Subsequent review showed that this crack had been identified in 1980 and NRC 9975 and was also discussed in NRC Report No. 50-413/80-33.
27. Knowledge of Improper Electrical Wiring - It was determined that the wiring problems were a minor problem in the Administration Building and did not involve safety related areas.

#### Summary

The status of all of the items discussed above was still very preliminary and technical interviews were still being conducted and evaluated. There is a definite sense that all of the DPC investigation team members were pursuing the concerns in a very objective manner with one possible exception. The individual assigned to follow the concern about vendor welds appeared to have a preconceived

JUL 16 1984

notion that there was not a problem. After a discussion with Mr. Hollins, we were assured that the vendor weld area would include field trips with the concerned workers to identify the vendor welds in question and that each case would be evaluated.

  
\_\_\_\_\_  
J. J. Blake  
  
\_\_\_\_\_  
B. Uryc

MEMORANDUM TO CASE FILE

TYPE ACTION <input checked="" type="checkbox"/> RECORD OF CONVERSATION <input type="checkbox"/> CASE REVIEW / STATUS <input type="checkbox"/> OTHER	PARTICIPANTS	ALGR	FILE NO.	84-0012
		B. Uryl	DATE	08.10.84
	CONFIDENTIALITY REQUESTED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	TIME	10:10 PM

SUMMARY ALGR was contacted to determine how things were going personally and on the job. He stated he was doing fine and that things on the job were going well. He stated he has been briefed on the results of DPC's investigation and he was impressed with the depth of the technical evaluation and he is satisfied that his concerns have been resolved. He also said he is satisfied with the personnel actions that DPC has taken and that as a result of DPC actions, there has been a great uplifting among the workers. ALGR stated that he feels everyone involved has done a great job and he is satisfied w/ actions to date.

PREPARED BY	BRUNO URYL JR.	DATE	08.10.84
-------------	----------------	------	----------

ACTION REQUIRED

---



---



---

REVIEWED BY		DATE	
-------------	--	------	--

MEMORANDUM TO CASE FILE

(19)

TYPE AND DATE  
 CASE REVIEW  
 OTHER

PARTICIPANTS R. HOLLINS  
B. URYC

CONFIDENTIALITY REQUESTED YES NO

FILE NO. 84-0012  
 DATE AUG 16 1954  
 TIME 3:05 PM

SUMMARY Regarding RII followup of DPC investigation, I advised Hollins we wanted to contact those individuals who expressed concerns. Hollins stated there was the issue of confidentiality which DPC gave these individuals. I explained we could call these individuals and conduct our followup over the phone if DPC would provide home phone numbers. Hollins advised he would check with his management and get back to me.

PAGE OF

PREPARED BY BRUNO URYC, JR.

DATE AUG 16 1954

ACTION REQUIRED

REVIEWED BY

DATE



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W.  
ATLANTA, GEORGIA 30303

20

AUG 31 1984

Duke Power Company  
ATTN: Mr. H. B. Tucker, Vice President  
Nuclear Production Department  
422 South Church Street  
Charlotte, NC 28242

Gentlemen:

SUBJECT: REPORT NO. 50-413/84-88 AND 50-414/84-39

On March 13 - August 24, 1984, NRC inspected activities authorized by NRC Construction Permit Nos. CPPR-116 and CPPR-117 and Operating License No. NPF-24 for your Catawba facility. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed inspection report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

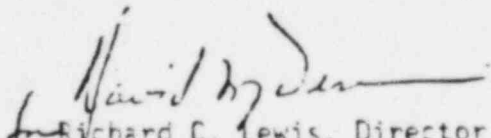
The inspection findings indicate that certain activities violated NRC requirements. The violation and references to pertinent requirements, are presented in the enclosed Notice of Violation. We have concluded that your submittal of August 3, 1984, which forwarded the results of your investigation into these matters adequately addresses these elements which would normally be required in response in this Notice of Violation. Therefore, a specific response to the Notice of Violation will not be required.

In accordance with 10 CFR 2.790(a), a copy of this letter, its enclosures, and your reply will be placed in NRC's Public Document Room upon completion of our evaluation of the reply. If you wish to withhold information contained therein, please notify this office by telephone and include a written application to withhold information in your response. Such application must be consistent with the requirements of 2.790(b)(1).

The responses directed by this letter and the enclosures are not subject to the clearance procedures of the Office of Management and Budget issued under the Paperwork Reduction Act of 1980, PL 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

  
Richard C. Lewis, Director  
Division of Reactor Projects

Enclosures: (See page 2)

~~8502060893~~



Enclosures:

1. Notice of Violation
2. Inspection Report Nos. 50-413/84-85  
and 50-414/84-39

cc w/encls:

R. L. Dick, Vice President - Construction  
J. W. Hampton, Station Manager  
James L. Kelley, Chairman  
Atomic Safety and Licensing Board  
Dr. Paul W. Purdom  
Administrative Judge  
Dr. Richard F. Foster  
Administrative Judge  
Robert Guild, Esq.  
Palmetto Alliance  
Jesse L. Riley  
Carolina Environmental Study Group

ENCLOSURE 1

NOTICE OF VIOLATION

Duke Power Company  
Catawba

Docket Nos. 50-413 and 50-414  
License Nos. NPF-24 and CPPR-117

The following violation was identified during an inspection conducted on March 13 - August 24, 1984. The Severity Level was assigned in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C).

10 CFR 50, Appendix B, Criterion II, Quality Assurance Program requires, in part, that the applicant shall regularly review the status and adequacy of the Quality Assurance program, and that management of other organizations participating in the Quality Assurance program shall regularly review the status and adequacy of that part of the Quality Assurance Program which they are executing.

Contrary to the above, the Quality Assurance Program in the area of welding, was apparently not reviewed for adequacy in that a welding foreman and his supervisor were able to create an environment which led some workers on the foreman's crew to perceive that QA requirements could be suspended to complete specific assignments.

This is a Severity Level IV violation (Supplement II).

850706@396



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W.  
ATLANTA, GEORGIA 30302

Report Nos.: 50-413/84-88 and 50-414/84-39

Licensee: Duke Power Company  
422 South Church Street  
Charlotte, NC 28242

Docket Nos.: 50-413 and 50-414

License Nos.: NPF-24 and CPR-117

Facility Name: Catawba 1 and 2

Inspection Conducted: March 13 - August 24, 1984

Inspectors:

J. J. Blake  
Jerome J. Blake, Section Chief

8/31/84

Date Signed

Bruno Uryc  
Bruno Uryc, Investigations Coordinator

8/31/84

Date Signed

Approved by:

A. R. Herdt for  
A. R. Herdt, Branch Chief  
Engineering Branch  
Division of Reactor Safety

8/31/84

Date Signed

### SUMMARY

Scope: This special, announced inspection involved 80 inspector-hours on site and in the NRC Regional Office in the areas of monitoring and reviewing the Duke Power Company investigation of concerns identified during a meeting in the NRC Region II Office on March 13, 1984 (see Inspection Report Nos. 50-413/84-31 and 50-414/84-17 dated April 23, 1984).

Results: One apparent violation was found in the area of inadequate implementation of the quality assurance requirements in the welding program.

8502060399

## REPORT DETAILS

### 1. Licensee Employees Contacted

R. L. Dick, Vice President-Construction, Acting Project Manager  
A. R. Hollins, Investigation Director

NRC Resident Inspector

P. K. VanDoorn

### 2. Exit Interview

The inspection scope and findings were summarized during a telephone conversation on August 29, 1984, with Mr. R. L. Dick. The licensee was advised that there would be one new violation as a result of this inspection.

Violation (50-413/84-88-01; 50-414/84-39-01): Inadequate Implementation of QA Requirements in the Welding Program (Paragraph 6).

### 3. Licensee Action on Previous Enforcement Matters

(Closed) Unresolved Item (50-413/84-31-01; 50-414/84-17-01): Fabrication of Socket Welds. This item concerned allegations that socket welding had been done without proper records on hand, without regard for interpass temperature, and without regard for authorized weld bead deposit sequence. During the conduct of the Duke investigation (as described in paragraph 5 of this report), these three concerns were pursued during the worker interviews. The concern about interpass temperature control was also the subject of metallurgical studies by Duke and by Brookhaven National Laboratories under contract to NRC Region II. Results of the investigation of these concerns is as follows:

#### a. Welding Without Proper Records On Hand

This was investigated by Duke and reported under the heading, "Process Control" in their final investigation report. The conclusion of that report was that there had not been a widespread problem but there had been cases where supervisors had urged welders to start work prior to paperwork being issued and/or to continue work while the paperwork was at another location. There was no evidence of defective work due to the fact that in each case the worker involved was aware of the work requirements. Duke concluded that corrective action in this case would include meetings with workers and supervisors to ensure that there was a correct understanding of the exact procedural requirement in this area.

b. Welding Without Regard for Interpass Temperature

During the Duke investigation into this matter, one of the welders offered to demonstrate how sockets had been welded in violation of interpass temperature requirements. The licensee's investigative team allowed the welder to demonstrate the technique of welding of sockets using a nearly continuous welding technique (interpass temperature exceed 700°F). Using the demonstration weld as one of the samples, the licensee made up eight socket welds. Two of each of the following sizes:

- 2-inch, Sch. 40 Pipe welded to 2-inch, 3000 #coupling
- 1-inch, Sch. 40 Pipe welded to 1-inch, 300 #coupling
- 1-inch, Sch. 160 Pipe welded to 1-inch, 6000 #coupling
- 2-inch, Sch. 160 Pipe welded to 2-inch, 6000 #coupling

One socket sample from each set was welded with an interpass temperature of 350°F (the maximum allowed by procedure) and the companion socket from each set was welded with no interpass temperature controls. The test welds were cut in half to provide two, 180-degree segments of each test weld. One segment was forwarded to NRC Region II's contractor, Brookhaven National Laboratory (BNL), for metallurgical analysis and one segment was metallurgically analyzed by Duke Metallurgical Laboratory. The results of the analyses by both BNL and Duke showed that all of the sample welds were acceptable when compared with the ASTM A-262 Practice A test for susceptibility to intergranular stress corrosion cracking. Duke metallurgists also used the test samples and other appropriate samples available from the Catawba weld test facility to develop a technique for conducting ASTM A-262 Practice A tests on welds in the field.

A metallurgical expert from BNL observed field tests on weld joints at Catawba and concluded that the techniques employed by Duke provided an acceptable method of determining the sensitization of stainless steel socket welds.

The conclusions reached by the licensee as described in the final report of the Duke investigation were that the violation of interpass temperature requirements was not widespread, was not directed by the welder's foreman, and if it did occur, it would not have had an adverse affect on the integrity of the welds in question. Based on the review of the Duke report and inspection activities described in paragraph 5 the NRC feels that there is reason to believe that violation of interpass temperature did occur in isolated instances and that when it did occur, it was probably because the welder's perception that his foreman was directing him to ignore the procedure to meet the schedule. This condition is considered to be an example of the QA problem described in the violation described in paragraph 6 of this report.

c. Welding Without Regard for Authorized Weld Bead Deposit Sequence

This concern involved welders who stated that because of space limitations they altered the welding sequence from that described in the procedure. The conclusion reached by the licensee was that the techniques described by the welders did not constitute a violation of the procedure and therefore, no procedure changes were required. NRC agrees that there was no technical violation of the procedure, but is concerned that welders did the work with the perception that they were in violation of the procedure. This is another indicator that some of the welders at Catawba were working under some perceived production pressures from their foremen.

This unresolved item is closed and the concerns are a part of the violation described in paragraph 6 of this report.

(Closed) Unresolved Item (50-413/84-31-02, 50-414/84-17-02): Unauthorized Removal of ARC Strikes. This item was investigated by the licensee who could find no evidence that ARC strikes were removed from anywhere but the weld zone without proper authorization and documentation. The valve body described during interviews by NRC did not show evidence of ARC strike removal, neither did any of the similar valves in the vicinity. The allegation that a foreman had removed an ARC strike without authorization could not be substantiated. The hardware that was purported to be involved showed no evidence of ARC strike removal. The NRC considers this unresolved item to be closed as the perceived production pressure conditions which were purported to be the cause of the alleged procedure violation are the subject of the violation described in paragraph 6 of this report.

4. Background

NRC Inspection Report Nos. 50-413/84-31 and 50-414/84-17 dated April 23, 1984, provided the details of how the concerns about foreman override originated; what actions were taken in the NRC Region II inquiry of the concerns; and the actions taken by Duke Power Company to investigate and resolve the issues.

Throughout the licensee action on these concerns, periodic status reports were provided to the Regional Office, and followup monitoring of the progress was performed by Region II as described in the following paragraphs.

On April 18, 1984, a senior member of licensee management met with members of the Region II staff to provide an update on the status of the licensee investigation. During the meeting, the licensee representative provided details concerning the formulation of the investigative team, the formation of a review board and the development of their investigative approach. The licensee representative also briefed the staff on the investigative activity that had been accomplished to date which included additional concerns which had been raised during interviews with licensee employees, as well as the description of technical issues being developed.

On April 27, 1984, senior members of the Region II staff were briefed on the status of the licensee investigation. The licensee was informed that the staff would conduct a continuing on-site review of the licensee's investigation to include a review of the technical adequacy of the investigation and a review of the administrative and investigative methodology being utilized by the licensee.

#### 5. Review of Duke Investigation

During the period May 1-3, 1984, members of the Region II staff conducted the first on-site review of the licensee's investigation. The review of the investigative methodology included examination of the techniques and methods used during personal interviews conducted by the licensee; documentation of the interviews; credentials of the interviewers; and, the general adequacy of the investigative process. Approximately 146 unsigned affidavits were reviewed by the staff. These affidavits were prepared as a result of the interviews conducted by the licensee. The staff personally interviewed the licensee interviewers to determine the adequacy of their preparation and ability to conduct interviews. The staff was satisfied that the four individuals selected to conduct interviews were well qualified for the task. The staff found that the investigative process had been initiated from a high level of licensee management and responsibility was fixed at the highest levels of licensee management. A professional engineer was assigned to direct the Duke investigative effort. This individual was selected from the licensee's corporate staff. Several individuals who had been interviewed during the investigation were personally contacted by the Region II reviewers to determine their view and impressions of the process. These individuals reported that they were satisfied that their interviews were conducted in a professional manner and that they were given ample opportunity to express their concerns to the licensee. Throughout this period of review by the staff, licensee representatives were available to answer staff questions and clarify procedural matters for the staff.

On May 24, 1984, another on-site visit review of the licensee's investigation was conducted. The licensee's investigative plan and proposals to initiate resolution of the concerns expressed by employees was reviewed. These procedures were found to represent a valid and logical approach to resolving the concerns.

During the period June 12-13, 1984, another on-site review was conducted. Briefings were conducted with those individuals appointed by the licensee to lead the technical teams assigned to address technical concerns. These individuals were well prepared to discuss the actions of their particular teams. The Investigation Director described the action he planned to ensure that the technical teams conducted the appropriate followup. The Investigation Director also discussed the proposed personnel actions in connections with those issues categorized as employee relations concerns. The staff was advised that the personnel action proposals would be submitted to licensee senior management officials. In addition, the staff reviewed an additional 105 affidavits and these were found to be thorough and well written.

During the period July 23-24, 1984, a final on-site visit was conducted to continue the staff's review of the licensee's investigation. This particular visit centered on examining the proposed resolution of technical concerns. Also, the investigative methodology being used to provide feedback to the employee concerns was also reviewed. The staff was also advised that the proposed recommendations relative to the employee relation concerns had been approved for implementation by licensee senior management.

#### 6. Review of Investigation Report

On August 3, 1984, by letter from Duke Power Company Legal Department to the Atomic Safety and Licensing Board, the licensee forwarded the final report. "Investigation of issues raised by the NRC staff in inspection reports 50-413/84-31 and 50-414/84-17."

As discussed in paragraph 5 above, the conduct and depth of the licensee's investigation was reviewed periodically during the course of the investigation. The review of the final report was conducted to evaluate the technical detail and context of the licensee's conclusions.

The licensee's report not only addressed the issues and questions raised by NRC in Inspection Report Nos. 50-413/84-31 and 50-414/84-17 but also reported all the concerns which had been raised during their interviews of over 200 construction craftsmen.

The principal conclusions reached by Duke Power Company were that: (1) quality construction standards were being met at Catawba, and (2) the foreman override issue is not a pervasive problem at Catawba. The investigation did identify the fact that there were definite problems associated with some specific first line supervisors and one second line supervisor.

The licensee reported that one first line welding supervisor was to be removed from his supervisory position; his supervisor, the general foreman, was also removed from his supervisory position; and the superintendent was to be formally counseled regarding his role in allowing conditions be what they were. In addition, three other supervisors were to be formally counseled as to how their words and actions might have been understood to mean that workers were to ignore quality requirements for the sake of production deadlines. Duke also concluded that communication sessions should be held with construction craftsmen and supervisors to preclude repetition of the misunderstanding which were involved in the majority of the worker's concerns.

Based on the review of the final investigation report; the inspection trips to review the conduct of the investigation; and discussions with licensee representatives, Region II has concluded that the situation which existed with the welding foreman and his supervisor, who were removed from supervisory positions because they perpetuated the atmosphere that procedure controls could be waived when production pressure dictated, should be



considered a violation of 10 CFR 50, Appendix B, Criterion II, which requires that "The applicant shall regularly review the status and adequacy of the quality assurance program. Management of other organizations participating in the quality assurance program shall regularly review the status and adequacy of that part of the quality assurance program which they are executing."

The following information is pertinent to the conclusion that formal response to this violation is not required.

- a. The final Duke Power Company investigation report acknowledges that the condition cited in the Notice of Violation exists.
- b. The answers to the questions of the reason for the violation, the corrective actions and results and the actions to prevent recurrence are fully answered in the licensee's August 3 submittal.
- c. Full compliance was achieved by completion of the Duke Power Company recommended personnel actions.

#### 7. Followup Interviews by Region II Staff

As part of the followup by Region II consideration was given to contacting those licensee employees who expressed concerns during the investigation. One of the problems encountered with proceeding to contact these individuals was the fact that the individuals were advised by the interviewers that their information would be held in confidence. This, in essence, was a pledge of confidentiality given to the individuals that were interviewed. The staff considered going to the site to contact these individuals, however, it was felt that such an action could possibly draw undue attention to the individuals by virtue of the fact that arrangements to talk with them would have to be made through their supervisors. This was a particularly sensitive area for these individuals since personnel actions had resulted from their statements. It was then decided to telephonically contact the individuals at their homes and conduct an interview after explaining why they were being contacted by telephone. The staff felt that there were two important issues that should be addressed with these individuals. The first was to determine if they were contacted by the licensee and satisfied with the resolution of their concern. The second was to determine if they were advised by interviewers that they could contact the NRC if they were not satisfied with the results of the licensee investigation. The Investigation Director was contacted and requested to provide the home phone numbers of all those individuals who expressed concerns. There were 37 individuals who expressed concerns during the licensee investigation. The staff has contacted 27 of these individuals and they have all stated that they were satisfied with the results of the licensee investigation and they felt that their concerns were appropriately addressed during the investigation. Of the remaining 10 individuals, nine have no phone or have an unlisted number, and one could not be contacted. Based on the large sample already contacted and their consistent satisfaction with how their concerns were addressed, the staff will continue to attempt to contact the remaining individuals but will not amend this report unless a differing opinion is voiced.

MEMORANDUM TO CASE FILE

TYPE ACTION <input checked="" type="checkbox"/> RECORD OF CONVERSATION <input type="checkbox"/> CASE REVIEW / STATUS <input type="checkbox"/> OTHER  TC	PARTICIPANTS <u>K. VAN DOORN</u> <u>B. URYC</u>	FILE NO <u>84-0012</u>
	CONFIDENTIALITY REQUESTED    YES    NO	DATE <u>SEP 04 1984</u>
		TIME <u>1:15PM</u>

SUMMARY I called Van Doorn to brief him on fact that inspection report was sent out and that we had 9 individuals left who were not contacted on followup. I advised him of decision to not actively pursue the 9 individuals. I gave him the names of the 9 and suggested that should he have any contact w/ them during his inspections that he should inquire as to their satisfaction with the results.

PREPARED BY <u>BRUNO URYC, JR.</u>	DATE <u>SEP 04 1984</u>
---------------------------------------	----------------------------

ACTION REQUIRED

---



---



---

REVIEWED BY	DATE
-------------	------