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2 INTERVIEW OF: MR. CHARLES SNYDER

3

4 DATE: MAY 12, 1957

5

6 PLACE: WOLF CREEK GENERATION
7 STATION
8 BURLINGTON, KANSAS

9

10 INTERROGATOR: MR. H. BROOKS GRIFFIN
11 U. S. NUCLEAR REGULATORY
12 COMMISSION -- REGION IV
13 611 Ryan Plaza Drive
14 Suite 1000
15 Arlington, TX 76011

16

17 STENOGRAPH REPORTER: WILLIAM J. JENNINGS, CSR

18

19 ALSO PRESENT: MR. JAY E. SILBERG of
20 SHAW, PITTMAN, POTTS &
21 TROWBRIDGE
22 2300 N. Street, NW
23 Washington, D. C. 20037

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EXAMINATION

1

2 BY MR. GRIFFIN:

3 Q. For the record, this is an interview
4 of Charles Snyder, S Y N D E R, who is employed
5 by Kansas Gas & Electric.

6 A. No.

7 Q. What is the new name?

8 A. Wolf Creek Nuclear Operating
9 Corporation.

10 Q. The location of this interview is the
11 educational facility located near the nuclear
12 site. The date is May the 12th, 1987. The time
13 is 9:03 AM. Present at this interview are Chuck
14 Snyder and his representative, Jay Silberg, and
15 on behalf of the NRC, myself, H. Brooks Griffin.

16 Chuck, I need you to stand and raise
17 your right hand. I want to swear you in for the
18 contents of your testimony.

19 (Whereupon Mr. Charles Snyder,
20 having been first duly sworn to tell the truth,
21 the whole truth, and nothing but the truth,
22 testifies as follows:

23 Q. (By Mr. Griffin) Before we go into
24 the questioning, I would like to direct a few
25 questions to you, Chuck, about Mr. Silberg's

1 appearance here today. What is your
2 understanding of his reason for being here
3 today?

4 A. To be familiar with the questions, the
5 answers, in order that, if for any reason at a
6 late date I need legal representation, he is
7 familiar, has some familiarity with the issue.

8 Q. That's a new one on me.

9 A. That's my understanding.

10 Q. For the purposes of this interview, is
11 Mr. Silberg representing you or is he
12 representing the company?

13 A. It's my understanding, again, he is
14 representing me.

15 MR. GRIFFIN: Mr. Silberg, is
16 that also your understanding?

17 MR. SILBERG: Yes, sir.

18 MR. GRIFFIN: It's my
19 understanding, based upon what you have told me
20 today before we went on the record, that you
21 will also be representing others that I have
22 asked to interview. Is that correct?

23 MR. SILBERG: Yes. Mr.
24 [redacted] and Mr. Johnson have both expressed
25 their desire that I sit in on the interviews,

(a, 7047D), portions

1 your interviews, with them.

2 MR. GRIFFIN: All right.

3 Q. (By Mr. Griffin) Chuck, could you
4 tell me -- give me kind of a narrative on your
5 background with your work at Wolf Creek and your
6 employment with the licensing?

7 A. I came to work for Kansas Gas &
8 Electric, who up until the first of the year was
9 the operating partner for Wolf Creek Generating
10 Station on June the 2nd, 1980, as project
11 construction supervisor. In March of 1982, I
12 was loaned out to INPO in Atlanta, Georgia, for
13 purposes of developing evaluation criteria for
14 the construction performance evaluations of all
15 nuclear power plants under construction at that
16 time. I remained there until December of 1983,
17 and I came back to Wolf Creek at the request of
18 Glenn Koester, vice-president, nuclear. I was
19 asked to come back to coordinate the development
20 of information relative to our rate case
21 hearings, which were first scheduled to commence
22 in 1985. Approximately the 1st of August of
23 1984, Glenn Koester contacted me and asked me if
24 I would assume the duties of manager, quality
25 first. I met with him. I discussed the

1 position. I accepted the responsibility. On
2 August the 20th, I assumed responsibilities for
3 managing the quality first program and the
4 quality first organization.

5 Q. When you came into Q-1, it was already
6 an established program --

7 A. Yes, sir.

8 Q. -- and it had procedures?

9 A. Yes, it was, and it had procedures.

10 Q. You replaced Owen Thero as the
11 supervisor of Q-1?

12 A. Not really. I would like to
13 elaborate, if I may. Owen Thero's title, prior
14 to my coming to the organization, was quality
15 first team leader. When I took over, as it
16 were, the responsibility of managing the quality
17 first, I came in as manager of quality first.
18 Prior to that there was a manager of quality
19 assurance, who the team leader reported to.
20 Technically, I replaced that manager. Owen
21 Thero had another title then, which was
22 interview supervisor. But I didn't replace him,
23 per se, because he never was a manager.

24 Q. Is the manager you are referring to
25 Rudolph?

1 A. That's correct.

2 Q. Joe, do you know why you were brought
3 in to replace Rudolph?

4 A. I was never told why. I have to
5 assume, again, that my record of having been
6 able to manage and accomplish tasks brought
7 about the request made by Glenn Koester that I
8 come in and take it over.

9 Q. At the time that you took over Q-1,
10 what was its mission?

11 A. It's my understanding from the design
12 to the implementation to my involvement
13 throughout it all was to receive concerns from
14 individuals associated with the project,
15 investigate those concerns, form facts together,
16 draw conclusions. If conclusions were drawn
17 that indicated corrective action was necessary,
18 to assure that individuals responsible for
19 corrective action were aware of the need. Then
20 to also ensure that corrective action took place
21 with verification process having been performed
22 by Q-1 people for the verification that took
23 place.

24 Q. So part of Q-1's procedures called for
25 verification of corrective action after the

1 affected organization had completed that action?

2 A. That's correct.

3 Q. Was this in existence, this
4 verification process, in existence from the time
5 you began through, say, licensing in March of
6 1985?

7 A. I believe it was in effect. Here,
8 again, I might have changed some of the
9 methodology. But, yes, it was in effect.

10 Q. At the time that you took over Q-1,
11 were employees who had made concerns to Q-1
12 being recontacted about the results of the Q-1
13 investigative findings?

14 A. To the best of my knowledge, when I
15 took it over, they had been or were being in
16 line with procedure, and that is, if a person
17 requested they get feedback, they were then
18 notified by whatever means they requested, by
19 letter, by phone, whatever.

20 Q. Did you continue this feedback to the
21 allegeders?

22 A. Yes, I did.

23 Q. What types of allegations did Q-1 take
24 as a matter of course? What categories or what
25 types of concerns?

1 A. Categorize safety related as a
2 general category, for example. It could have
3 been a concern relative to documentation, a
4 concern relative to hardware, a concern relative
5 to the procedure or the methodology of an
6 activity, concerns in the general category of
7 wrongdoing. It could have been intimidation,
8 harassment, discrimination, records
9 falsification, drug use. For the record, I
10 would like the recognition, though, that drug
11 use early in the procedure was not construed to
12 be part of wrongdoing. It was in the functional
13 category, which made it automatically fall with
14 security or some other organization by
15 procedure. We then had the other -- what we
16 referred to as functional concerns, which would
17 be cost and schedule, management improprieties
18 or incompetence, which were in this -- again in
19 this category of functional, and resulted in
20 those concerns being transferred somewhere else
21 for resolution.

22 Q. I can understand some of the others,
23 but do you know the basis or background for the
24 decision to put drug use or abuse in the
25 category of functional concerns?

1 A. No, I do not. I simply inherited,
2 again, that procedure, that flow chart, as it
3 was. There is a flow chart depicting --

4 Q. So Q-1 took drug abuse allegations but
5 did not investigate them? Is that right?

6 A. That's correct.

7 Q. They were referred to who?

8 A. Whatever organization was felt was
9 responsible for doing something. Again,
10 performing investigation, performing
11 surveillance, whatever. It was just automatic
12 by procedure that these were transferred.

13 Q. How many organizations performed these
14 functions, besides security? I understand
15 security --

16 A. I don't know how many. I would rather
17 explain to you the process. The organizations,
18 the individuals in the organization, who fell
19 outside the fence, so to speak, and by that I
20 mean the confines of the plant, those were sent
21 to the construction manager. Those dealt with
22 other than KG&E personnel, normally. They were
23 contracted personnel. Those that might have
24 been an allegation with inside the fence or the
25 KG&E operations people or whatever were sent to

1 the plant manager. Both of those individuals
2 had control over the security department. The
3 security department reported to both
4 individuals. There is evidence that some
5 activity was direct, with the security group,
6 rather than through the plant manager or through
7 the construction manager, but that was primarily
8 prior to me taking over the organization, and I
9 felt the necessity of making sure those
10 individuals were aware of what was happening
11 rather than interfacing directly with security
12 without their knowledge.

13 Q. Was it your understanding that the
14 drug allegations eventually found their way to
15 the security departments?

16 A. Yes.

17 MR. SILBERG: I'm sorry? During
18 what period of time? Are you talking about
19 before Chuck took over or --

20 MR. GRIFFIN: Yes.

21 Q. (By Mr. Griffin) From the time that
22 you took over for --

23 A. Yes.

24 MR. GRIFFIN: For the purpose of
25 this interview today, by the way, I'm going to

1 be emphasizing the time period from the origins
2 of the program in early 1984 really through --
3 primarily through December of 1984. Now, there
4 will be some aspects or some questions that
5 extend up into licensing, which is March of
6 1985, but I'm really focusing on a relatively
7 brief period of time here.

8 MR. SILBERG: My question was
9 whether you were focusing on the period before
10 Chuck took over the program or after --

11 MR. GRIFFIN: I understand.

12 MR. SILBERG: -- but still
13 within this 1984 time frame.

14 A. My understanding, I would have assumed
15 those had the involvement of our security
16 organization. An assumption, possibly, on my
17 part.

18 Q. (By Mr. Griffin) Okay. Chuck, when
19 you replaced Rudolph as the manager over Q-1,
20 was it the intent of KG&E to take Q-1 out from
21 under the QA organization at that time?

22 A. If I might elaborate again, the
23 quality first organization was in the early
24 stages, early implementation, managed
25 administratively by the manager of quality

1 assurance. When I assumed responsibility as the
2 manager of quality first, I reported to the
3 director of quality. The director of quality
4 was not director of quality assurance but
5 director of quality in general. I just want to
6 make that distinction. It was not quality
7 assurance, it was quality.

8 Q. At the time that you took over, Q-1
9 was also removed from QA procedures? Is that
10 right?

11 A. We revised procedures, reidentified
12 them, so that they were out of the quality
13 assurance procedures and into the quality
14 program procedures, and ultimately then out of
15 quality program, even, completely.

16 Q. When did that last part take place?

17 A. In November of 1984, when I was
18 directed to report to the group vice-president
19 of technical services. Complete removal from
20 the nuclear department.

21 Q. Chuck, I want to ask you a few
22 questions relating to things that occurred,
23 really, before your time, that relate to the
24 origins of the Q-1 program. I'm looking at a
25 project policy procedure, I believe, Ref. 00,

1 dated 11/83, signed by Mr. Koester. I have just
2 got a couple of questions out of this document.
3 I will read them to you. It says, "Allegations
4 will be routinely investigated by an appointed
5 office within the KG&E organization, internal
6 audit, quality assurance organization, or the
7 legal department." So, in reading this, I have
8 concluded that there were a variety of
9 organizations that were going to be performing
10 investigations. Was that your understanding?

11 A. No. I don't recall having read that
12 book. If you want my opinion, I will give it to
13 you.

14 Q. Okay.

15 A. That evidently was developed prior to
16 any plan or any design, as it were, to have a
17 concern reporting their investigating system.
18 The reason I say that, you will find the
19 document in December of 1983 which addresses
20 allegation reporting. Then you will find a
21 later document in February of 1984 with the
22 concern reporting system, as we know it now, the
23 quality first system. That was a directive from
24 Glenn Koester. So I think this was only
25 something in the interim, before they recognized

1 the need for a full-blown program, per se.

2 Q. Okay. Well, my question, once Q-1 was
3 created, were there other organizations, other
4 parts of KG&E, that were performing
5 investigations? I know legal was --

6 A. Yes.

7 Q. -- but were there others beyond legal?

8 A. And, again, the procedures stated that
9 those concerns, and I will use the broad term,
10 functional, which included drug issues, by the
11 way, at that time, would be transferred to the
12 responsible organization for their action. Now,
13 by "action," I have to assume investigation and
14 resolution.

15 Q. This is more an observation than a
16 question. This same document, headed
17 "Allegations," this procedure, it says --

18 MR. SILBERG: This is a November
19 1983 document you are talking about?

20 MR. GRIFFIN: Yes.

21 Q. (By Mr. Griffin) It says, in 28.6.4,
22 "The decision to an in-depth investigation shall
23 be communicated to the NRC."

24 A. I'm sorry, could you --

25 Q. "The decision to an in-depth

1 investigation shall be communicated to the
2 NRC." Now, as you said before, the Q-1 came
3 into existence soon after this. Based on your
4 institutional knowledge of the origins of the
5 Q-1 program, was it intended that the NRC would
6 be notified of in-depth investigations?

7 A. Not to my knowledge, Brooks.

8 Q. Chuck, I'm looking here at interoffice
9 correspondence, dated September the 17th, 1984.
10 It's to distribution from you. The subject is
11 "Notification of quality first program revision
12 and effect on project organization." Was this a
13 notification of procedural changes that were
14 being implemented?

15 A. May I look at it?

16 Q. Sure.

17 A. Basically this was a change of forms
18 for identifying deficiencies and notification
19 for corrective action.

20 Q. So you were going from quality program
21 violations to quality first action reports?

22 A. Action requests.

23 Q. Action requests?

24 A. Yes. Then the quality first
25 observation, also. If you would like an

1 explanation, I can offer that, too.

2 Q. Okay. Let me --

3 A. There was a procedure for processing
4 the QPVs and a QPDs, which was a QA procedure.
5 We again were no longer associated with QP in
6 any way, shape, or form. It seemed appropriate
7 to then develop a form, as it were, a document,
8 that would address our activities and have
9 procedures relative to the processing rather
10 than utilize theirs. Again, they were retained
11 documents from our records, so there was no
12 change in that respect, relative to
13 identification of problems and deficiencies,
14 again in line with our commitments, to make sure
15 they were documented.

16 Q. Chuck, at the time that you were
17 selected to head the Q-1, there had been a
18 series of events involving Mr. Rudolph. I don't
19 expect you to have extensive knowledge of this,
20 but do you know if the events surrounding the
21 search of Mr. [REDACTED] truck or the alleged
22 blackballing of Mr. [REDACTED] or other allegations
23 made against Mr. Rudolph regarding alleged
24 kickbacks had anything to do with a decision to
25 change managers of the Q-1 program?

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1 A. I do not. I was not aware of any of
2 those at the time that -- up until the time I
3 took the program over. I had no knowledge
4 whatsoever.

5 Q. At the time you did take this over,
6 some of these were under investigation by Q-1
7 investigators? Is that right?

8 A. I believe the issue of blackballing
9 was, and it was sometime after that before the
10 issue of kickbacks was even brought forward. I
11 had no knowledge of the vehicle break-in
12 whatsoever.

13 Q. That was before your time?

14 A. Yes, and there was no QA -- there was
15 no quality first concern relative to that
16 issue.

17 Q. Well, tell me if I'm wrong, but wasn't
18 the person whose vehicle was broken into, wasn't
19 he being, at the time this vehicle was being
20 searched, wasn't he being interviewed by Q-1 and
21 weren't Q-1 people aware that his vehicle was
22 being entered while he was making --

23 A. I find no record in the file, and I
24 have not searched the file diligently, but I --
25 again --

1 Q. So this is news to you?

2 A. Yes, that issue.

3 MR. SILBERG: I'm sorry, the
4 question was whether quality first was aware of
5 the break-in at the time it was taking place?

6 MR. GRIFFIN: Yes.

7 MR. SILBERG: Okay.

8 Q. (By Mr. Griffin) I will make an
9 observation, Chuck. I reviewed, and it's been
10 two weeks, and I would like to say for the
11 record that you were very helpful in arranging
12 for me to make those files available and make it
13 easy for me to review that. I did find
14 information in the files that referenced these
15 activities, that specifically questions were put
16 to Mr. ¹⁷⁰⁰⁷⁰ while he was being interviewed by
17 Q-1 that -- if they objected to his vehicle
18 being searched. But you just -- that was just
19 before your time and --

20 A. Yes, and I had -- like I say, I had no
21 knowledge -- again, I knew of the blackballing
22 allegation, but I had no knowledge of a break-in
23 allegation.

24 Q. Chuck, one of the approaches I have
25 taken in my investigation was to rely heavily on

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1 the testimony of former Q-1 investigators. I
2 want to ask you about your initial meeting with
3 the Q-1 investigators. It was alleged during
4 this meeting that you made certain statements
5 about what you intended to accomplish and what
6 you wanted to accomplish in relation to fuel
7 load. At that time the projected fuel load
8 date, it's my understanding, from the testimony
9 I have received, the filling -- or the date
10 being used was December 1984. It was alleged
11 that you indicated or stated that it was your
12 intention to have these cases closed by December
13 of 1984, and that that was a mandate, so to
14 speak, and that you intended to accomplish it,
15 and that you were putting the Q-1 investigators
16 on notice that these hundreds of allegations
17 were to be closed within the next few months.
18 Is this true?

19 A. Your statement is not true.

20 Q. Is my characterization -- okay. My
21 characterization is not true?

22 A. That's correct.

23 Q. Okay. Could you explain.

24 A. Remember the -- I have to go back in
25 my memory, and I could very well have said and

1 probably did say that my intentions were to
2 staff, to train, to pursue getting all of the
3 concerns investigated, resolved and closed out,
4 prior to scheduled fuel load. This is a
5 planning effort. It has nothing to do with a
6 mandate. I was not given any mandate, "You must
7 have this done." I told nobody in the
8 organization, "You must have this done."

9 One thing I would like to bring up at
10 this time, and it's an offering of mine, you
11 recognize that, I inherited the work force, by
12 and large. Many of them who were not there when
13 I got there had already been committed to by my
14 predecessor. I went in with a work force who I
15 had very little knowledge of their abilities. I
16 had very little knowledge of their experience,
17 other than on paper. You don't motivate anybody
18 without a pep talk. It's necessary if you are
19 going to manage people to give people credit for
20 their abilities, to make them aware of your
21 presence to assist, the presence of other people
22 to assist where they need help to do a job.
23 It's what is in most circles termed a morale
24 building exercise. Anybody, in my opinion, who
25 tends to get anything accomplished, must

1 establish some goals, and that is exactly what I
2 do, but there were no mandates.

3 Q. Well, I understand what you are saying
4 about setting goals, supporting fuel load date.
5 The context in which numerous former Q-1
6 investigators that I interviewed put this
7 initial meeting was something a little --
8 characterized it somewhat different, in that it
9 was a mandate. "We have got this many cases,
10 and they will be closed, and anybody out there
11 in the audience who doesn't go along with this
12 can look for some other employment." There was
13 another aspect of this same meeting.

14 Now, the only reason I'm stressing
15 this is that I have heard this from a
16 sufficiently large number of people that were
17 in attendance at the meeting that interpreted
18 the statements that way, that this was the
19 mission, and it was going to be accomplished.
20 Then, jumping ahead, as we know, you were
21 successful. These hundreds of allegations were
22 closed in a very short period of time. Of
23 course, that is why I'm here today. It's part
24 of my investigation to see whether or not
25 these investigations were adequate and

1 sufficient and whether they would have logically
2 or reasonably -- whether it's reasonable to
3 assume that they were adequate.

4 My question is, did you put this goal
5 to them in such a way that it would or could
6 have been interpreted that they had to have
7 these things closed by December?

8 A. In my opinion, no, I did not put it to
9 them that way.

10 Q. Did you tell anybody -- did you tell
11 the assembled group that, if they couldn't meet
12 this mission, this goal, that they better look
13 for some other employment?

14 A. To the best of my knowledge, I don't
15 recall having told them that, no. Again, I
16 would like to interject, I went beyond that
17 group and staffed additionally. If you look at
18 the record, on the dates of adding people,
19 looking at the work load, whether or not the
20 work load was increasing or decreasing, you can
21 see the addition of people corresponding to the
22 needs.

23 Q. We will get to that a little further
24 in the interview, Chuck. Obviously if you
25 have -- I don't have any -- I don't have a

1 figure of how many hundred concerns you had to
2 investigate when you took over this
3 organization, but it was substantial. It was in
4 the hundreds.

5 A. Yes.

6 Q. You had a relatively small force.

7 A. (Witness nods head).

8 Q. I'm aware that you increased staff.
9 You had other variables to contend with. One
10 was that, at the rate that allegations were
11 being received by Q-1, there was the potential
12 for literally hundreds of more allegations to be
13 received during this same period that you were
14 trying to close the hundreds already in
15 existence. So there were -- some of the
16 observations that I have taken from some of your
17 former employees address both sides of this
18 issue, not only additional staffing, but "How do
19 we set up for the potential of hundreds of other
20 allegations to be made."

21 A. May I elaborate on something else --

22 Q. Sure.

23 A. -- just for your clarification and for
24 the record? Probably very few of these
25 individuals who you have discussed this issue

1 with, relative to understanding a mandate or
2 whatever, recognized the organizational effort
3 that was going on at the same time. Number one,
4 I signed the coordinator, who looked at who was
5 doing what, how they were doing -- how it might
6 affect another organization, what do we have
7 that is like or similar to this allegation, so
8 we can utilize our manpower best without taking
9 every concern and reinventing the wheel.

10 Secondly, we put it in a computer
11 bank. It was necessary so we had control and we
12 didn't have to go back again and keep records by
13 hand. This was organization that many of those
14 folks were not aware what was happening. They
15 were back associating with the old do-it-by-hand
16 business, and we were taking advantage of the
17 modern technology we had available to us. Plus
18 we eliminated right up front the biggest
19 stumbling block or bottleneck there was, and
20 that was taping the majority of the interviews
21 and then having one person transcribe them
22 before we could ever start an investigation.
23 The problem was getting the material to do an
24 investigation. They didn't understand that.

25 Q. Tell me about that. What was the --

1 you have given one explanation, the basis for
2 the decision not -- to no longer tape
3 interviews. Were there other considerations why
4 the use of tapes were removed?

5 A. I was directed to stop using tapes.

6 Q. By who?

7 A. By Mr. Glenn Koester.

8 Q. What was his reasoning? Did he offer
9 one?

10 A. I don't know. He did not give me a
11 reason. I was given direction. I would
12 interject that, had he not at that time, it
13 would have been shortly thereafter that I would
14 have stopped accepting some very -- possibly in
15 some extreme circumstances have continued to use
16 them, but there was no way to get work done with
17 having to transcribe everything off of a tape
18 that was pages and pages and pages long. We
19 couldn't do an investigation.

20 Q. I don't understand. What was the
21 problem with getting the tapes transcribed?

22 A. Two things. One was available
23 manpower, knowledgeable of the technical
24 portions. You have seen our files. You see
25 missing words. You see misunderstandings.

1 People who had no real technical background of
2 the subject matter. The poor quality of the
3 interview, which I think you will find is
4 apparent, if you go back and read some of the
5 transcripts.

6 MR. SILBERG: Excuse me. When
7 you say lack of available manpower,
8 knowledgeable and technical background, are you
9 referring to the interviewers or to the people
10 who were typing the transcripts?

11 THE WITNESS: People typing the
12 transcripts.

13 A. Very, very tedious operation.
14 Superfluous information in most cases. It was
15 not even necessary that an investigation could
16 have been formed without much of it. That is a
17 personal observation. You may or may not agree
18 with that. That was the biggest bottleneck when
19 I took over the program.

20 Q. (By Mr. Griffin) Okay. Let me ask
21 you a couple follow-up questions about that.
22 One, you say, is the cost and scheduling
23 problem. You didn't want to pay to have the
24 tapes transcribed, so you did away with the
25 tapes. Then the superfluous information. You,

1 as the manager, don't you have the wherewithal
2 to have the -- to direct how your people will
3 conduct these interviews?

4 A. It was already done.

5 Q. Well, I know in the past, but I'm
6 talking about you made a decision to do away
7 with this as the information-gathering tool, and
8 I'm trying to --

9 A. I gave guidelines.

10 Q. Yeah. The guideline was to remove the
11 tapes.

12 A. The guidelines were how to perform an
13 interview.

14 Q. Okay. What were your guidelines?

15 A. I would have to go back to the
16 procedures. I don't specifically remember.

17 Q. Okay. I have read that, I have read
18 that.

19 A. Okay.

20 Q. Let me make an observation, and then I
21 would like for you to respond to my
22 observation. I have read some of those early
23 transcripts, and to some degree I will agree
24 with you, they do ramble. They are not
25 focused. But it seems to be the fault of the

1 interviewer. I'm sure it does take a long time
2 to transcribe tapes, because we sometimes do
3 that in my business, and that is difficult.
4 However, in my review of your case files and in
5 the review performed by some of my peers and
6 other contingents of the NRC, you seem to have
7 gone from a system of using a cumbersome system,
8 using these taped interviews, to going to a
9 system which essentially distilled the interview
10 down to one or two lines. In a lot of cases,
11 there is really no backup documentation to
12 indicate what was said in these interviews. So
13 I make the observation that you streamlined your
14 system by going from -- at least having a
15 vehicle to know what the person said to a
16 vehicle where the individual investigator who is
17 carrying around this information in his mind and
18 is distilling it in one or two sentences, which
19 are listed as, "This is the allegation." Now,
20 I'm not saying that is true in every case, but
21 many of the case files I reviewed, we just
22 simply don't have available to us whatever that
23 person may have said in the interview. All we
24 have is the resulting allegation. I would like
25 for you to comment on the accuracy of what I

1 have said.

2 A. I think it's essential to understand
3 the two functions, the interviewing and
4 investigative function, which we put into place
5 in the operation. The interviewer was the one
6 who had initial contact with an alleged or
7 person with a concern. By procedure, that
8 concern was written down, and in the alleged's
9 own handwriting, if possible. They voiced a
10 concern. From there, if they voiced a concern,
11 we attempted to draw particulars out of them,
12 enough whereby we could start an investigation.
13 The investigator always had the right, in fact
14 the coaching, as it were, to re-contact the
15 alleged, if he needed additional information. I
16 think what you were saying, from our
17 conversation earlier, and what I have seen you
18 look at, where you have a problem is the contact
19 the investigator had with the alleged relative
20 to notes of what they discussed and the real
21 in-depth issues.

22 Q. Okay. Let me ask a clarifying
23 question. Are you saying that the Q-1 file,
24 then, does not contain the results of the
25 interviewer's work?

1 A. No, that's not what I'm saying.

2 Q. I'm just saying that, as I reviewed
3 the files, once the taped transcriptions were
4 done away with, and the organization -- I mean,
5 as time passed, the documentation showing what
6 the interviewees had said was distilled down to
7 a point where it was summarized in one or two
8 sentences, often, and the reason I'm emphasizing
9 this is because the conclusions also, and you --
10 this is something we will get into later. I
11 want to talk about the -- some of the reviews
12 already performed by the NRC and your criticisms
13 of the way you operated, but this doing away
14 with bulky transcripts and going to one- or
15 two-sentence summaries of whole interviews seems
16 to me placed great reliance on the memory of the
17 interviewer, who would have had to convey this
18 information to the investigator. Verbally, I
19 suppose. Certainly -- it's certainly not
20 contained in the file.

21 A. If I might make an observation, I
22 think you are not seeing part of it, possibly.
23 You see areas in the files, long dissertations,
24 about concerns, problems, interests, whatever,
25 from some individuals. These were primarily

1 people who walked in. These were primarily
2 people who called in. The majority of the
3 concerns in the files are people who
4 terminated. As you know, our process was that
5 everyone who terminates comes to quality first
6 as part of the checkout procedure. Many people
7 simply sign their name, if they look at the
8 files. I will go back again to the processing
9 out. They are not files, but you have access to
10 those if you would like to see them. People are
11 processed through the program. No concerns.
12 There is another block for those having concerns
13 to indicate their concerns and a brief
14 description of the concerns. The majority of
15 the people who filled that out, if they had any
16 concerns, it was a one-liner. They did not want
17 to expound any more, had no interest in
18 expounding any more. In most cases it was a
19 non-problem, even though we accepted it as a
20 problem. It was just like something -- somebody
21 else had talked about it, and they knew somebody
22 else had talked about it in some cases.

23 Q. When these people were there, if they
24 had a concern, put a one liner, and they were
25 not interviewed before they left?

1 A. Oh, yes, they were. They were
2 examined to expound further, to give us
3 additional information. Some did, some didn't.
4 Some had no desire to. Some said, "That is all
5 I'm going to give you."

6 Q. I don't want to break it down to a --
7 I'm not even -- I don't have the wherewithal to
8 break it to a case-by-case basis, but what I'm
9 speaking, across the board, when you did away
10 with the taped interviews what we have left is
11 these one-liners, and you are saying, "Well, the
12 possibility is that that is all they really
13 wanted to say," but based on what had gone
14 before, apparently the people earlier in the
15 program, when their interviews were being
16 transcribed, said a great deal more than just
17 one line. As you say, some of them even
18 rambled.

19 A. Yes.

20 Q. Obviously the NRC has already
21 criticized Q-1 for its lack of documentation,
22 and I don't want to belabor that.

23 A. Uh-huh.

24 Q. For the purpose of this interview, an
25 understanding of how you could have gone -- or

1 why you chose to go from one extreme to the
2 other. You were accepting as the -- as the
3 supervisor, you were accepting the one- or
4 two-line summaries of what issues these people
5 had raised. And I agree, they have no
6 specificity. They don't say what pipe, what
7 weld, what -- when, who to talk to, what people
8 were involved. There is just no background.
9 Other contingents in the NRC have already
10 criticized you for this.

11 The other -- the main question I have
12 for you, the absence of this information, which
13 would be necessary to an investigator to make a
14 meaningful investigation, was it ever present
15 and has it been removed from the files, or does
16 it --

17 A. To the best of my knowledge, nothing
18 has ever been removed from the files. I say it
19 was never present, unless -- unless someone did
20 without my knowledge, which I doubt.

21 Q. So these brief descriptions of the
22 allegations were all of the investigators had to
23 go with?

24 A. I would say yes.

25 Q. Okay.

1 A. Again, I would like to interject,
2 though, that what you saw was the result of in
3 many cases long telephone conversations,
4 telephone allegations, walk-in. If you look at
5 the rec rd, you are going to see, in numbers,
6 themselves, the Ts and the Ws and the HOTS --

7 MR. SILBERG: The T is for
8 telephone and --

9 THE WITNESS: T, terminating; W,
10 walking; and HOT, telephone. If you look at the
11 numbers, you can tell those were all primarily
12 up to a point in time, which my management of
13 the program had nothing to do with changing
14 that. I'm simply saying that that was the way
15 it fell.

16 Q. (By Mr. Griffin) Well, I'm not here
17 to criticize you. I'm here to interview you.
18 I'm just trying to find out what your
19 interviewers were doing and what your
20 investigators were doing. The sampling of the
21 files -- on the more significant issues, I had
22 the luxury of talking to your former
23 investigators, so I was able to concentrate on
24 those that were significant to them, for one
25 reason or another. I just wanted to make sure I

1 had a clear understanding of why there is so
2 little documentation in the files relative to
3 the issues being investigated. You have offered
4 what I suppose is your best explanation on
5 that.

6 Let me move on. I think one of the
7 procedure changes that you instituted was the
8 use of observations. Is that right?

9 A. Quality first observations, that's
10 correct.

11 Q. Could you describe that?

12 A. I would like to go back to the prior
13 document utilized, if I may, in the
14 description.

15 Q. Yes.

16 A. When I took control of the program,
17 the organization utilizing the quality program
18 violation document, the quality program
19 deviation document, the violation was one as it
20 -- as the name implies, was a violation of some
21 requirement. It was necessary then to document
22 that as a finding and recommend corrective
23 action, so on and so forth. The deviation was
24 one where they deviated from a requirement, but
25 it was not necessarily a violation. Again,

1 there was a different response to the deviation
2 than there was to the violation. The quality
3 first action request was developed in lieu of
4 the quality program violation. In other words,
5 there was a specific problem that was
6 identified. We could get our arms around it, so
7 to speak, and identify this problem. It was
8 documented on this form that was sent to the
9 organization responsible for fixing. It follows
10 more-or-less in line with QPV. The quality
11 first observation was initiated in order to
12 bring to the attention of the affected
13 organization and to quality assurance and the
14 quality assurance organization our recognition
15 of a potential weakness. By definition, the
16 quality first action request was relative to
17 specific concerns that have been brought to us
18 that we were investigating. The QFO in most
19 cases identified something that was outside the
20 immediate interest area or the defined concern.
21 In either case, it required corrective action.
22 In the case of the QFO, if it were
23 substantiated, if an in-depth investigation or
24 review by that organization showed that our
25 recognition of potential weakness, if it were

1 real, it required corrective action on their
2 part and verification of same.

3 Q. The Q-1 investigators, then, under
4 your supervision, if they encountered a
5 deviation deficiency, something without
6 correcting, or something that they thought
7 needed investigating during the course of one of
8 their investigations, were not allowed to pursue
9 these other issues -- is that correct?

10 MR. SILBERG: I'm sorry, the
11 other issues being things --

12 MR. GRIFFIN: Other deviation,
13 concerns, things that needed to be corrected.
14 Their job was identifying those on a QFO.

15 Q. (By Mr. Griffin) Would the answer be
16 yes, that they were not allowed to investigate
17 these?

18 A. If these issues were not directly
19 associated or part of the concern they were
20 assigned to investigate, that's correct, they
21 were not allowed, if you want to use the word
22 "allowed," to pursue an investigation of those
23 issues. That was not a concern brought to
24 quality first.

25 Q. They did have a right to report these

1 on the observation form, and it went to the
2 other organization that --

3 A. They had responsibility to identify
4 those on the QFO.

5 Q. When I was doing my review, Chuck, I
6 noticed that you provided me with some of the
7 QFOs that I had requested. I don't want to go
8 into any of them specifically, but one thing I
9 wanted to ask you about, I noticed that there
10 seemed to be -- that QFOs seemed to have been
11 addressed by the affected organizations in a
12 relatively narrow frame of time. In other
13 words, there is a number of them, but they all
14 seem to have been addressed in a brief period of
15 time. The closure dates are all within about a
16 week of each other in May of 1985.

17 Now, one of the criticisms -- one of
18 them most often repeated by former Q-1
19 investigators that I interviewed was that they
20 were filling out these QFOs, and they were being
21 sent as procedure, indicated to the affected
22 organizations, but that the organizations were
23 not reviewing the documents, and there was no
24 action. These people expressed a lot of
25 frustration. A lot of them also expressed

1 something a little bit more disquieting, and
2 that is the fact that maybe what they were
3 investigating was not significant, but what they
4 had observed as part of that investigation they
5 believed was very significant. However, because
6 they were under restriction from, say, opening a
7 new investigation on that, and then seeing that
8 it was not being acted upon, when they would
9 check back to the affected organization on the
10 observation, which you might guess would lead to
11 a lot of frustration and also suggest that these
12 things that were more significant, or were
13 significant, would not be addressed before fuel
14 load, and in some instances people believed that
15 this was a -- not an acceptable -- that -- way
16 of handling it, because these things maybe could
17 not be corrected or adequately corrected after
18 criticality --

19 A. Do you want me to expound?

20 Q. I would like for you to make an
21 observation.

22 A. I felt, when we initiated QFO, that I
23 would get the response of the organizations to
24 cooperation. Quality assurance procedure lies,
25 the verification of action or inaction on the

1 part of the QFO. What was their
2 responsibility. They would do this through
3 scheduled audits, surveillances, to assure that
4 this had also been addressed, just like any
5 other deviation. It's true, we found a
6 reluctance to respond. So I had one avenue,
7 and that was to make this known to the project
8 director, which I did. I was here every day
9 in status meetings on that project. I made
10 it known to him, and he ensured that action
11 would be taken. In fact, if you look at our
12 records -- even though we procedurally did not
13 track QFOs, I have all of the records on QFOs,
14 the reason for that being the cooperation of
15 project director to tell these organizations,
16 "You will respond to the QFOs. You will go out
17 and do the job you have to do to assure that
18 this is taken care of." And it was taken care
19 of. You will find the record shows that they
20 were closed out. Again, it was my job as a
21 manager to make it known to the project director
22 that somebody else was not doing their job, and
23 it was corrected.

24 Q. I understand the point you are making
25 about that, but then tell me, who originated the

1 restriction, I will use the word "restriction,"
2 that these -- that these other deficiencies
3 identified or potential deficiencies must be
4 reported on the QFO? Weren't you the
5 originator?

6 A. Oh, yes.

7 Q. So you are saying, "I originated, I
8 made this restriction on my Q-1 investigators,
9 and I informed the affected organizations that
10 they weren't responding in a timely manner. I
11 pointed this out to them." But didn't you have
12 sufficient flexibility as the Q-1 manager
13 that -- if you saw inaction or you saw that
14 these things were not being responded to in a
15 timely manner, didn't you have the authority to,
16 say, pick these things up as new Q-1
17 investigations, had you chosen to do so?

18 A. I could have possibly upgraded them to
19 the QFAR, had I felt the need to, if I thought
20 there was some effort out there to keep from
21 doing an investigation, or an evaluation, even.
22 Again, though, I'm going to expound a little
23 bit. The quality first program was developed to
24 address employee concerns. That is for the
25 record. You know that, I know that. It's

1 exactly what we did. We addressed employee
2 concerns. If during the course of that
3 investigation there was a potential weakness
4 identified, if any investigator wanted to make
5 that an employee concern, that was his option.
6 If he wanted to come forward and put his name on
7 it, that "This is a concern I have, put it in
8 the system, employee concern," it would have
9 been addressed as an employee concern. There
10 was no way and there is no way that you can take
11 people and let them dictate how you run a
12 program. Somebody has to manage it.

13 Q. I understand.

14 A. I managed a program.

15 Q. Okay. I understand that. Let me say
16 this. Some of the former people who worked in
17 your program were so irate about this particular
18 subject that they indicated that they would have
19 liked to have been the alleger, making the
20 concerns, but that it was prohibited, that they
21 were required to report these on to QFOs, and
22 once they, through discussions with Mr. Patrick,
23 over in QA, realized that they were going into a
24 drawer and were not being addressed, and I'm not
25 talking about one individual, I'm talking about

1 several of your people, went over and followed
2 up on these things, and -- did you ever have any
3 of them say, "I would like to make a Q-1
4 concern"?

5 A. No, I did not, and they were never
6 prohibited from that. The procedures,
7 themselves, say any person associated with the
8 project has the right to make a concern. They
9 could have picked up that telephone at home and
10 called anonymously, like other people did. They
11 had that option.

12 Q. So, if I understand what you are
13 saying, Chuck, you are saying, "We took the
14 employee allegations. We investigated them. We
15 reported these other things to other people.
16 These were things that were identified. They
17 were not raised by allegers. Therefore, it's
18 somebody else's responsibility."

19 A. That's correct. I would like also the
20 record to show that we did in fact follow up on
21 them.

22 Q. As I said earlier on, it looks like,
23 around the last week of May, they were -- there
24 is quite a bit of activity on these things, but
25 of course that is two months after --

1 A. But it's in a lot shorter time than
2 some of the original investigations. Interviews
3 came in in March, April, May, June, July, and
4 August, that were never investigated until I got
5 the interview.

6 Q. I guess the overlying theme here that
7 I was hearing was that the observations were
8 used to not address concerns, and the reason
9 that the Q-1 management, being primarily you,
10 didn't want to see these things addressed, is
11 because it was another investigation that had to
12 be done, that this was inconsistent with the
13 general approach of saying, "We have got this
14 many cases, we have to get them closed by
15 December, we don't want to pick up new things,"
16 and this was -- that will be the recurring theme
17 for this interview. Most of the allegations
18 that have been made against you are directed at
19 this general theme. Limit the number of new
20 concerns, close the existing concerns, don't
21 pick up any new items. Clear the decks of
22 anything that will interfere with fuel load."
23 This is just one of those.

24 A. Doesn't it make sense, though, that I
25 had no control over what was going to keep

1 coming in?

2 Q. Based on my interviews with some of
3 your people, that is still in -- there seems to
4 be some conflicting opinions on whether you had
5 control of that, in that you supervised those
6 who were conducting the interviews.

7 A. But I'm talking about people
8 terminating.

9 Q. You provided me with a list of numbers
10 of people that were terminating being
11 interviewed, and I know that during your months
12 that you were supervisor, Q-1, through fuel
13 load, the numbers of exiting employees in Q-1
14 remained about the same. They remained in the
15 400 to 500 range. Yet the number of concerns
16 taken by the people dropped off dramatically.

17 A. Here, again, you had to be in the
18 program to understand why. You can't come from
19 the outside and understand it.

20 Q. Well, I'm relying on these insiders
21 here who have explained to me why. That is
22 what -- we will get to that in a little while.
23 I don't want to get ahead of myself here.

24 A. Yes.

25 Q. Chuck, when you took over Q-1 -- you

1 were talking about QPVs and QPDs awhile ago. If
2 any of these action documents or if a QFAR were
3 elevated, and I hope that is the right word, to,
4 say, a higher priority document, like an NCR or
5 a corrective action report, a CAR, did that
6 cause these -- was that sufficient for closure
7 of a Q-1 concern?

8 A. If the upper tier document, I will
9 refer to it, contained all of the elements of
10 the lower tier, the QPD, QPV, QFAR, if all of
11 these were contained within this other upper
12 tier document, then that upper tier document was
13 responsible for closure, either QPD, QPV, or
14 QFAR, in that there were within the quality
15 programs the methodology, the requirements, to
16 address, resolve, and verify corrective action
17 on those issues, or issue, if it were a singular
18 one.

19 Q. How did your Q-1 investigators, if
20 they were beginning their investigation or were
21 in the midst of it, and it went to a higher
22 tiered document -- did they just reference that
23 document, and that was the basis for closure?

24 A. I can't speak to every case, but I
25 will make a general statement, that if the facts

1 were there, if the upper tier document -- they
2 could verify that it addressed all of the
3 concerns, as it were, all of the attributes of
4 the concern that they were working on, and had
5 QPD, QPV, or QFAR, if they were sure they were
6 there, they had the option of closing that out,
7 as it were, saying, "This other document is
8 addressing this issue."

9 Q. Would they normally list -- since the
10 issue was unresolved at that point, would they
11 generally list the allegation that substantiated
12 that point, even if they hadn't finished their
13 investigation?

14 A. Generally, I would say yes. That
15 would be -- again, there would be no need for
16 the upper tier document if it were not
17 substantiated on that one particular issue.

18 Q. One of the other criticisms that some
19 of your former employees made was the
20 prohibition that you put in place after you took
21 over, and that was that discussing cases among
22 themselves. Could you explain the basis for
23 this?

24 A. Yes. It's my understanding that the
25 team that I assumed control over, and they liked

1 to call themselves a team, functioned as a team,
2 in that they would all go out with bits and
3 pieces of a concern and all come back and get
4 together and sit down, including the office
5 girls, whoever was involved, and all sit down in
6 one big happy family and discuss the issue, and
7 they would get their directions the next day to
8 march, to do this, that, or the other thing.
9 There were a lot of people involved who had no
10 need to be involved. A lot of people had
11 information about investigations who had no need
12 to. It's not their business to know what was
13 going on in that application.

14 When I took responsibility for the
15 organization, I had supposedly qualified
16 interviewers, supposedly qualified
17 investigators, supposedly qualified clerical
18 people, supposedly qualified lead people, as it
19 were, supervisors. When I say "supposedly," I
20 had to rely upon their credentials given to me.
21 Recognize, again, they came from all over the
22 country. If I hired a man as an interviewer, I
23 did not expect to have someone hold his hand for
24 him to do his job when it came time for him to
25 do it. If he was qualified, he should be able

1 to do his job. If I hired an investigator, and
2 his expertise was in a certain area, and that is
3 what was advertised when I hired him, I expected
4 him to be able to do his job without somebody
5 holding his hand.

6 Now, I think you could go back and
7 question any of them, where I prohibited the
8 group meetings. I did not prohibit him gaining
9 particular information. If he knew somebody
10 else in the organization had some specific
11 knowledge about something that would benefit him
12 in doing his investigation, he was free to do
13 that. If he needed guidance, he was instructed
14 to go to his supervisor and get the guidance.
15 If his supervisor was unable to provide it, come
16 to me, and I would provide it.

17 Q. Okay. You have identified the single
18 point that, I guess, some of your employees had
19 the most concern with, and that is drawing upon
20 the technical expertise, fellow investigators,
21 who had this extensive and -- and an appreciable
22 number of these people said, "We were prohibited
23 from doing this, and therefore I didn't," and
24 they considered that this h' diminished their
25 ability to resolve the issues, because they felt

1 like the prohibition was broad, or specific
2 number, that they would be in trouble with you
3 if they discussed these -- some of these
4 technical concerns. But you are saying that was
5 not your intent?

6 A. That's not true. In fact, they
7 could -- anything they could justify to me, they
8 all knew that I would listen to justification
9 arguments.

10 Q. One of the things I would like to
11 spend a little time doing -- by the way --

12 (Whereupon, a short recess was
13 taken.)

14 MR. GRIFFIN: Back on the
15 record, and Mr. Silberg wants to ask a couple of
16 clarifying questions.

17 MR. SILBERG: Chuck, when you
18 talked before about the interviewers distilling
19 the concerns down to one or two sentences, was
20 there any program or procedure which told an
21 interviewer to try to get the specifics of a
22 concern? You know, which pipe and which person,
23 I think, are the examples that Brooks used. If
24 that information was available, would the
25 interviewers have tried to get at --

1 THE WITNESS: Yes, I believe
2 so. The interviewers were given instructions.
3 A guideline was issued, which is currently part
4 of the procedures, relative to conducting
5 interviews. In fact, I don't recall the
6 specific date, but during the time when Owen
7 Thero's position was supervisor of interviewers,
8 we had several training sessions relative to the
9 interviewing process, and I attended the session
10 and personally requested Owen to give the
11 training session on how to conduct interviews,
12 the line of questioning, the reiteration of the
13 concern, the reading back of the concerns to the
14 allegers, so there was no mistake of what the
15 concern was. In fact, the guidelines -- the
16 instructions were developed jointly with all of
17 the interviewers in the organization. They all
18 had their input as to what ought to be the
19 process or the guidelines for interviewing.
20 Whether or not every interviewer followed those
21 guidelines in that training session, I'm not
22 sure, because I was not the person involved in
23 every interview, and the results of the
24 interview might not reflect that. However, the
25 effort was put forward by the individuals

1 responsible to do it.

2 MR. SILBERG: Would you have, as
3 part of the training or procedures or your
4 instructions, told the interviewers only to give
5 you one or two sentences of a very general
6 concern or to give you and the investigators as
7 specific a concern as possible, identifying all
8 of the information that would be necessary for
9 an investigator to go out and look into the
10 problem?

11 THE WITNESS: The instructions
12 given were to get as specific as they possibly
13 could. In fact, during the interview process,
14 if it were something of a technical nature,
15 relative to discipline, electrical, mechanical,
16 or civil in nature, they were instructed to draw
17 from these individuals who had that very
18 technical expertise to also participate in the
19 interview in order that we not miss anything
20 that the alleged would have to say or have a
21 misunderstanding of the content.

22 MR. SILBERG: That's all.

23 Q. (By Mr. Griffin) To follow up on
24 that, Chuck, once the tape-recorded interviews
25 were dispensed with, I think I realized during

1 my case review that, as the numbers got larger,
2 which means cases that were taken, the
3 interviews that were performed while you were
4 supervising tended to get shorter and shorter.
5 The documentation in the files got shorter and
6 shorter. It did standardize the reporting
7 process, which helped quite a bit, but
8 without -- I don't have a list of cases here,
9 because I didn't look at all 700 or 800 cases,
10 and I can't say, "Okay, 500, after you took
11 over, are not sufficiently documented on the
12 interview," but using my best available
13 information, which is the former Q-1
14 investigators and my very limited case review, I
15 was disappointed in the amount -- or the lack of
16 information, and my question to you, why were
17 you willing to accept such a lack of specificity
18 on these things across the board?

19 MR. SILBERG: Are we talking
20 about on the concerns or the final reports?

21 MR. GRIFFIN: No, on the
22 interviewers. We are talking about just that
23 part of it at this point.

24 A. I will respond to that this way. We
25 have always utilized a standard form, which you

1 are familiar with, the concern disclosure
2 statement, the reason being we want the
3 specifics, naming the individual badge, who they
4 worked for, and so on. The majority of the
5 people who gave us any input would not even stay
6 to supply any additional information. These
7 were people who were terminating and going out
8 the door. For the most part, they really didn't
9 even want to tell us anything. Many of them
10 felt compelled to convey certain information to
11 us. Most of it was of no significance, when you
12 look at the numbers, vast numbers. So it was
13 not a matter of our efforts. It was a matter of
14 their lack of cooperation. They were leaving
15 the project.

16 Q. (By Mr. Griffin) Why was it that,
17 earlier on in the project, when Mr. Thero was
18 running the show, why were they so cooperative
19 then and so uncooperative later on?

20 A. It's an assumption on my part, if I
21 may answer. It's an assumption. I have no
22 facts, so I have to draw -- make an assumption.
23 It appears we experienced the influx of allegers
24 who had in their minds legitimate concerns at
25 this point in time. The program was opened up.

1 They had an opportunity to come forward, where
2 heretofore they supposedly didn't. At least not
3 in the outside organization, an independent
4 organization. They took advantage of that.

5 We also saw that, the later on you
6 went in the program, fewer people who were
7 disgruntled about being laid off. Nobody wanted
8 to be laid off first. And I could go back and
9 look through the files, and I could draw out
10 names of people who had concerns because they
11 were being laid off. They were promised, "I'm
12 going to be the last to be laid off, not the
13 first," and it didn't happen that way. It was a
14 matter of money, it appears, again. I'm
15 assuming from my knowledge of the people that we
16 processed, the attitudes of the people, that the
17 further you got in the program, the more obvious
18 it was everybody had to get laid off someday, so
19 that later we didn't have the problem about
20 being laid off early like the first ones did.

21 Q. I understand what you are saying, and
22 it sounds as if that certainly would have to be
23 factored into what we might speculate the answer
24 might be. However, some of your former
25 employees here had some other -- speculated some

1 other ways, and that is that because of the
2 limits placed upon how the cases were being
3 conducted and everything, that the program had
4 lost credibility later in the game, and that
5 exiting employees didn't feel like that it was
6 worth their time to make concerns, raise
7 concerns, to Q-1. This is the theme that
8 several repeated, and due to other explanations
9 that I have received. Nevertheless, with the
10 numbers that you have provided me, the number of
11 exiting employees remained fairly constant
12 through the program, but I put together a little
13 line chart, and beginning in August of 1984, the
14 closure rate per investigator and the closure
15 rate per month for the Q-1 program made an
16 enormous spike in my little chart, and the -- at
17 that -- during that same month that you took
18 over, the number of concerns taken by Q-1
19 dropped off dramatically and continued to drop
20 off through the life of the project.

21 The other variable, as I have already
22 discussed, the number of exiting employees
23 remained relatively stable. So the way this was
24 interpreted by some of your subordinates was
25 that these various changes that you had made in

1 the program had resulted in less investigative
2 effort, more case closures, and a desire not to
3 take allegations. We have speculated here as to
4 what some of the things were that could have
5 caused this, but nevertheless it did happen.
6 Have you got any observations about my
7 characterization of your subordinates --

8 MR. SILBERG: It's kind of hard
9 for us to characterize the --

10 A. If I hear it again, I must make some
11 assumptions. Okay? One was that the program
12 was successful. Okay? If I am going to take
13 any credit for success, then I guess I would
14 address it that way. Organization -- again,
15 contrary to what others might say, the biggest
16 single problem in the organization, when I took
17 it over, was a backlog of untyped interview
18 notes in order to start an investigation.

19 Q. (By Mr. Griffin) Okay. Now, we have
20 covered that.

21 A. Yes.

22 Q. You have -- if you are going to bring
23 cost into the --

24 A. No, no, no.

25 Q. If you say that KG&E couldn't hire or

1 MR. SILBERG: This was over what
2 period of time? Per month or per week?

3 MR. GRIFFIN: Per month, because
4 that is the way the statistics were kept.

5 Q. (By Mr. Griffin) Now, as you
6 increased the number of investigators that you
7 had, which was -- you know, obviously they could
8 produce more work, and you would expect to see
9 more cases, concerns closed, and they were.
10 However, the closure rate per investigator per
11 month went from the three to four to five range
12 up to a peak up here, right before targeted fuel
13 load, to as much as -- I think it was 11 1/2
14 cases per month, with some of your investigators
15 closing larger than an average of a case a day.

16 A. I agree with that.

17 Q. At the same time, the other variable
18 here, the number of concerns being documented by
19 Q-1, dropped off rather dramatically. So you
20 have got the lines going in two opposite
21 directions, which gives you a -- from the
22 perspective of some of your -- of some of your
23 subordinates, that you have effectively shut
24 down -- not stopped completely, but slowed down
25 the number of concerns put into the Q-1 program,

1 and you have managed to, either through good
2 management, although that is what -- some of
3 these people don't have exactly that
4 perspective, you have managed to get the case
5 closure rate up so dramatically that you are --
6 that people are closing cases one a day.

7 This also included, in some cases,
8 wrongdoing, which I'm more familiar with. If
9 you have got a guy closing one wrongdoing case a
10 day, that is rather dramatic. A month's worth
11 would be ten years for me. It takes me -- you
12 are talking about doing 33 cases. That is
13 probably ten years for me, yet you have a guy
14 there that can close them one a day. So what
15 these people -- what your subordinates -- not
16 all. Some of them are strong advocates of your
17 management style, your program, and they were
18 proud to be part of it. A majority, though,
19 don't feel that way. A majority point to these
20 numbers, and they say, "What we have got here
21 is, we have a man who got these cases off the
22 books before fuel load, and he was successful.
23 He did KG&E a good job."

24 A. Am I -- are you wanting me to
25 respond?

1 Q. I want you to respond to my
2 characterization of what your former employees
3 have said.

4 A. May I do it without interruptions?

5 Q. Uh-huh.

6 A. Okay. The reason I ask that, forget
7 about cost of schedule. That is not my
8 interest, when I explained this.

9 The date you see on this -- when I
10 look at July and August, August having been the
11 day I came in, I think you will find that the
12 middle of August, this number went way down, by
13 your own chart. Okay? Right in here. At the
14 first of -- by the middle of September, it was
15 down to nearly an all-time low. Not as low as
16 over here, but it was -- I look at this, and I
17 see roughly the 15th of August it started to go
18 straight down, the 15th of August.

19 Q. Well, you know these line charts don't
20 work this way. This just represents the whole
21 month. It's between there and there.

22 A. Okay. But, again, I came in this time
23 frame, nearly the first of September.

24 Q. Well, see, what we are talking about
25 here is -- the critical point on this chart is

1 this point right here and this point right here.

2 A. That's right.

3 Q. Right here you started a dramatic
4 increase and right here you started a decrease,
5 decrease in allegations received, and a dramatic
6 increase.

7 A. Uh-huh.

8 Q. There are several possibilities.

9 A. When I look at the 1st of August on
10 this, and it shows the increase on the rate of
11 investigation, the activity, relative to closing
12 out, this -- but this goes hand in hand. To
13 close, you have to investigate it, that's the
14 way we operated, unless you already have
15 evidence that somebody else has investigated
16 this earlier, and it was the same -- same
17 concern, or very similar, so you could utilize
18 some of that information.

19 Again, in August of 1984, the buildup
20 had started. There had been commitments made to
21 bring people on. Not people I had chosen, but
22 people that the QA manager had reviewed their
23 resumes. They would say, "We want this person
24 on board." They gave an option of either not
25 bringing them on or bringing them on. He

1 interviewed them. I would not go back and
2 reinterview them and look at their credentials.
3 I believe they knew what they were doing when
4 they looked at these people. We brought them on
5 board.

6 Again, at that point in time, if I had
7 had 100 investigators, I couldn't have worked
8 all of them, because the data was not available
9 to do the investigations. It was still on
10 tape. Again, I corrected that. I had people
11 working overtime. I put more people on it so we
12 could get that information on the street. The
13 majority of the interviews were all taped. For
14 what reason, I do not know. Some of them were
15 very simple. Some of them were not the long,
16 drawn-out things that you see. It appeared to
17 be a habit, rather than write, was to listen.
18 To me, that is a sign of laziness, if that is
19 all you are going to do is listen, if you don't
20 want to take time to write. But that is my
21 personal opinion again. Okay?

22 So the reason you see this was a
23 combination of people being committed to come
24 in, and you can go back and look at the records
25 from July and August, and bringing people in the

1 21st of August, the 28th of August, the 2nd of
2 September, 5th of September. Whatever. The
3 record shows when they were agreed to be brought
4 in, assigned to that activity. We did our best
5 to get information ready, to give them cases to
6 investigate when they hit the door. We trained
7 them. There were certain required training and
8 procedures. We had to take care of required
9 training. That took maybe several days, in some
10 cases, before a person could get involved in
11 doing the job that they were going to do.

12 Anyhow, that was the only interference
13 there was, when they came on board. By
14 "interference," I mean anything restraining them
15 from getting to work, having the tools to work
16 with. That is, having the interview notes and
17 everything so they could start an
18 investigation. But, prior to me coming in,
19 again, there was no way that they could go over
20 to that organization. The people had never done
21 anything, since they didn't have the tapes
22 transcribed. You see this drop again. I can go
23 back to this point in time, when they started
24 laying off the people, and the facts bear me
25 out, if you go look at the records, the

1 interviews. The people who were unhappy,
2 because they were being laid off, they -- it was
3 a matter of fact at this point in time here, we
4 are getting this job done.

5 Now, that -- you know, a person can
6 believe me or not. You can listen to those
7 people, listen to me, whatever you want. But
8 you will find that there weren't near the
9 unhappy employees in that time frame that there
10 were earlier on, plus we had picked up the
11 majority of the walk-in ones. If you go look at
12 the records, see how many walk-in cases there
13 were after a certain point in time. We even
14 went to the point, and it was a matter of
15 procedure, we still do it, people who were
16 terminated without coming through the program.
17 There is hundreds of letters we wrote.
18 Hundreds. Responses were very meager, though.
19 There are some responses, but very few, relative
20 to the number of letters sent out. There was no
21 longer a real interest. Now, that was not
22 because of me. I didn't do any advertising.
23 Nobody went out and advertised, said "Chuck
24 Snyder took this organization over, so you can't
25 trust it any more." There wasn't time to do

1 that. If you think of people, how could you
2 have reached the people on that job site and
3 said, "Forget about quality first." There was
4 no way. When I went in there, I went in to do a
5 job, and that was to address the concerns we
6 had, to make sure every individual who came
7 through the program had an opportunity to voice
8 their concerns, with the assurance that the
9 concerns would be investigated. If they were
10 found to be substantiated, with merit, they
11 would be addressed with corrective action and
12 verification of that corrective action. If they
13 wanted a response, we would give them a
14 response. Very simple. The numbers had nothing
15 to do with my management. The numbers had to do
16 with the posture, as it were, of the project at
17 that point in time.

18 Q. Okay. I --

19 A. As I look back on it, there were
20 enormous numbers here of concerns that had not
21 been investigated. So you and I have, I think,
22 over the months past, to a degree, discussed
23 that. Not in this detail. So I don't think
24 it's anything new with me giving you what might
25 be construed to be philosophy.

1 Q. Some of the factors you raised
2 certainly would influence these numbers, but
3 some of these factors that your subordinates
4 have raised would also, if true, affect these
5 numbers.

6 A. I'm sure --

7 Q. I'm not saying -- we don't look at
8 this graph here and say this is a conclusion.
9 I'm just saying, some people believe these
10 numbers are important because they show, when we
11 get over here to December of 1984, the cases are
12 closed, and there is not very many new ones
13 coming in, and yet the number of exiting
14 employees is still relatively high. So, mission
15 accomplished, you know. Nothing is going to
16 stop fuel load.

17 A. If I may make one other comment
18 relative to this, and the progress of the
19 program in general, to the best of my knowledge,
20 I took no one in my confidence within the
21 interview or the investigative group, other than
22 the supervisors, and made them aware of
23 statistics and the progress. The interviewers
24 and the investigators were given a job to do,
25 specifically, and they were expected to do their

1 job. It was not my responsibility to make known
2 to them the project, what was happening in the
3 project, and --

4 Q. No. If you thought that was what I
5 was saying, I'm not. What they are saying is,
6 under your supervision, the program lost
7 credibility. People quit coming. People didn't
8 want to make allegations to Q-1 any more. That
9 is the thrust of it.

10 A. The thrust of it, that is not true.

11 Q. And that the interview processes were
12 changed and the instructions to the interviewers
13 were changed, and all of these various factors
14 resulted in people making fewer concerns, even
15 though the number of exiting employees going
16 through Q-1 remained constant.

17 A. I would disagree with -- here, again,
18 I had a more general knowledge and touch with
19 the entire situation than they did on just
20 individual specifics.

21 Q. I appreciate your perspective on
22 factors that could have affected those numbers.

23 I would like to move now to -- I will
24 give you an opportunity, I think you have been
25 waiting for it, to make some observations about

1 some of the reviews that have taken place of
2 your program. This is hardly a first, and some
3 of the criticisms that have already been aimed
4 at the program from the various organizations.

5 Beginning in September, Mr. Madsen
6 came in and looked at some of your files.

7 MR. SILBERG: This is September
8 of --

9 MR. GRIFFIN: 1984.

10 Q. (By Mr. Griffin) Do you recall his
11 reviews of your files?

12 A. Yes, I do.

13 Q. Okay. This went on for some time. He
14 was primarily looking at technical issues.
15 Based on my review of his inspection reports,
16 the findings relative to your handling of
17 technical issues appear to be generally
18 favorable. Also, in this same time frame,
19 William Ward from OI, Bill Ward, came down and
20 did an examination, not -- or an evaluation, is
21 the proper word, an evaluation, of the KGSE
22 investigative process, of which Q-1 is only a
23 part. In reviewing Mr. Ward's work, and I think
24 you, in the last month or two, had access to
25 that finding, I have distilled out of that

1 certain criticisms that he had of the program.
2 Mr. Ward's review occurred in September and
3 October. Obviously, you had just started in
4 August, so maybe much of what he was reviewing
5 here were what things you had inherited. I
6 still would like you to respond to some of his
7 criticisms, get your perspective on the
8 observations he made in his one- or two-week
9 review.

10 Ward was critical of the fact that
11 there seemed to be no central control for KG&E
12 groups conducting investigations and no
13 standardization of work product. He was
14 concerned that Q-1 did things one way, the Q-1
15 information going to the project managers, like
16 Mr. Fouts or the Daniel people, for whatever
17 investigative activity, like you were talking
18 about, drugs, that there was no standardization,
19 so everybody was just kind of handling these
20 things as they saw fit. Did you ever attend any
21 meetings or have any discussions about
22 standardizing the process?

23 A. No, I did not. Could I respond to
24 this chronologically in general?

25 Q. Yes.

1 A. Relative to Glen Madsen -- in
2 September, in fact, was the first time I met
3 Glen. He came in and made me aware of what his
4 position was. We gave him free access to any
5 file we had, to look at anything he wanted to
6 look at, any questions that he wanted to ask,
7 and expect to get responses. He and any other
8 individual, other than OI, I have to qualify it
9 that way, who came in to see us to look at the
10 files, always exited with us, made us aware of
11 their perceived weaknesses, the findings. In
12 every case we got a report later, identifying
13 these. In every case we incorporated the
14 recommended changes. In every case. There were
15 some, like, seven or eight reports I'm talking
16 about, now, between September of 1984 and June
17 of 1985. In that time frame. Hopefully I have
18 adequately addressed that involvement relative
19 to recommendations and weaknesses.

20 Now, in September of 1984, Ben Hays,
21 who was director of OI, Bill Ward, assistant to
22 the director of OI, and Richard Herr, who was
23 Region IV field director of OI, visited the
24 site. They spent the better part of a day with
25 me. We discussed the objectivity of the quality

1 first program. We discussed the philosophies
2 employed and methodologies. Bill Ward spent the
3 majority of his time running somewhere else,
4 other than visiting with me, and I know of one
5 particular instance where he was with our chief
6 of security. But that is the only person I know
7 he was with specifically.

8 The only words I ever got out of OI in
9 that meeting was why wasn't I making people wear
10 their -- they were about 30 days, to go DOL,
11 when they leave this project, if they have a
12 problem. And my answer was then, my answer is
13 now, that is not my responsibility. I'm not a
14 government agency. Sometime in the, and I'm
15 guessing, now, the spring of 1985, Richard Herr
16 came to visit me. He spent the better part of a
17 day with me. Again, we discussed primarily one
18 particular issue, one case, which I had complied
19 with OI requests to make them aware of a
20 substantial wrongdoing concern. I sent him the
21 information. He came up and we discussed it.

22 The report that you are talking about
23 that Bill Ward evidently generated in December,
24 that is the date on it, he accumulated the
25 information in September or October, November.

1 I saw that report for the first time in August
2 of 1986. At that time, I took action on his
3 philosophy, if nothing else in there. A lot of
4 it is his philosophy. I assume it's his
5 philosophy. I brought about some changes. I
6 made words to my management of the need, based
7 upon his perception, what we had to do to get a
8 total investigative program. That, in
9 chronological order, is the reports, my
10 responses, or my involvement.

11 Q. Chuck, we have talked about this
12 before, before today, and I know your
13 frustration in not having had NRC direction and
14 criticism and feedback from OI, particularly, on
15 this. However, by December the events that are
16 the focus of my investigation are essentially
17 complete. We are reaching back in time before
18 that. I understand your frustrations, but the
19 facts have already -- I mean, what is done has
20 already been done. You may have the greatest
21 system in the world now. The focus of this
22 investigation is what happened back in the last
23 half of 1984. For the purposes of this
24 interview, I'm going to provide you with a forum
25 to express your concerns and your weaknesses,

1 you think, in the NRC oversight and everything,
2 but the questions will primarily be along the
3 lines of perceived deficiencies by your own
4 people, and in this case Mr. Ward, of things
5 that he discovered in reviewing your program.
6 If you want to make statements about what went
7 on or what happened or what could have happened,
8 otherwise, that is fine. I want to provide you
9 with an opportunity to do that.

10 A. Could you ask me questions
11 specifically?

12 Q. I am.

13 A. Okay.

14 Q. I'm going to do that. One of the
15 things that Ward believed he discovered was a
16 particularly strict interpretation of what was
17 reportable. You read his report. He learned --
18 I believe he learned from the -- from his site
19 visit that it was a two-part -- to qualify under
20 a 50.^{15(e)}~~00~~ was a two-parter, one that a
21 construction deficiency, if uncorrected, could
22 adversely affect the safety of operations during
23 the life of the plant, which was the first
24 element, and the second element, that a
25 significant breakdown in the quality assurance

1 program -- if these two factors existed, then it
2 was a reportable item.

3 At the time -- my question is, at the
4 time that you assumed supervision of Q-1, was
5 this -- were you using both this two-part
6 criteria to determine whether something was
7 reportable?

8 A. To the best of my knowledge, it was.
9 I simply continued with a methodology of
10 evaluating. I made no changes in the
11 methodology of evaluating the --

12 Q. As a supervisor, what was your
13 interpretation of the reportability
14 requirements?

15 MR. SILBERG: Wasn't there a
16 form that existed before you --

17 THE WITNESS: I'm trying to --

18 A. Maybe I can best answer it this way:
19 Owen Thero had been involved in quality
20 assurance activities for many, many months,
21 years. He was responsible as the team leader
22 for the correct evaluation, the filling out of
23 the forms, words, and so on. When he was
24 assigned -- when I took over the responsibility
25 of interview supervisor, he retained that

1 responsibility, because that paper was generated
2 in that part of the house. It was just a
3 natural thing for him to continue doing that.

4 Now, I did not go in and determine
5 whether or not the methodology was correct. One
6 thing I would like you to understand, again, is,
7 shortly after I came in, NRC, Region IV, was
8 also looking at everything. They brought the --
9 they did not bring to my attention any
10 deficiency in that arena. Again, I didn't see
11 any perceived deficiency until August of 1986,
12 in Bill Ward's. That was the first word I had
13 been given. That's the first indication that I
14 had that there was any problem with our
15 methodology.

16 MR. SILBERG: Isn't the
17 reportability to termination usually something
18 that goes to INE as opposed to --

19 THE WITNESS: Yes.

20 MR. SILBERG: So Madsen would
21 have been the --

22 THE WITNESS: Yes. They were
23 the natural ones.

24 A. That was something we reviewed in
25 detail with them at the time. Again, I had no

1 negative feedback from those folks. I guess,
2 if -- again, if I had had a negative feedback,
3 then I would have got deeper involved in it.
4 But, with no negative feedback, I see no -- at
5 that time, and in retrospective, any need for me
6 to have gotten involved. Again, as manager, I
7 was busy addressing problems. What I could
8 delegate, that would run smooth, I delegated
9 it. I had to keep it all running smooth.

10 Q. (By Mr. Griffin) Mr. Ward's point was
11 here, if you had a significant breakdown in the
12 quality assurance program, but you didn't have
13 the other aspect, you weren't -- apparently
14 weren't reporting it, and he thought that this
15 was not a viable interpretation of the reporting
16 requirements. From what you have just said, I
17 get the impression that maybe you did not get
18 into this subject very deeply --

19 A. I did not.

20 Q. -- and that is the answer.

21 A. Yes, sir. I did not.

22 Q. But this problem or what we perceive
23 to be a problem with reportability also extended
24 to issues of wrongdoing, had to meet this same
25 two-part criteria, and the, you know, the OI's

1 point of view, and I would like to think the
2 NRC's point of view, that, if either one of
3 these conditions existed, it was a reportable
4 item. Not both of them together only, but
5 either one of them, separately.

6 An example I would raise is one of
7 the documents you referred -- or you provided to
8 me when I was doing my case reviews, which was
9 the -- the NCR on the Diss-alvo tape issue. The
10 NCR -- on the front page of the NCR, there is a
11 blank for 50.^{65(e)} reportability. I assumed this
12 was a substantial and important thing, and it
13 took you all years to correct this deficiency.
14 However, under your reportability evaluation,
15 this is not -- this is marked as not a
16 reportable item. I think the philosophy of what
17 was reportable, because the ~~NRC~~^{NRC} is only given
18 credit for, like, 1/2 to 1 percent inspection of
19 a nuclear facility, and we rely on the licensee
20 telling himself, when he sees a deficiency, and
21 that extends to wrongdoing.

22 I want, for the purpose of this
23 interview, to get a clarification on what your
24 understanding of the reportability requirement
25 was. But your testimony, if I'm hearing it

1 correctly, is that you did not make this
2 distinction.

3 A. That's correct.

4 Q. Okay.

5 MR. SILBERG: I'm sorry, this
6 distinction between --

7 MR. GRIFFIN: It is a two-part
8 thing.

9 Q. (By Mr. Griffin) I noticed each one
10 of your files had reportability documents in
11 there. Sometimes they would say, "Yes, this is
12 reportable," with no signature. Then, in front
13 of that, there would be another reportability
14 item for the same concern, and it would say,
15 "No," and it would be signed.

16 A. But there is a preliminary finding.
17 The preliminary did not require signatures. It
18 was simply a process of showing that we had
19 looked at -- that it was -- that it was under
20 evaluation, on preliminary. Again, it was a
21 procedural thing that was put together, and we
22 simply maintained procedure obligation.

23 Q. Who wrote the -- who filled out the
24 forms on the reportability?

25 A. Different people did. I don't --

1 Q. I mean, under your supervision. Was
2 it the investigator, or was it the supervisor,
3 or who --

4 A. To the best of my knowledge, it was
5 with the interview group, who took all of the
6 facts, when it was -- to start with, the facts
7 that we had to work with, preliminary, and then
8 the facts that the investigator came up with.
9 It was in the interview group. I'm going to
10 say, off the top of my head, the interview
11 supervisor. But I'm not going to swear to that,
12 because I would have to go back and look at
13 signatures and so on.

14 Q. In the way you were operating, when
15 the investigator had completed his legwork, so
16 to speak, he referred the information back to
17 the interviewer for close-out? Is that right?

18 A. That's right.

19 Q. That was the system you were using?
20 Then the interviewer also had the responsibility
21 for recontact --

22 A. Yes.

23 Q. -- of the allegor --

24 A. The check-off sheet and all that, to
25 close it out.

1 Q. So, under your supervision, the
2 interviewer was making the ultimate call on
3 reportability?

4 A. Based upon the facts provided by the
5 investigator.

6 Q. Okay. Another criticism Mr. Ward made
7 of Q-1 was that he believed that the emphasis
8 was placed on hardware aspects related to
9 wrongdoing issues and that, as a result, the
10 reports did not focus on the elements of
11 intent. Now, an example of this, or a good
12 example that might be, and I think this is one
13 you have been anxious to discuss with OI, is the
14 Q-1 investigation filed by NRC, OI investigation
15 on the color coding of drawings by two
16 supervisors. I think the OI recently received a
17 memo from Mr. Withers, W I T H E R S, you know,
18 which I presume was your primary criticism of
19 this. This is a good example of intent, I
20 think. You pointed out -- Mr. Withers pointed
21 out in his memo that the -- that these drawings
22 are not inspection documents, and to my
23 knowledge nobody ever has indicated that they
24 were. However, it's my understanding -- and I
25 wasn't the investigator on that case, but it was

1 my understanding that those documents were
2 relied upon by inspectors to know what areas
3 remained to be inspected. Now, I'm using this
4 as an example of intent. What did the
5 ~~interviewers~~^{supervisors} intend when they colored in those
6 areas, to show that these areas had been
7 inspected and the inspection criteria had been
8 accepted? Now, in Mr. Withers' review of the
9 cases, he felt that your people were saying,
10 "Okay, the hardware is okay, this is ^{not} an
11 inspection document, and that is the end of
12 our concern," whereas, from the NRC's
13 perspective, what other things did these
14 people -- what other -- what other inspections
15 did these supervisors influence with this same
16 intent? What about the validity of the
17 program? Mr. Ward perceived that you were
18 saying, "Okay, there is nothing wrong -- we
19 don't have to rely on those color-coded
20 drawings, so that is the end of the problem."
21 Was that your perspective?

22 A. No. If I may elaborate again, on that
23 particular investigation, the allegation was
24 falsely marked-up drawings.

25 Q. But that is the language of your

1 people, that is not our people.

2 A. No, no, no. I'm saying that is the
3 allegation. Okay. We investigated that
4 allegation. We found out -- we found in fact
5 that there were falsely marked-up drawings. We
6 substantiated that. We required corrective
7 action to be taken to correct that condition, to
8 the extent that they had to go back, in order to
9 satisfy the investigator in the organization and
10 me that they corrected all discrepancies on
11 those drawings. They had to do some evaluative
12 work relative to some encased bolted and welded
13 connections on steel beams. They had to go back
14 and re-evaluate some information relative to lot
15 numbers and heat numbers and other identifying
16 marks. In fact, if one were to read the quality
17 first file, I think you are going to find that
18 it is very objective, addressed the entire
19 falsely marked-up drawings allegation, to the
20 extent that everyone was satisfied that the
21 problem had been adequately addressed and
22 resolved.

23 Q. Back to what I was -- to Mr. Ward's
24 criticism, you have spoken about -- you got the
25 hardware right. The focus of his criticism is

1 that, in a case like this one, the focus seems
2 to be on getting hardware right. What was done
3 to these supervisors who falsified these
4 color-coded drawings? What steps were taken to
5 determine what other things they may have
6 adversely affected, using the same philosophy?

7 A. There is two answers you are looking
8 for.

9 Q. That's two questions.

10 A. Two questions. Let me address first
11 what happened to the individuals. At the time
12 we initiated the investigation, one of the
13 individuals had been transferred to another
14 site, was no longer on this project. There were
15 some phone conversations with him, if I remember
16 correctly, to get information that he thought
17 was necessary. The other individual or
18 individuals who were involved were interviewed
19 by quality first investigators. These same
20 individuals were part of the corrective action,
21 or they participated in the corrective action.
22 We did not expand that investigation to
23 determine if they had done like -- or had like
24 actions in any other area, nor did we
25 incarcerate them.

1 Q. I know you didn't incarcerate. What
2 the NRC's concerns -- you said you got the hardware
3 way corrected, or you got it reinspected or
4 whatever needed to be done --

5 A. As far as I know, we --

6 Q. -- but what I'm driving at is the
7 philosophy of trying to determine the extent of
8 the damage that may have been when you realized
9 wrongdoing had occurred.

10 MR. SILBERG: I think the
11 question is why didn't you expand the
12 investigation.

13 MR. GRIFFIN: Better put.

14 A. I guess my only honest answer would be
15 ignorance.

16 Q. (By Mr. Griffin) Well, this is going
17 to be a recurring thing. Not ignorance. But
18 this is going to be a recurring thing as we
19 proceed with this interview, and it may become
20 tiresome to you, but OI, on each of these
21 wrongdoing issues, as we get into them, as you
22 will see -- why did -- why did you choose to
23 ignore -- if somebody said, "They are screwing
24 up all of the welds, and here is one as an
25 example," and you go fix that weld, and that is

1 the end of the problem, case closed, this
2 philosophy is foreign to the NRC. Not just OI.
3 I'm just wondering if there was a conscious
4 decision in Q-1 to take this approach so that
5 you could achieve quick case closures on these
6 hundreds of items.

7 A. No. When I said ignorance, I -- this
8 particular issue, I spent many hours personally
9 involved with it, because I had to assure that
10 corrective action took place. It was a
11 monumental task. It only involved, as you are
12 aware -- again, I spent many hours personally
13 involved in that issue.

14 Q. Yes, I know you spent -- you have told
15 me you spent a lot of time fixing the hardware.
16 I'm just asking you -- this is what we in the
17 NRC call root cause. Was there a conscious
18 decision not to explore what other areas these
19 people may have adversely affected --

20 A. No.

21 Q. -- what their potential instructions
22 as supervisors to their inspectors, how -- if
23 there were any other areas where they had not
24 been complying with the procedures or with the
25 intent of what -- of the inspection process?

1 I'm just asking you, is there a conscious
2 decision to limit these things to just the --
3 just the hardware that you -- that has been
4 specifically alleged to have been adversely
5 affected?

6 A. No. All I can do is go back again and
7 say, when I said ignorance, it was not until I
8 saw what Bill Ward wrote and -- and -- I'm
9 trying to remember any other area, where this
10 was brought to my attention, anyway. Never
11 having been made known to me, and me never -- I
12 guess "expectations" is a better word, not
13 knowing what expectations were relative to this,
14 what OI's methodology would have been.
15 Therefore, I was using -- utilizing methodology
16 where I was addressing the concerns.

17 Q. I understand your testimony. Okay.

18 MR. SILBERG: You said you
19 didn't incarcerate them.

20 THE WITNESS: By that I mean I
21 did not -- well --

22 MR. SILBERG: I mean, was any
23 disciplinary action taken against them?

24 THE WITNESS: I don't believe
25 so. The reason I made that statement, there is

1 one case that we pursued, and Brooks is aware of
2 it, and Richard Herr and I discussed it in
3 detail, and I guess "incarceration" could have
4 been a terminology that would have been
5 appropriate for that particular one, action
6 taken against the responsible individual.

7 MR. SILBERG: Would it have been
8 quality first's responsibility to initiate, if
9 not incarceration, then disciplinary action
10 against the supervisors who were involved in
11 this color coding?

12 THE WITNESS: At the time I
13 would have said no, and after having read what
14 expectations were now, I would say possibly
15 yes.

16 Q. (By Mr. Griffin) Let me make a
17 statement here. OI is not going to tell Q-1 how
18 to run its shop. We can make suggestions. We
19 certainly don't expect you to go over and talk
20 foully to the guy that works for another division
21 or even another company. We know that doesn't
22 take place. However, as the investigative
23 branch of the licensee, if you find that
24 somebody has -- if you substantiate wrongdoing,
25 we are going to question you, what kind of

1 follow-up there was to that wrongdoing. In
2 fixing the weld, it does not -- it is not the
3 end of the wrongdoing. That is just the
4 hardware part of it. That is the only point I'm
5 trying to make here, is whether you all
6 consciously stayed away from any kind of a
7 thing, other than just fixing the hardware.

8 A. Again, this one issue, questioning
9 that was asked, the line of questioning, the
10 response was, from the involved individuals,
11 that they -- and I'm going to have to draw from
12 memory. They did not feel they were involved in
13 wrongdoing, when they were marking up these
14 drawings. They did not do it to meet the
15 system. In many cases, it was assumption that
16 they marked up the drawings as they did. So,
17 here, again, the direct response to that, I
18 had -- it was not that we didn't recognize the
19 possibility. It was just that, again, in our
20 methodology, we had what appeared to be adequate
21 responses from these people, the rationalization
22 of why they did certain things, and we did not
23 automatically feel that they were guilty of
24 having done something wrong, so to speak. It
25 was one of those things, again, just trying to

1 get across to you, it was considered, but we did
2 not pursue it, possibly, from the same vantage
3 point that OI would pursue it.

4 MR. SILBERG: Perhaps just to
5 get a better story on the record, this
6 transcript, do you want to explain a little bit
7 on what their explanation was as to why they
8 performed this color coding?

9 THE WITNESS: I'm going strictly
10 from memory. I believe that their explanation
11 was that they believed that the other
12 individuals had or someone had inspected these
13 attributes earlier. Another explanation was
14 that the indications or the marks they made on
15 the drawings were only relative to confirming
16 that the material was located where it was
17 supposed to be. There were many explanations
18 offered. Once, back again, to accepting
19 responsibility -- and the only defense I have
20 again is, at the time, I was not aware of the
21 potential significance for not having performed
22 it the way OI would have performed it. That is
23 the only response I have.

24 MR. SILBERG: Wholly apart of
25 how OI might have gone about it, were you, at

1 the time, satisfied that there was no indication
2 that there had been other episodes of this kind
3 of conduct in other areas?

4 THE WITNESS: I had no
5 indication of a conspiracy, per se, or an
6 organized effort to do something contrary to
7 project requirements. I saw no evidence of
8 that. We had other investigations, which we
9 addressed, also, but I did not pull all of these
10 together and say, "I have one big wrongdoing
11 effort underway." I never approached it that
12 way. I saw no reason to. Again, we addressed
13 each concern on its own merit at the time. It
14 was necessary that I do as good a job as I could
15 on each one.

16 MR. SILBERG: The specific
17 concern here was that these drawings had been
18 marked up incorrectly and --

19 THE WITNESS: Falsely marked
20 up.

21 MR. SILBERG: That was
22 substantiated?

23 THE WITNESS: That's correct.

24 MR. SILBERG: Corrections were
25 made to those drawings and the hardware that was

1 associated with those drawings?

2 THE WITNESS: That's correct.

3 And verified.

4 Q. (By Mr. Griffin) It's not really my
5 intent to dwell on this, but the philosophy of
6 identifying wrongdoing, fixing the hardware, and
7 ignoring the more important seriousness of what
8 led to the wrongdoing, the intent of those that
9 did wrong and what other things they may have
10 affected, is a criticism that NRC has.

11 A. I would interject this. It was not a
12 philosophy.

13 Q. Well, we will -- as we go through more
14 of these, we will see.

15 Let me switch subjects, Chuck. Were
16 any of your Q-1 investigators involved in the
17 allegations made against Mr. Rudolph about
18 kickbacks?

19 A. Not against my investigators. But,
20 again, I think I need to elaborate. An
21 ex-investigator was the alleger.

22 Q. What happened to this subject?

23 A. An investigation was performed jointly
24 between quality first and KG&E legal
25 department.

1 Q. Do you all have a file? Does Q-1 have
2 a file on this issue?

3 A. Yes, we do.

4 Q. Do you know what the Q-1 conclusion
5 was relative to the kickback issue?

6 A. The best of my memory, we were unable
7 to substantiate that he in fact was guilty of
8 participating in any scheme for kickbacks,
9 bribes, whatever. There was just no evidence to
10 substantiate it after our investigation.

11 Q. Didn't he testify that he had received
12 money from some source?

13 A. Oh, yes, but that was relative to a
14 contract. That was relative to having performed
15 a service. That was not for anything else.

16 Q. I see. That service that he provided
17 was outside the scope of his authority as
18 manager of --

19 A. That's right. It was on -- just for
20 way of clarification, it was an application
21 outside even the project.

22 Q. All right. One of the most
23 often-heard criticisms among the former
24 investigators I interviewed, which -- they felt
25 that there were time limits placed on them for

1 conducting investigations and getting them
2 closed and that, even though Bob Scott was the
3 supervisor that they interfaced most closely
4 with, that you were kind of the guy that did the
5 arm twisting. Is that true?

6 A. No. I never did any arm twisting.

7 Q. Did you limit the time in which
8 investigators had to work on cases?

9 A. No, I did not limit the time that they
10 had to work on cases.

11 Q. You never had any complaint to you
12 about -- that they were having their
13 investigations cut short or that they were --

14 A. No, not to my memory.

15 Q. Chuck, at any time, from the time you
16 took over Q-1, was there ever any purging of
17 documents from the files?

18 A. Not to my knowledge.

19 Q. I mean, for any reason, was there ever
20 a decision made by anybody that a certain
21 document shouldn't be in there in the first
22 place and therefore should be removed?

23 A. Not to my knowledge. I will make one
24 statement, though, again. We did transfer
25 files, but this was not a purge.

1 Q. You are talking about to legal?

2 A. Yes.

3 Q. I'm not talking about that, either.

4 A. Okay.

5 Q. I want to touch on -- I'm going to be
6 asking you about certain cases, Chuck. I know
7 you didn't do the investigations. I will be
8 drawing on your memory. Therefore, I'm not
9 going to be asking you intimate details about
10 these things, even though -- I mean, if you know
11 something about it, because it was a big issue
12 or something, I would appreciate any kind of
13 further explanation you could give, but there
14 are certain aspects of certain investigations
15 that I want to question you about.

16 One of those -- the first one is --
17 the number is [REDACTED] Item 2. This was the
18 external pipe cleanliness investigation, which
19 involves swipe tests. Most of the cases I'm
20 going to be talking to you about here today were
21 mentioned by a number of these people. They
22 seemed to be aware of some of the more
23 significant or sexy issues, and this was one of
24 them.

25 The only aspect of this case that I'm

1 interested in is, information was developed
2 during the Q-1 investigation that the sampling
3 process used to resolve this issue, once the
4 pipes had been cleaned, one of -- it was learned
5 or it was -- this information was developed
6 during the course of -- by the Q-1 investigator,
7 that information was transmitted to the people
8 cleaning the pipe as to what areas would be used
9 in the sampling process, and only those areas
10 were cleaned. Do you remember this aspect of
11 this investigation?

12 A. No knowledge whatsoever of it.

13 Q. Okay. Well, this was reported, I
14 believe, by the Q-1 investigator. Regardless of
15 your -- the other aspects of your procedures,
16 about writing observations or something, here is
17 an allegation of wrongdoing developed by your
18 own program that was not either addressed in
19 this investigation or in any subsequent
20 investigation.

21 A. That was never made known to me in any
22 way, shape, or form. This is the first I have
23 heard of that, out of your mouth.

24 MR. SILBERG: I'm sorry, the
25 issue was that someone was telling the

1 construction people which pipes would be
2 sampled --

3 MR. GRIFFIN: The investigator
4 learned during his investigation which areas
5 were going to be resampled after the pipes were
6 cleaned, and only the pipes were cleaned where
7 the sampling was going to occur. Therefore, it
8 didn't require a lot of cleaning, if you are
9 only cleaning what is going to be sampled. When
10 you conduct the sample, then everything looks
11 good.

12 Q. (By Mr. Griffin) I just wondered if
13 there was a conscious decision on your part to
14 not pursue this or --

15 A. No. This is the first I have heard of
16 this. I have never read of it. It's the first
17 I have heard of it.

18 Q. Let me move on to another subject.
19 One of the early -- I think this is Thero's,
20 before you became the Q-1 supervisor, but it was
21 ongoing after you assumed control. The issue on
22 the missing MSSWR structural steel wall cards.
23 Were you the supervisor when/ () was
24 removed from the program, ()

25 A. When he was what?

7D, portions

1 Q. Removed from Q-1.

2 A. I believe () was out of the program
3 when I took it over.

4 Q. Did you ever hear any explanation from
5 any of your fellow managers as to why Mr.
6 () was removed?

7 A. No, I did not. I never asked, and no
8 one ever volunteered, to the best of my
9 knowledge.

10 Q. Well, I will tell you that many of the
11 people I interviewed thought that Mr. ()
12 removal was retaliation for having raised a
13 significant issue and pursuing it aggressively,
14 and he was taken out of Q-1 and placed back in
15 audit, which was perceived to be a demotion by
16 his fellow investigators, and was said to have
17 had a chilling effect on the investigative
18 process. You are not aware of that?

19 A. I have no knowledge of that
20 whatsoever. Absolutely none.

21 Q. Let's go back to the investigation
22 that had to do with -- it was the allegation
23 with the blackballing of Mr. () I think
24 the investigation was [REDACTED] Item 2. In
25 this case, I think Mr. () was the

6,7C & 7D, Returns

1 investigator. When I reviewed the report on the
2 Q-1 file, Mr. [REDACTED] report contained in
3 the file shows that case to be -- that it was
4 substantiated. Is that your recollection?

5 A. No, it's not. I had occasion this
6 past week to look at that file, at that
7 particular issue, because of your interest in
8 it. That is not so. What I find in there are
9 notes relative to the investigation. I find a
10 summary prepared by Mr. Thero, addressed to me.
11 Mr. Thero has drawn conclusions that are
12 contrary, in my opinion, to the facts that were
13 generated in the case.

14 Q. Okay. So the fact that the -- the
15 mere fact that you received the memo from Thero
16 didn't mean that you accepted his philosophy?

17 A. That's correct.

18 Q. So this investigation was ultimately
19 proved to be unsubstantiated?

20 A. That's correct.

21 Q. I would like for you to explain your
22 philosophy in this case, Chuck. The
23 investigator, Mr. [REDACTED] doesn't --
24 performs an investigation. He concludes that
25 blackballing has occurred.

617C47D, portions

1 MR. SILBERG: He just said --

2 THE WITNESS: No.

3 A. He did not draw any conclusion.

4 Q. (By Mr. Griffin) Well, I interviewed
5 Mr. [REDACTED]

6 A. The file doesn't contain any
7 conclusion.

8 Q. I interviewed Mr. [REDACTED] Mr.
9 [REDACTED] said he draw the conclusion -- what
10 we are getting to here is the fact that
11 apparently you didn't draw that conclusion. I
12 want to know your philosophy about changing
13 investigative conclusions.

14 A. If I might, again, Mr. [REDACTED] did
15 not produce any conclusions in the file. The
16 only conclusions in the file at the present
17 time, to the best of my knowledge that were ever
18 in the file, was a memorandum from Mr. Thero,
19 addressed to me. Mr. Thero at that time was the
20 interview supervisor. He was not the
21 investigation supervisor. He was not part of
22 the investigations. He offered a conclusion
23 which was not in any way construed to be nor did
24 it say was the conclusion of the investigator.

25 Q. In my interview with Mr. [REDACTED]

6,7047D, Porters

1 as the investigator, he said that he believed
2 the man had been blackballed, and that was his
3 investigative conclusion. He reported that to
4 his supervisor. Then the general consensus is
5 that, at a level above Mr. [REDACTED] or Mr.
6 Thero, a decision was made, after reviewing the
7 facts, that that was not the conclusion. Does
8 Mr. Thero believe that Mr. [REDACTED] was
9 blackballed?

10 A. Evidently, according to the memo in
11 the file, he does.

12 Q. But you didn't? Is that correct?

13 A. That's right.

14 Q. This gets to the gist of something
15 that I had to wrestle with the whole time I was
16 doing the case, and I think other contingents in
17 NRC have, too. That is, this idea of the
18 investigator making a call or arriving at a
19 conclusion and a supervisor arriving at another
20 conclusion, that is relying on what? If he is
21 relying on what is in the file, then I would
22 make an observation that he doesn't have that
23 such information to work with, one of the great
24 criticisms the NRC has had of Q-1, which is lack
25 of documentation. The basis of you drawing a

G, 7C & 7D, portions

1 separate conclusion on this, did you avail
2 yourself not only to what was contained in the
3 file but also of the complete information that
4 Mr. [REDACTED] had used to make -- to draw his
5 conclusion?

6 A. To reach my conclusion, I -- and I
7 have got to go back again. I assume, again -- I
8 have to put that in there, because that has been
9 some time ago that I did this. I assume that I
10 utilized only that information contained within
11 the file.

12 Q. Okay. That is the flaw I see in this
13 process.

14 MR. SILBERG: Well, if I --

15 MR. GRIFFIN: Let me make my
16 point.

17 Q. (By Mr. Griffin) The NRC comes in and
18 reviews these files. Obviously we are
19 disappointed in the lack of documentation. We
20 had difficulty drawing conclusions on any of
21 these things, because the allegation may consist
22 of one sentence, and the investigative report
23 may say, "I talked to people, and I looked at
24 files, and I said it's unsubstantiated." That
25 is not much to review. There may be more than

6,7C47D, portno

1 that, but it may be sufficiently cryptic that we
2 can't make much more out of it than that. Now,
3 you are telling me that you are going against
4 your investigator's conclusion.

5 A. I didn't say that.

6 Q. Okay. If you will accept for a
7 moment, my conclusion, based on Mr. [REDACTED] ⁽²⁰¹²⁾
8 testimony to me, that his conclusion was that --

9 A. He never told me that, though.

10 Q. Well, if you didn't ask him -- is that
11 your testimony? You didn't ask him? You looked
12 at the files, and then you changed the
13 conclusion?

14 A. No, I didn't. Again, the only
15 conclusion in the file was one that was reached
16 by the interview supervisor, not the
17 investigation supervisor, not the investigator,
18 but Mr. Owen Thero, whose title on September the
19 12th, I believe that was the date, 1984, was
20 interview supervisor. He had no involvement
21 whatsoever in the investigation. He offered an
22 opinion, and his opinion is in error. The
23 investigator drew no conclusions in that file.
24 There are none in there. There never were any
25 in there, evidently.

6,70 & 70, portions

1 MR. SILBERG: Brooks, this is
2 one of the few files that I actually went
3 through, because you had raised this. I don't
4 know what is in all of the other files. This
5 file happens to have a lot of information. I
6 mean, it has interviews with the alleged. It
7 has interviews with the people who gave the
8 recommendations at both Mr. Rudolph and -- at
9 Arkansas Power & Light, or Arizona Power &
10 Light, and it has Mr. Thero's memo. I read
11 those files cold, and I had not heard about this
12 individual concern or the blackballing.
13 Frankly, there is no way on earth that you could
14 reach the conclusion that Mr. Thero reached.

15 MR. GRIFFIN: Is this your
16 testimony?

17 MR. SILBERG: Yes. I'm just
18 telling you what I saw.

19 MR. GRIFFIN: I'm not here to
20 debate with Mr. Snyder for the purpose of this
21 interview whether he was right or wrong.

22 MR. SILBERG: No.

23 MR. GRIFFIN: If you think that
24 is where I'm going --

25 MR. SILBERG: No. The point is,

1 you said there was no information in the file,
2 on which someone could base another conclusion.
3 That may be true in other cases, but there is a
4 lot of information in this particular file.

5 MR. GRIFFIN: I will give you
6 that point, there is a lot of information,
7 because the interview with the APS, Arizona
8 Power Service, people, was characterized in
9 there.

10 Q. (By Mr. Griffin) The only point that
11 I'm getting at here, and I don't want to sit
12 here and drill on this one case all day, because
13 that is not -- no one case makes the program,
14 but I want to find out what you relied upon to
15 change -- to arrive at a separate conclusion
16 from what your subordinates did, the people who
17 actually performed the work. And you told me.
18 You reviewed what was in the file --

19 A. That's correct.

20 Q. -- and you drew a different
21 conclusion, and you have the final word.

22 A. But, again, the significance, Brooks,
23 I would like to bring out, is Owen Thero had no
24 involvement in that investigation. The
25 investigator was [REDACTED] did not

C, 7C + 7D, returns

1 offer a conclusion in that.

2 Q. All right. Do you know if Mr.
3 [REDACTED] offered a verbal briefing or a
4 conclusion to Mr. Thero before Mr. Thero wrote
5 that information?

6 A. I do not. He does not in his report
7 say that.

8 Q. Those reports don't say a lot of
9 things, Chuck. I'm asking you, you didn't avail
10 yourself to Mr. [REDACTED] position on this --

11 A. I don't remember. I don't remember
12 having --

13 Q. Are you concluding that Mr. Thero
14 didn't, either? Mr. Thero's and Mr.
15 [REDACTED] conclusions are the same. Yours is
16 the one that is different.

17 A. Again, I don't believe I asked Mr.
18 [REDACTED] but I wouldn't swear to that.

19 MR. SILBERG: He also didn't
20 know, I'm gathering, what [REDACTED]
21 conclusion was when he drew his conclusion.

22 MR. GRIFFIN: Yes, that seems to
23 be the case.

24 Q. (By Mr. Griffin) How many other cases
25 have you changed in this fashion?

6,7097D, part 1

1 A. Again, I don't like the word
2 "changed." I didn't change anything. There had
3 no responsibility for drawing conclusions,
4 number one. Okay? Now, without having talked
5 to the investigator, if you want to put it that
6 way, without having sat down and asked
7 ██████████ as the investigator of record, "What
8 was your conclusion," I don't know of any
9 other. Again, I would have to go back to case
10 after case after case. I don't recall.
11 Remember, when I took over the program, I put
12 up -- and this is -- this is imperative that you
13 understand this. August the 21st, when I took
14 it over, I reorganized. I put in an
15 investigator's supervisor. I put in an
16 interview supervisor. The investigator's
17 supervisor had the responsibility for ensuring
18 that investigative reports were written. This
19 is evidently one that was in the middle that had
20 been completed, supposedly all of the work done
21 on it, before Bob Scott ever got into the
22 process of re-reviewing and getting the
23 investigative report. It's only when I went in
24 that I had investigative reports written. They
25 were using surveillance reports and they were

6,7007D, Porters

1 using whatever prior to that time to document an
2 investigation. I put in place a requirement,
3 "You must document on an investigative report.
4 You, as the investigator, must put down all of
5 the facts. You, as the investigator, must draw
6 the conclusions from the facts. The
7 investigator, supervisor, will review it, after
8 you complete it."

9 Q. Hold that thought, because when we go
10 through the rest of these things, and when we
11 discuss the lack of documentation in that file,
12 to draw any conclusion whatsoever, we -- this is
13 just the -- the first of many. I found
14 difficulty in drawing any conclusion on many of
15 these files, relying on what was in the files.
16 The philosophy that has been conveyed to me by
17 these former investigators was that they were
18 acting often as I perceived NRC inspectors do.
19 They go out and look at documents they need to
20 look at, they talk to people who they need to
21 talk to, and then they draw a conclusion, and
22 the agency accepts that conclusion. This
23 philosophy, during the interview with Q-1
24 investigators, is consistent with what NRC
25 inspectors do. In other words, the file may not

1 contain the testimony of individual witnesses.
2 It may not contain summaries of the files that
3 were reviewed or documents that were reviewed.
4 It may indicate that the people were talked to
5 and the files were reviewed, but it may not be
6 very elaborate in showing the basis for drawing
7 the conclusions.

8 A. That very well could be.

9 Q. So I can't draw conclusions from
10 looking at the files. To some degree I would
11 have to -- if I had faith, I would have to rely
12 upon what the Q-1 investigators did. When I go
13 back and I interview them, and they say, "No,
14 there was a problem with this" or "There was a
15 problem with my investigative conclusion being
16 changed," and then you tell me that you are
17 relying on the files, and I have looked at the
18 files, and I don't think I can rely on them, I'm
19 not sure that this is -- I considered this maybe
20 faulty methodology, in changing or in drawing a
21 conclusion from an incomplete file. If you were
22 prepared to rely upon these people and upon
23 their judgment, and you did not require them to
24 document the interviews thoroughly, and you
25 didn't let them tape the interviews, and they

1 were permitted to half-heartedly document
2 whatever other evidence they availed themselves
3 of, then for you to come along and say, "Well,
4 I'm going to use this file to change a
5 conclusion," I could -- I'm not sure that I
6 agree with that. You may -- you may disagree
7 with my perception here, but I want to have a
8 clear understanding, not just on this case, but
9 on others. This is the method you are employing
10 to change investigative conclusions or arrive at
11 a separate conclusion or to determine that it
12 has no merit, and you don't have available all
13 of the information they did. I'm not sure that
14 this is a good approach.

15 A. I don't think that is the approach.
16 Again, a transition period, when things were not
17 well defined, when we didn't utilize the new
18 forms and the like, is the only thing I can
19 speculate here happened on this particular one.
20 Again, later on, it was required that each
21 investigator fill out that investigative
22 report.

23 Q. I have looked at those investigative
24 reports, Chuck, and they are not -- they don't
25 thoroughly detail it. They will say, "I talked

1 to five people." So? What did they say? It
2 doesn't say. What questions were they asked?
3 What were the responses? It doesn't say. I
4 reviewed documents -- it may turn around and say
5 "I reviewed CAR 19" or "I did this" or -- most
6 of them are not totally incomplete. There are a
7 few that are. But the language of the
8 investigative reports clearly shows that other
9 resources were tapped for the investigators to
10 arrive at their conclusions. The only point I'm
11 trying to make here is, you were prepared, at
12 least in this case, to draw a conclusion from
13 incomplete information.

14 MR. SILBERG: In this case --
15 getting back to this case, it's not clear, at
16 least based on my quick looking at the file,
17 that that was incomplete information. In this
18 case. Maybe there was other stuff, but
19 certainly the key documents were there. The
20 interviews with the people were there for me to
21 look at, for you to look at, for Chuck to look
22 at.

23 Q. (By Mr. Griffin) So you think this
24 was just a --

25 A. This was in a transition period, I

1 think, Brooks, because -- I guess what I'm
2 saying -- I will not disagree with your
3 perception of the adequacy of the investigative
4 report or whatever, from your standpoint. I'm
5 saying that I don't think you are going to find
6 where an investigative report was prepared,
7 after you put into place the procedures that the
8 investigators must do, that you will find I
9 disagreed with the investigator in the outcome.

10 Q. Well, as we go through some of these
11 others, we will see.

12 A. That's fine.

13 Q. Let's move on. I think we understand
14 each other on this point, and we continue to
15 disagree about the process.

16 A. Yeah.

17 Q. I understand what your testimony is,
18 and that is what the purpose here today is.

19 (Whereupon, a discussion was
20 held off the record.)

21 Q. (By Mr. Griffin) We have had a
22 15-minute philosophical debate off the record
23 about the legality of blackballing, whether it's
24 truly anything that we can identify
25 specifically. Let's resume the interview here.

1 One of the -- going back for a minute,
2 one of the criticisms that Mr. Ward had,
3 specifically, and I have heard this repeated,
4 and I would just like your comments on this, is
5 many Q-1 investigations did not attempt to
6 evaluate the potential scope of the allegations
7 but rather tended to treat each as an isolated
8 incident. Do you understand what is being said
9 here?

10 A. Yes, I understand that.

11 Q. This is one of the most sensitive
12 parts of the whole Q-1 program for the NRC, this
13 treating -- putting a Band-Aid on the one thing
14 identified and not looking beyond it. Could you
15 explain why you employed the way of focusing on
16 these concerns that you did?

17 A. Let me deal with numbers to start
18 with. By that I mean, I get a person who has
19 one concern, dealing with numbers, and that
20 concern is one issue or truly one concern. It
21 does not branch out. On the initial interview.
22 An investigator is assigned to investigate
23 that. That investigator pursues that concern.
24 Now, if during the course of that investigation
25 that that investigator did he identifies

1 potential weaknesses, not within the confines of
2 that particular concern, the instruction was,
3 prepare a QFO and identify --

4 Q. I understand what you are saying,
5 Chuck. You have taken a little different
6 perspective, and we have already covered that
7 ground. Maybe a quick hypothetical. The QC
8 says, "I have been intimidated by my
9 supervisor." There is 15 guys on this crew.
10 The Q-1 investigation, of course, is already an
11 interview, in the allegor. You go in and ask
12 the supervisor, "Did you intimidate him," and he
13 said "No," and you close it out,
14 unsubstantiated. To not determine whether any
15 of those 15 other guys experienced intimidation
16 or trying to use -- to determine whether they
17 could corroborate it, that the allegor was
18 intimidated, is the type of limiting of scope
19 that the NRC has heartburn with.

20 Now, if, during the interview, if it's
21 conducted thoroughly enough, the guy says,
22 "There's a pipe broken, one pipe broken, and
23 here is the location," that is a one-shotter.
24 If the guy says, "All of the welds done by this
25 crew on the switch gear are faulty, go look at

1 this one," and then you go look at this one, but
2 you don't look at any others, again, that is
3 limiting the scope in a way that the NRC would
4 be critical of, back then and today or at any
5 time. Yet, based on the testimony of these
6 people, over and over again, they were required
7 to focus, they could not expand it, and absent
8 observations, and I'm talking about expanding
9 the investigation, and -- I would like just a
10 further explanation as to why you choose to
11 employ this methodology.

12 A. Can I isolate again for the sake of
13 clarification? I don't think that you have
14 allegations relative to the wrongdoing
15 involvement, recognizing -- and [REDACTED] ^{(b)(7)(D)}
16 handled all of the wrongdoing allegations.

17 Q. No, he didn't. Mr. Brooks and Mr.
18 [REDACTED] closed out H&I and all that --

19 A. At a later date, but let's go back to
20 the time frame we are talking about. Okay?

21 Q. Okay.

22 A. [REDACTED] ^{(b)(7)(D)} was responsible for the
23 INH. Everybody knew that. I don't recall a
24 person coming to me and saying, "I need to get
25 involved in INH. I can't do it right. We are

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1 not going far enough or anything else." I just
2 don't know of anything like that. So, if you
3 will, accept that for the INH issues right now.
4 But let's go back to the other, the ones of a
5 technical nature, if you want to classify them
6 as that.

7 MR. SILBERG: Is it your point
8 that [REDACTED] had free rein, or based on his
9 experience, as an investigator, would carry his
10 investigation to what he thought to be the
11 appropriate scope?

12 THE WITNESS: Yes.

13 MR. GRIFFIN: I find fault with
14 that, because he is not even the one who did the
15 interview, so he didn't know the original
16 scoping, what was originally available to him.

17 MR. SILBERG: No, I was just
18 trying to get on the record the relevance of the
19 fact that [REDACTED] had responsibility for
20 INH.

21 MR. GRIFFIN: I knew that.

22 A. What you told me, Brooks, was that
23 these people complained about not being able to
24 go far enough, and just for the purpose of
25 clarification, I don't think you found that

[Handwritten signature]

1 relative to his investigations and people
2 wanting to get into the INH arena.

3 Q. (By Mr. Griffin) No. Mr. Ward said
4 that, based on his review, he found, over and
5 over again, that this is the way the
6 investigations were scoped. He saw an immediate
7 need, and so did Mr. Driskill, when he came back
8 through, and so have I, as I have gone through
9 my very superficial case review. Over and over
10 again we have encountered what we believe we
11 have now established as a -- as a method of
12 operation here, where in fact the -- each one of
13 these allegations was treated as an isolated
14 incident. Based on the testimony of the former
15 Q-1 investigators, yes, this is the philosophy
16 that you put to them, as you mentioned before,
17 observations, and -- but I want -- what I want,
18 and I need from you here, is an explanation, as
19 to why you chose to adopt this approach. Was it
20 just to close cases quickly, so you could get
21 them off the books before fuel load?

22 A. No, and that is not the case, but I --
23 again, can I speak to other than wrongdoing?

24 Q. Yes. I'm talking about across the
25 board here.

1 A. Again, I'm trying to address the
2 allegations made to you, okay, and I'm saying,
3 I do not know, and I don't think you do, of any
4 of the people saying that they were not able to
5 go far enough in the INH arena. What I'm
6 hearing --

7 Q. You just want to talk about
8 wrongdoing.

9 A. No.

10 MR. SILBERG: He's trying to
11 separate the two.

12 A. Eliminate wrongdoing from this
13 discussion. I don't see -- it's very
14 complicated. I'm wanting to address the other
15 issues, the stuff that other -- people other
16 than ~~(b) (7) (D)~~ were involved in.

17 Q. (By Mr. Griffin) Go ahead.

18 MR. SILBERG: Is his assumption
19 correct, that there is no complaint on narrowing
20 the scope or having too narrow of a scope of
21 wrongdoing?

22 MR. GRIFFIN: No. The NRC is
23 critical of -- based on what is available in the
24 file, which we know is incomplete. I mean, this
25 is not a -- this whole interview process, on

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1 this subject, program operated by many
2 individuals, is difficult at the outset. But,
3 no, I'm not prepared to draw a line anywhere,
4 because as soon as you start to try to draw a
5 line, you realize how many variables there are
6 that affect that, that keep you from drawing
7 that line.

8 A. The reason I wanted to draw the line,
9 if I can explain, is I'm trying to address my
10 methodology. That is what you asked me to do.

11 Q. (By Mr. Griffin) Go ahead and draw
12 the line, then, because I need to know your
13 methodology.

14 A. I'm saying I don't want to mix the INH
15 in with it. I know the feeling of OI on the INH
16 issue. I want to address what I perceive to be
17 allegations made to you by ex-employees in the
18 quality first program, relative to them being
19 strapped down, or whatever terminology you want
20 to use, relative to being controlled.

21 Again, in order to perform a function,
22 and that was to do what we committed to the
23 employees, associated with Wolf Creek Generating
24 Station, we committed to listening to their
25 concerns, to investigate their concerns, to

1 accumulate the facts, to draw conclusions,
2 assure them a corrective action would take
3 place, and notify them of corrective action
4 after we verified it. Now, in so doing, making
5 that commitment, in following to implement it,
6 it was my decision to assign a concern to an
7 individual. My interest was to get that concern
8 resolved. Okay? That concern has got to be
9 resolved. It can't stay out there for six
10 months, eight months, a year. We must resolve
11 it. The name of the game is do it in a timely
12 fashion. That is the way you get the results
13 you want. You have to take corrective action to
14 correct something. You can't let it go forever
15 without correcting it. So you concentrate on
16 looking at the objective, which was the
17 concern. If during the process of that concern,
18 again, something else reared its ugly head,
19 whatever you want to call it, at that point in
20 time it is a potential weakness, and I think
21 anybody and everybody would agree with me.
22 Until you convince yourself, until you do an
23 in-depth evaluation or investigation, it's a
24 potential.

25 Again, if those -- any of those

1 investigators thought that that was a real
2 weakness or a real concern, all they had to do
3 was call on the telephone, say, "I've got a
4 concern that quality first has to investigate."

5 Q. Okay. So that is your answer. These
6 people, if they didn't feel like they should --
7 if they didn't feel they were allowed to go far
8 enough in their investigations, the investigator
9 should have become an alleger, anonymous or
10 otherwise?

11 A. He had that option.

12 Q. I don't think that is a good
13 methodology, and I'm making a little out-of-
14 school comment here, but that is not --
15 investigators don't do that. Investigators have
16 to establish the integrity of their
17 investigation, and they cannot put on blinders
18 and say, "I'm just going to look at this one
19 weld, and I'm not going to look at the other
20 welds." To suggest that investigators should
21 then become allegers, to turn other
22 investigators in, who are going to have to wear
23 those same blinders, is not a valid approach.

24 MR. SILBERG: The point I think
25 Chuck is making or trying to make is that, if

1 the other weld problem or potential other weld
2 problem turned up, there was a mechanism for
3 that, and that was the QFO.

4 MR. GRIFFIN: But based on my
5 conversations with the investigators, the
6 insiders, the people that would know, not
7 relying on my own judgment, they said that these
8 things were going over to QA or going over to
9 the effective organization. There was no reason
10 to believe that these people were going to go
11 back and conduct an investigation to see -- to
12 try to scope these problems. Q-1 seemed to be
13 the group on site that had the time, the
14 wherewithal, the support, and the authority to
15 properly scope these things. To say, "Well,
16 we are going to pass the scoping aspect of this
17 on."

18 Q. (By Mr. Griffen) I'm just -- we don't
19 need to go too much further into this, Chuck,
20 but I'm -- I'm just the last in a long line of
21 people who have been critical of Q-1 on this
22 subject. I was looking for and asking you for
23 an explanation. I think I understand your
24 testimony, but --

25 A. There is one thing I need to interject

1 yet on top of that.

2 Q. Okay.

3 A. Relativity played a big part in it.
4 Just relativity. You talked about one weld.
5 You talked about welds on a piece of switch
6 gear. There is no way that, in our methodology,
7 if one weld had been called out on switch gear
8 number so-and-so, or in a switch gear by a
9 manufacturer, that we would have looked at just
10 one weld.

11 Q. Well, your former investigators, and I
12 can't recall the names, but essentially, as a
13 body, as a group of people who were doing this
14 work for you, disagreed.

15 A. Could I offer -- could I offer an
16 explanation why I think they disagreed?

17 Q. Sure.

18 A. The majority of these people you are
19 talking to are ex-QA people, quality assurance
20 people, who have been trained to do audits.
21 That is their life. An audit, an investigation,
22 I'm sorry to say, are not the same. You see, we
23 have a philosophical difference between the NRC
24 and us. You have inspectors, and you have
25 investigators. Now, in the quality first

1 program, we had investigators. We don't have
2 inspectors. They are not criminal
3 investigators, number one. They take direction
4 from whatever the concern is voiced. That is
5 the direction, and they pursue it to come to
6 some resolution on it. They are not auditors.
7 An auditor looks at a whole program. That is
8 what an auditor looks at. An auditor does not
9 look at a very small part of anything.

10 Q. Well, the ones I have found so far
11 that scope the one you do are Q-1
12 investigators. NRC investigators scope -- we
13 try to find the outward bounds of the problem.
14 We don't care anything about finding one weld or
15 one person that was intimidated. We want -- the
16 very first thing we are going to do is find out,
17 how big is the problem.

18 MR. SILBERG: I guess that is
19 the difference. Quality first defined the
20 program. It wasn't OI. It didn't define itself
21 as OI.

22 MR. GRIFFIN: He brought this
23 up. I'm not suggesting he did. He's saying,
24 "We didn't apply the audit methodology. We
25 didn't apply the NRC inspector methodology. We

1 don't inspect OI methodology. We employed our
2 own."

3 A. That's correct.

4 Q. (By Mr. Griffin) Your own people were
5 highly critical of this choice of limiting the
6 scope, to look at just the one -- the one little
7 weld, the one little document that there may
8 have been a probe with or the one inspector or
9 whatever. Frankly, the NRC wants to know -- and
10 like I said, at the outset, this is one of the
11 most sensitive issues. They want a clear
12 understanding of why you chose to employ this.
13 These people here --

14 A. It was not to me --

15 Q. The majority of these people believe
16 that that is the reason, that, if you used this
17 QA methodology, how are you ever going to get
18 these things closed before December. You
19 can't.

20 A. That's not the case. Brooks, if I had
21 received 1,000 allegations from these people, if
22 they had wanted to bring those, I would have had
23 to have investigated those allegations in the
24 program.

25 Q. Do you really think that would have

1 been the best way to resolve the issues, to have
2 Q-1 investigators to become allegers, to make
3 other allegations to other Q-1 investigators?

4 MR. GRIFFIN: Did any of these
5 people or anybody complain to you that QFOs were
6 not being handled properly?

7 THE WITNESS: No, they did not.
8 If my memory serves me correctly, they were --
9 several of them were not happy that they were
10 not able to go on further and further.

11 Q. (By Mr. Griffin) You two have jumped
12 ahead here. You said they could do this. I
13 have seen no -- in my interviews or in looking
14 here, I haven't seen any evidence to suggest
15 that the Q-1 investigators, en masse, became
16 allegers. There is one or two instances of
17 that. You were just saying that they had this
18 opportunity. They didn't do it.

19 MR. SILBERG: My question is a
20 different one. The question is, did they make
21 known to Chuck their -- not through anonymous
22 calls, but did they go in to Chuck and say, "I'm
23 unhappy the way the QFOs are being handled by
24 QA," or whoever they are referred out to?

25 THE WITNESS: No. They made

1 known, many of them, their dissatisfaction with
2 developing and implementing the QFO, but never
3 did any of them come to me and have a problem
4 with the handling of the response that was
5 coming back.

6 Q. (By Mr. Griffin) Do you know if any
7 of them went to Mr. Scott or Mr. Thero and then
8 voiced lavish concerns on this subject?

9 A. No, other than what I received back,
10 that they were unhappy with having to generate
11 them. In other words, relinquish -- the concern
12 was relinquishing what they thought was in their
13 control to somebody else. That was the only
14 concern that was made known to me.

15 Q. Okay. I think I understand your
16 testimony on that.

17 A. Okay.

18 Q. We could go a lot further, I'm sure.
19 When Mr. Denise arrived up here with
20 his task force, in their report, which I
21 reviewed, one of the parts -- one of the points
22 that they were critical of was the
23 inappropriateness of the feedback to Q-1 from
24 organizations that were to support the closure
25 of cases. I suppose, in the exits, since they

1 do exits, they must have discussed this
2 thoroughly.

3 A. They did.

4 Q. Based on my own picture or view, I did
5 not see any appreciable amount of evidence that
6 Q-1 was doing a particularly critical review.
7 Is this something that you all acknowledged to
8 Mr. Denise during this exit, or did you disagree
9 with him on this subject?

10 MR. SILBERG: I'm sorry? A
11 critical review of feedback?

12 MR. GRIFFIN: Yes.

13 A. Let me again relate chronologically,
14 if I may. I think the point in time you are
15 talking about with Mr. Denise, making known to
16 me or the organization making known, the absence
17 of feedback, was in the May 27th, 1985, review,
18 the big review with 17 NRC people reviewing our
19 files.

20 Q. (By Mr. Griffin) Uh-huh.

21 A. Immediately following that, we took
22 steps --

23 Q. Okay. I understand what you are
24 saying. I appreciate it. I appreciate that you
25 are going to say that you changed your program.

1 For the purpose of this interview and time,
2 let's -- I know that you were responsive, and
3 you have said many times to me that just "NRC,
4 tell me what you want, and we will be
5 responsive." They were critical, for the
6 purpose of this interview, though, they were
7 critical of the feedback. My question is, do
8 you disagree with Mr. Denise's criticism that
9 the -- that the feedback was not meaningful?

10 MR. SILBERG: At what point?
11 This 1984 period?

12 MR. GRIFFIN: Yes, back when
13 these investigations took place.

14 A. Just in generalities, I would agree
15 that it was not meaningful, based on what they
16 presented us at that meeting.

17 Q. (By Mr. Griffin) That cuts off a lot
18 of questions I would have.

19 MR. SILBERG: What was the
20 reason why you think there wasn't better
21 feedback at that point in time?

22 THE WITNESS: Because
23 procedurally the instruction was to transfer
24 these concerns out, and "transfer" has a
25 connotation that you transfer all

1 responsibility. By that I mean being able to
2 sleep at night and feel that you did the job
3 right, you know.

4 Q. (By Mr. Griffin) Yes, but
5 procedurally you all had a built-in system where
6 you would review it and determine the adequacy
7 of the feedback.

8 A. No, not at that time.

9 Q. You --

10 A. Only the response back to substantiate
11 or unsubstantiate. I did not have the
12 requirement to go in and review the details --

13 Q. I looked at a lot of the files, and it
14 has -- Mr. ^{67057D} [REDACTED] signature is on neither
15 every one of them --

16 A. Verification of corrective action.

17 Q. You're evaluating that there was
18 corrective action, but you didn't evaluate the
19 merits?

20 A. It all depended on the nature and the
21 time frame. I have to look at the dates of the
22 reports. We made changes.

23 Q. Chuck, one of the other investigations
24 performed by Mr. [REDACTED] had to do with a
25 fellow by the name of [REDACTED] This is a

1 concern that was at the outset of the program,
2 but the concern itself wasn't investigated and
3 closed until October. This is one of those
4 cases where Mr. (b)(7)(C) -- hang on a second.
5 This is one of those cases where Mr. (b)(7)(C)
6 again concluded that the -- that the allegation
7 was substantiated or true. A man had been
8 harassed and intimidated by the start-up
9 manager. This is also one of those things
10 that -- this was escalated to legal -- he was
11 eventually reinstated. However, the allegation
12 is that the list is unsubstantiated. In
13 reviewing the file and interviewing the people,
14 do you have any allegation that is substantiated
15 by the investigator, listed as unsubstantiated
16 on the report, it is -- a guy files a case,
17 which he wins, and is reinstated, and the
18 inconsistency of the -- of the investigator's
19 understanding of his findings and how they were
20 reported, the way it's reported ultimately by
21 Q-1, and then the remaining inconsistency of the
22 guy -- I mean, I know that reinstating a guy or
23 making a monetary settlement with him is not an
24 admission of wrongdoing by the agency, but how
25 would -- how does this come to be and how --

G.7C & 7D, Porters

1 there are a series of these cases where -- it's
2 unsubstantiated, but the guy wins his case or
3 the investigator concludes that a -- concludes
4 that harassment, intimidation, or discrimination
5 took place.

6 MR. SILBERG: Could I just get
7 an understanding of the chronology? This is a
8 case that I haven't at least heard of before.
9 He was -- he filed a concern --

10 MR. GRIFFIN: He made an
11 allegation.

12 MR. SILBERG: That was after he
13 had been terminated on the project?

14 MR. GRIFFIN: I don't have a --
15 let's see.

16 MR. SILBERG: I'm just trying to
17 understand how this --

18 MR. GRIFFIN: You are asking me
19 to reproduce stuff from the file. We know the
20 file is incomplete. I'm not sure I can give you
21 a full -- the parts of it that I can give you
22 are that -- I -- this employee said he was
23 harassed and intimidated by the start-up
24 manager. He was advised that he should take his
25 problems inside first. They interviewed the

1 start-up manager, and he said, "Well, this guy
2 is a ~~criing~~^{criing} bitcher," and they asked -- after
3 this guy continued to complain, the start-up
4 manager asked that his subordinate supervisor,
5 "Have you got anybody we could maybe, like, let
6 go?" Of course, this guy's name made that
7 list. He was terminated. However, he fulfilled
8 a vital function, in that he was one of only two
9 diesel operators on site certified by Colt.
10 However, Mr. [REDACTED] concluded that the
11 layoff was a retaliatory act, and he also
12 further concluded it was a violation of
13 10-CFR-2-10. Like I say, eventually the guy was
14 reinstated.

15 A. I have never even heard the name.
16 That is why I'm sitting here puzzled.

17 Q. (By Mr. Griffen) It's
18 unsubstantiated. When I see that, I can't --
19 obviously you don't have any -- you don't have
20 anything to offer on this.

21 A. I'm not familiar with the case nor the
22 name nor anything else.

23 MR. SILBERG: When you say it's
24 unsubstantiated, is that something that Chuck
25 signed, or is that the report that --


6.7C47D, Pontino

1 MR. GRIFFIN: It's the official
2 Q-1 conclusion.

3 Q. (By Mr. Griffin) These files exist in
4 a variety of forms, and I wouldn't even start to
5 speculate what any particular interoffice memo
6 means, whether that is the final conclusion, or
7 whether the investigative report is the final
8 conclusion, or whether the -- you know, the
9 files were all sufficiently different that I --
10 that, in spite of the fact that you instituted a
11 procedure that had a reporting format and all
12 that, the files are sufficiently different, that
13 they are all subject to interpretation. When I
14 find myself interpreting, I'm more inclined to
15 rely on the investigator. In this case, he made
16 a call. However, the Q-1 file says he was -- it
17 was unsubstantiated.

18 A. I have absolutely no knowledge of that
19 one.

20 MR. SILBERG: Do you have the
21 number of that? We can look at it. I certainly
22 would be interested.

23 MR. GRIFFIN: If you want to
24 satisfy your curiosity -- it's NRC 
25 Item 19, if you want to ^{satisfy} ~~satisfactory~~ your

1 curiosity.

2 A. That was a very early one.

3 Q. (By Mr. Griffin) In terms of taking
4 them, but it was in concern with -- it was
5 closed in November.

6 The next one would be [REDACTED]
7 Item 17. This was another H&I investigation
8 performed by Mr. [REDACTED] against a guy
9 named -- for -- on -- the allegor was a guy
10 named [REDACTED] Do you remember that?

11 A. I'm remember that one.

12 Q. He eventually received a settlement
13 and was reinstated. Is that right?

14 A. That's correct. To the best of my
15 knowledge, he was.

16 Q. My question on this one, Chuck, is --
17 and I want to kind of reach back to the one we
18 just got through talking about with Mr. -- with
19 [REDACTED] whatever his last name is. One thing that I
20 think I saw, as I went through these, page nine,
21 discrimination and falsification things -- I
22 could not see any evidence in there of any
23 repercussions to the people having been proven
24 to have been the discriminators or the harassers
25 or the intimidators. In the case of Mr.

617C47D, Posters

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1 [REDACTED] here, I think his major concern was
2 with Mr. [REDACTED] Do you know if Mr. [REDACTED]
3 ever had any kind of adverse action taken as a
4 result of having Q-1 -- having made the call
5 against him?

6 A. May I expand on the whole subject?

7 Q. Uh-huh, uh-huh.

8 A. This is the only INH case to my memory
9 where Mr. [REDACTED] came to me and said, "These
10 folks are guilty of intimidation and
11 harassment." After having discussed it with me,
12 we prepared a letter for the signature of Mr.
13 Richard Grant, who at that time was my
14 supervisor, making known to Daniel that, in our
15 opinion, they were guilty of intimidation and
16 harassment towards this individual, and we
17 demanded that they take corrective action. The
18 corrective action they took resulted in the
19 reinstatement of the individual, and not shown
20 in the file is another action that took place.
21 I requested a meeting with key management in my
22 organization, key management in Daniel
23 organization, and made known to them my desires
24 relative to corrective action toward Mr.
25 [REDACTED] by name. I told them that I would not

6, 7C & 7D, per terms

1 be satisfied with anything less than his removal
2 from the project. They assured me that it would
3 take place. That was as far as I went with
4 corrective action.

5 Q. It wasn't really in the Q-1 procedures
6 for you to instigate personnel action?

7 A. No, it was not, but here, again,
8 actions to preclude recurrence. I am also
9 obligated to that. The project is obligated to
10 that in general. That is the reason I took the
11 action I did.

12 Q. How about on this previous one? You
13 said you don't recall the case.

14 A. The name, I don't even -- I can't
15 equate to it at all.

16 Q. Let me ask you, even though you may
17 not remember some of these cases, there were
18 quite a few either Kansas or Department of Labor
19 cases that went against KG&E. Do you know if
20 there was ever any follow-up review taken by Q-1
21 as a result of these findings by legal, when
22 they did a more in-depth review of these
23 harassment and intimidation allegations?

24 MR. SILBERG: You are talking
25 about cases that started off as concerns?

1 MR. GRIFFIN: Yes, maybe even
2 were started, investigated, by Q-1, and all of a
3 sudden it switched, and legal would take the
4 lead.

5 Q. (By Mr. Griffin) Did you all ever
6 have any of those, once they were resolved, from
7 corrective action, or verification from
8 corrective action, by --

9 A. No, I did not. We are back again
10 under that old philosophy of transferring at
11 that time, so I did not.

12 Q. How did you close cases that were
13 transferred to legal? Did you close them as
14 substantiated or unsubstantiated?

15 A. Again, I would have to -- on
16 chronological application, we transferred a
17 concern. Based upon the procedures at that
18 time, it was construed to me that we were
19 finished with it, once we transferred it out.
20 We had no interest in substantiating or
21 unsubstantiating.

22 Q. But they are all marked one way or the
23 other?

24 A. If I might go back, again, okay,
25 chronologically, when Mr. Kent Brown took over

1 as my supervisor, he was the one, personally,
2 who said, "I believe we need to go back to these
3 folks and have them account to us whether or not
4 it was substantiated or unsubstantiated." At
5 that time I wrote letters to everyone who I had
6 transferred a concern to, made them aware of a
7 need, "Respond to us either substantiated or
8 unsubstantiated, this concern I sent you." That
9 is the reason it shows up in the file, based
10 upon the feedback from them.

11 Q. Okay.

12 A. Now, after May 27th, 1985 --

13 MR. SILBERG: Let's not -- I
14 guess we are -- let's try to stay away from
15 that.

16 Q. (By Mr. Griffin) That isn't going to
17 have an impact on this investigation
18 whatsoever. I appreciate you also have made
19 changes, probably quite a few. Let's move on to
20 the next one here. We are on the first page
21 here. We are here on the page. I don't want to
22 curtail your giving full explanations, but we
23 want to do this in our lifetimes.

24 (Whereupon, a discussion was
25 held off the record.)

1 Q. (By Mr. Griffin) By the way, the last
2 case, I think I may have referred to it as
3 [REDACTED] In fact, it may be [REDACTED]
4 The next one, [REDACTED] Item 3.
5 This is a harassment and intimidation case, Mr.
6 [REDACTED] handled, a fellow by the name of
7 [REDACTED] He alleged that a fellow by
8 the name of [REDACTED] who is a start-up
9 support, general superintendent, had told a
10 fellow by the name of [REDACTED] not to go to the NRC
11 because he had put 2,000 people out of work. Do
12 you remember that?

13 A. No, I don't.

14 Q. Okay. This is one of the ones I
15 pulled for a review. In this case, the case
16 file consists of -- it has an investigative
17 plan, as they all do, and it says, "We are going
18 to interview Mr. [REDACTED]" the alleged fellow
19 making this statement. About the only other
20 thing the file contains is a memo there, signed
21 by you and Thero, which says that site policy
22 will encourage employees to take their concerns
23 to the supervisors first, and then they may go
24 to the NRC, and the Q-1 file lists the concerns,
25 unsubstantiated, but there is no evidence to

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1 indicate any further work was done. As the
2 supervisor, were you aware that there were files
3 being closed with this little information in
4 them? I mean --

5 A. No, I was not. When you say "this
6 little," I'm assuming what you are telling me
7 was in there.

8 Q. Uh-huh.

9 A. When you say "little," you have
10 that --

11 Q. Yeah.

12 A. Again, I was involved in closing files
13 from the standpoint, if one was brought to my
14 attention, that someone felt I needed to be
15 involved in, so I can't just straight across the
16 board even talk about a little or a large amount
17 of information in the files.

18 Q. In this one, I'm re-covering ground
19 that other NRC people -- I mean, they looked at
20 files like this, 212 of them, and, I mean, it --
21 112 of them, and they found that --

22 MR. SILBERG: 77 they didn't
23 like.

24 MR. GRIFFIN: Yes.

25 Q. (By Mr. Griffin) This is just an

1 example where somebody says, "I was told this,"
2 and then essentially the file conveys that no
3 investigation took place. However, there is
4 closure on it, and the closure is that it was
5 unsubstantiated. There is no evidence that
6 anybody who could have corroborated Mr. [REDACTED]
7 concern was interviewed, even though the
8 investigative plan, work plan, suggests that a
9 full-scale investigation took place.

10 I guess I'm asking you this more from
11 a quality control standpoint, over your own
12 program. We found quite a few instances where
13 they didn't seem to be adequately documented.
14 Who was responsible for trying to see if there
15 was anything meaningful going on with these
16 investigative files, regardless of what Mr.
17 [REDACTED] may or may not have actually done to
18 resolve this issue?

19 A. Up until the time I took the program
20 over, I have to assume that Owen Thero had total
21 responsibility for that. After I took over the
22 program, I delegated that responsibility for
23 content to Bob Scott as the investigation
24 supervisor. If it was relative to adequate
25 information to give to the investigative groups,

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1 it would have been delegated to Mr. Thero to
2 supply that information.

3 Q. This is another one of those that
4 wasn't closed until November, so --

5 A. That does not mean that the
6 investigation was not complete ea -- early
7 on.

8 Q. Well, no, I agree with you. It
9 doesn't necessarily. But based on my interviews
10 and my -- and my case reviews, the investigative
11 activity, although a lot of times the notes and
12 such are not dated, the investigative reports
13 rarely show dates of when investigative activity
14 took place. This concern was taken in June and
15 resolved in November. As a matter of course,
16 though, I did see what I considered to be a
17 pattern, and that is people were anxious to
18 close concerns, to show the concerns closed when
19 they were closed. I didn't, either in the
20 interviews or in the document reviews, I didn't
21 see any instances where somebody would close a
22 concern and wait two months to report that the
23 concern was closed. The file would remain open,
24 maybe, for months, but people seemed to be
25 pretty anxious to show that they had closed a

1 concern. I didn't see any of that. On this
2 case, this one was closed in, what did I say,
3 November, and it's -- essentially no
4 investigation took place whatsoever.

5 MR. SILBERG: Or at least none
6 that shows up in the file.

7 MR. GRIFFIN: I guess that's
8 going to be the case on all of these.

9 A. The name, [REDACTED] I recall seeing, but
10 the rest of it, I don't have any knowledge right
11 now of any particulars on it.

12 [REDACTED] MR. SILBERG: You interviewed
13 [REDACTED] Did he provide any indication as to
14 whether he did an investigation on this or --

15 MR. GRIFFIN: There is no
16 information beyond what I have already
17 described.

18 Q. (By Mr. Griffin) The next one is
19 another H&I case. The reason I'm taking these
20 in the order I am -- the reason these are listed
21 in the order in which they are is because that
22 would -- the interview, one man, go through his
23 cases. This one had to do with harassment and
24 intimidation of [REDACTED] I
25 understand from a conversation that we had

6-20-70 notes

1 several days ago, Chuck, some of this stuff is
2 still pending. One guy won his case and the
3 other guy lost it or something like that. Both
4 lost?

5 A. Only one made a case.

6 Q. Okay.

7 MR. SILBERG: What is the file?

8 MR. GRIFFIN: [REDACTED]

9 Q. (By Mr. Griffin) I don't have the
10 item number on this one, but it is --

11 [REDACTED] -- this is another one of those where
12 [REDACTED] said he substantiated the allegation,
13 and the file and the computer printout here show
14 it as unsubstantiated. Do you happen to know
15 why?

16 A. This is the first indication you have
17 given me of one that I have had an intimate or
18 in-depth involvement in particular with

19 [REDACTED] That is false. [REDACTED] never
20 indicated to me in writing, verbally, any other
21 way, that he substantiated this case. The
22 record has to show that.

23 Q. Okay. Well, he thought he had.

24 A. What he thought and what is in the
25 record are two different things. I sent the man

6,7C+7D, printouts

1 back up there after I received a phone call from
2 those people, saying --

3 MR. SILBERG: I'm sorry? "The
4 man" and "those people" --

5 A. [REDACTED] one or the
6 other of them or both of them, called me, and
7 they had additional information. They were
8 going to go to the newspapers. They were going
9 to denote everybody's brother unless we went
10 back and talked to them. I sent [REDACTED] back
11 up to visit with them.

12 Q. (By Mr. Griffin) When would this have
13 been?

14 A. This would have been in the October or
15 November of 1984 time frame. Somewhere in
16 there. I sent him back up there. I also sent
17 John Baer of Danube, vice-president of power, up
18 to talk to them. [REDACTED] came back and said
19 they didn't have one more thing than they had
20 before. "They have nothing additional for me to
21 investigate. There is nothing to it." Those
22 were his words. Again, I'm involved in that
23 one, so I can, I think, respond to it.

24 Q. So [REDACTED] never
25 received any kind of monetary settlements with

G.7C+7D, portions

1 their employer?

2 A. To the best of my knowledge, they did
3 not.

4 MR. SILBERG: As I understand
5 it, ^{6,7c47D} [REDACTED] lawsuit was recently thrown out.

6 Q. (By Mr. Griffin) By Daniel? Right?
7 Or he was contesting it with Daniel? Is that
8 correct?

9 A. Yes, that's correct.

10 MR. SILBERG: Is there anything
11 in the file that indicates that [REDACTED]
12 substantiated --

13 THE WITNESS: No, there is not.

14 MR. SILBERG: -- the concerns?

15 THE WITNESS: No.

16 MR. SILBERG: I'm just
17 wondering, on Brooks's review, if he found
18 something in the file. Well, it's not
19 important. I think we looked at this file last
20 week, and I didn't see anything that indicated
21 that it was substantiated, either.

22 MR. GRIFFIN: There was one in
23 which ^{6,7c47D} [REDACTED] had made -- had initialed, by
24 his name.

25 Q. (By Mr. Griffin) Your name or Scott's

6,7c47D, portions

1 go on those reports, not the investigator's, at
2 some period of time.

3 A. The investigator's name goes up at the
4 top as the investigator.

5 Q. I noticed that one of them had a -- he
6 had initialed it.

7 A. At the bottom, they ordinarily
8 initial, after they complete them.

9 Q. Yes. This is the one. He had
10 initialed it. His initials are on there. That
11 would indicate to you, would it not, that he was
12 in agreement with the conclusion, which showed
13 this one as unsubstantiated?

14 A. That's correct.

15 Q. So, in this case, the fact that he
16 thought he had concluded that this was
17 substantiated was faulty memory on his part?

18 A. The records -- the record speaks for
19 itself, plus my knowledge, having been involved
20 with him in this. They both coincide or they
21 both are in agreement with the record and me.
22 He is out of sync as the third party.

23 Q. You mentioned the follow-up
24 information.

25 A. Yes.

1 Q. The report is addressing the original
2 allegation of harassment and intimidation.

3 A. That's correct, but we had already --
4 let me rephrase it. He had drawn his
5 conclusions prior to them saying that they had
6 new evidence or additional evidence. At that
7 time, I sent him back. So, if there was, we
8 could change the conclusion, if the evidence so
9 pointed that direction, and it did not.

10 Q. The next one is [REDACTED] Item 1,
11 so -- this apparently was an associate of
12 [REDACTED] a guy named [REDACTED] +2D
13 [REDACTED] He also, apparently in the same time
14 frame, alleged harassment, intimidation. Did
15 you ever get involved in or review this case
16 file or get involved in this issue that
17 [REDACTED] investigated?

18 A. To the best of my knowledge, I recall
19 him having determined it to be unsubstantiated.
20 I know some of the technical part of it --
21 another ongoing investigation. Better not do
22 that particular part of it.

23 Q. You are right about that, if it's
24 unsubstantiated. Out of this, my review of the
25 investigative file, the only people interviewed

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1 were the people accused of harassment and
2 intimidation. Is there a -- is this methodology
3 anything that you encouraged on the part of your
4 investigators for wrongdoing, if somebody says,
5 "He's a liar, go sit," and "No, I'm not lying,"
6 then go home.

7 A. No. I think if you go back to the
8 time frame when [REDACTED] was in our employ, I
9 relied upon his ability, knowledge, and
10 expertise to do a complete and thorough
11 investigation. When he left the organization, I
12 think you will find in the record there are some
13 guidelines and some involvement on my part, when
14 I felt that I had something less than [REDACTED]
15 involved. I think the record will support
16 that. The methodology was employed.

17 Q. Again, I don't need to re-cover the
18 same ground, but, you know --

19 A. I did not interfere with [REDACTED]
20 efforts.

21 Q. Does Q-1 management, to whom
22 [REDACTED] would have reported to, did they
23 accept the philosophy that you can just ask the
24 accused if he did anything wrong, and if he
25 denies it that is sufficient investigation? I

6,7C47D, Portions

1 mean, ([REDACTED]) was not a free spirit here. He
2 is reporting --

3 A. I don't know that I -- I know that I
4 did not in detail look at his work product at
5 the time.

6 Q. Did somebody in management?

7 A. I don't know. I don't know if Scott
8 did or not. I cannot address that.

9 Q. Okay. Like I say, this is just
10 another one of those that Driskill and -- was
11 critical of, because it's -- because it doesn't
12 seem -- the methodology is not correct to even
13 start to address whether the allegation was true
14 or not.

15 The next one I want to ask you about
16 is [REDACTED] Item 1. This is before your
17 time, Chuck, but I just wanted to find out
18 whether you had ever heard about this one. It
19 had to do with an acid etch test. It was for
20 stainless steel fittings provided by a company
21 called Crawford. The purchase order listed --
22 requesting these fittings, specified that the
23 etch test would be present. For four years,
24 Crawford sent the same etch test. Obviously,
25 the fittings over those years used different

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1 heat lots, and a different material was used.
2 So after four years an allegation was made to
3 Q-1 that this was not valid, that the etch test
4 used over and over by Crawford was not accurate,
5 because it didn't speak to the material used in
6 the fittings in that particular group. Did you
7 ever get involved with that one or know anything
8 about it?

9 A. No. The first knowledge I had of that
10 was two weeks ago, on your visit, when you
11 brought it to my attention. That was the first
12 I had any knowledge of it without having seen
13 the file.

14 Q. The way this was ultimately resolved
15 was just to change the procedure four years
16 later. Is this a type of corrective action that
17 Q-1 would buy off on or verify as being adequate
18 corrective action, to just change the procedure?

19 A. It's a pretty broad question.

20 Q. I mean, you do have a verification --

21 A. Philosophically, Q-1 would have
22 brought about whatever corrective action was
23 necessary, and the reason I'm phrasing it that
24 way is I do not know, without having the -- in
25 that particular one, personally, if there is

1 still or even was a need for that particular --

2 Q. See, you are talking -- we are talking
3 apples and oranges. You are talking about
4 getting the hardware fixed. The NRC enforces
5 the regulations relating to materials,
6 suppliers. Something on a purchase order, come
7 to 21. If you say that you want an acid etch
8 test to verify that the -- that that stainless
9 steel is -- conforms, then we hold those people
10 accountable for it, and they have to test, if it
11 calls for a test. These people didn't test.
12 But, to resolve the problem here, at this site,
13 four years later, you changed the procedure.
14 Not you, personally, but the site changed its
15 procedures.

16 Now, my only question, the only part
17 of this I'm interested in, is this: In your
18 verification of corrective action, do you accept
19 the philosophy of just simply changing the
20 procedures?

21 A. I don't think I can answer that,
22 Brooks.

23 MR. SILBERG: Let me try this,
24 because we have discussed this philosophy over
25 the years. Was it up to Q-1 to define what the

1 requirements, substantive requirements, for the
2 plant were, or was that someone you took and
3 accepted from other parts of the organization?

4 THE WITNESS: Quality first is
5 bound to confirm that activities are in line
6 with project commitments.

7 MR. SILBERG: So if the
8 substantive part of the project organization
9 determined, whether it's engineering or
10 operations or quality, determined that the
11 appropriate technical response was to change the
12 procedure and adopt a new procedure, you would
13 not second-guess the substance of that
14 decision? Is that correct?

15 THE WITNESS: No, I would not.

16 Q. (By Mr. Griffin) Okay. Then what
17 valid -- validity is there to you even verifying
18 the corrective action, if you are not going to
19 ever contest it or if you are not going to say,
20 "Hold it. You can't just blow this procedure
21 off. You have been requesting acid etch test
22 for four years." You can't come after and say,
23 "Well, we don't really need it any more."

24 A. I think you are misunderstanding. I
25 would confirm, okay, that it was a legitimate

1 understanding. I would not just say, "Since you
2 say it's not required --" I would make that
3 determination, that it's legitimate. Under our
4 operating methods, I would not go back to the
5 vendor and say, "Even though this was not
6 required, you continually supplied us
7 information that did not meet what was perceived
8 to be the requirements." Again, I would -- they
9 would not just change requirements, just for the
10 sake of changing requirements. That would have
11 to be legitimate, and I would have to verify
12 that there was ever any need. Okay?

13 Q. Well, when your Q-1 investigator
14 called Crawford to find out why this activity
15 was going on, which was clearly inconsistent
16 with the purchase orders you had been sending
17 them, the explanation was, "Oh, I thought it was
18 just supposed to be a one-time test."

19 A. It may have been.

20 Q. No. Each purchase order, each new
21 purchase, each new request for materials,
22 specified an acid etch test. Now, if you are
23 telling me that you endorse the fact that new
24 purchase orders don't really mean what they
25 say --

1 A. No.

2 Q. -- type thing, that philosophy --

3 A. No.

4 Q. -- I -- in this case, I don't -- we
5 don't need to argue this one.

6 A. No.

7 Q. In this case, Mr. [REDACTED] ⁶⁻²⁴⁻⁷⁰ in his
8 report, I gleaned, accepted the explanation that
9 the man had only believed that the etch test was
10 required one time, even though it showed it up
11 on all of the purchase orders after that.

12 A. Uh-huh.

13 Q. However, the only part of this I'm
14 asking you about is, do you accept the
15 validity, as it relates to your verification
16 process, of simply deleting the requirement that
17 this test -- should have been no need for it?
18 Do you understand what I'm asking?

19 A. If I had been knowledgeable of this
20 particular one, during of the course of the
21 investigation, I would not have been satisfied
22 unless additional work had been done. Relative
23 to the validity of the requirement, relative to
24 the correctness of the information showing up on
25 the purchase order, relative to the response, in

6-7C47D, portino

1 whatever manner, by the vendor. It appears
2 something was out of order. I would not have
3 had that closed out until I was sure everything
4 was in order.

5 MR. SILBERG: If engineering
6 told you, though, that the etch test was only
7 required once --

8 THE WITNESS: That's right.
9 Then I would have to -- I would believe that was
10 all it was required, was one.

11 MR. SILBERG: You would not
12 second-guess that?

13 THE WITNESS: I would not, but I
14 would have that information in the file, if it
15 was only required the first time. Then I would
16 request why purchase orders continually had it
17 on it, when there was no requirement to.

18 Q. (By Mr. Griffin) But there was a
19 requirement. The decision to change the
20 requirement was made after all of the fittings
21 had been arrived at and installed, and you were
22 no longer making any --

23 A. I'm not disputing that.

24 Q. Okay.

25 A. But I would have had some

1 justification for that in the file. Why? Was
2 it legitimate to change that requirement?

3 Q. Okay. Well, the only reason I ask
4 you this, and this was before your time, you
5 realize --

6 A. I know. I'm talking about the -- I
7 would have pursued it that way.

8 Q. The NRC has a problem with the -- if
9 this were to be representative of Q-1's work,
10 hopefully it would not --

11 A. Hopefully it would not be.

12 Q. The next one is [REDACTED] Item 6.
13 This one is by [REDACTED] It said that an
14 electrical QC inspector made an allegation that
15 an electrical QC supervisor had set quotas, so
16 many supports per week, on the QC inspectors.
17 In this case, [REDACTED] telephonically
18 interviewed the supervisor, who described this
19 quota per week as a goal rather than actually a
20 quota and that there had been no sacrifice to
21 quality.

22 That is the extent of the
23 investigative effort in this case, is calling
24 the guy that is accused of it, and he says, "Oh,
25 no, it's the goal, it's not a --" because, in

1 70 270 R. T. T. M.

1 this case, they said that they subsequently
2 identified numerous deficiencies in these
3 supports that had to do with fillet welds
4 and -- so, you know, later on, this is one of
5 those cases where there was a lot of re-work and
6 there was a lot of activity, but when you take
7 the investigation, and you have -- you interview
8 the bad guy, and he says, "Oh, no, that is --"
9 do you accept the validity of not verifying that
10 other inspectors should have been interviewed as
11 a part of the investigative process, and why --
12 why were your supervisors, under you, accepting
13 the one interview investigation into an
14 allegation like this, when at the time that it
15 occurred there were -- maybe -- I don't know
16 whether they knew about it, but they were
17 already well-known, that there was a big problem
18 on the fillet welds in the supports.

19 A. Again, in retrospect, if that is what
20 the file shows, that he only talked to that
21 individual -- if you are talking about my
22 personal philosophy, methodology, I would have
23 suspected that he would have talked to more than
24 one man in order to draw a conclusion.

25 Q. Tell me this, Chuck. I feel like I'm

1 beating on you with stuff you don't have
2 anything to do with or know about. Certainly,
3 if I made the wrong presumption -- didn't
4 someone in Q-1 review these files as they came
5 there?

6 A. No.

7 Q. Didn't they evaluate the validity of
8 the work?

9 A. No. Owen Thero had total free rein
10 before I came into the program. Bill Rudolph
11 controlled the program administratively only.
12 He reviewed time, authorized payment.

13 Q. This one was opened in August and
14 closed in November. I mean, I'm sorry, October.

15 A. Which means that -- if it was opened
16 in August, ^{4/22/70} [REDACTED] could have done his investigation
17 and had all of the information in the file
18 before I ever took it over. As far as I'm
19 concerned -- when he was questioned, like you
20 said, I'm through with that one, and it's ready
21 to be typed up.

22 Q. There is no Q-1 supervisor of his work
23 to see if he did a meaningful investigation?

24 A. Again, if it was prior to the time
25 that we re-organized and put in the

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1 investigative report, which required the
2 investigation supervisor to review it, it is
3 conceivable that Thero never looked at it, and I
4 thought he was done with it. ^(6, 7C+7D) [REDACTED] was a free
5 spirit, until I took over that operation, and by
6 that I mean a free spirit. To be very open with
7 you, I put controls upon these people when I
8 took it over.

9 Q. When did you -- you came in in
10 August.

11 A. Yes.

12 Q. This was closed -- the concern was
13 closed in September --

14 A. For all practical purposes, say
15 September. August the 21st.

16 Q. Okay. This is September the 20th, the
17 concern was closed.

18 A. Okay.

19 Q. Based on the other reviews that I have
20 done, ^(6, 7C+7D) [REDACTED] probably finished his investigation on
21 either the 20th or the day before. He finished
22 it, and that is it. He interviewed the
23 supervisor, and that in it, and the concern is
24 closed. Are you saying that, as of September
25 the 20th, your own supervisory staff would not

6, 7C+7D, Postum's

1 have been, at that time, reviewing his work?

2 A. No. Let me rephrase it again, in case
3 you misunderstood me. If he did his ^{Field} ~~fuel~~ work
4 prior to the time Bob Scott started assigning
5 responsibilities for investigating concerns,
6 prior to the time that Bob Scott was involved in
7 the planning, as it were, then ⁶⁻⁷⁰⁻⁷⁷ [REDACTED] would have
8 had that completed, and it would have just been
9 laid there for typing.

10 Q. So, on September the 20th, when he did
11 this one interview, closed his concern --

12 MR. SILBERG: We don't know that
13 he --

14 Q. (By Mr. Griffin) We don't know that
15 you weren't there yet, either. You want to
16 shove everything off on these --

17 A. No, I don't want to shove anything.
18 You are misconstruing what I'm saying.

19 Q. We are looking at a point that is well
20 into the time -- you have been there a month.
21 You had a month to get your people in line. You
22 only had three months to get all these things
23 closed.

24 A. No, not so. I had all of the time it
25 took.

6, 7C47D, Part 10

1 Q. Well, you were successful in getting
2 these closed in four months.

3 A. That was the goal. Okay?

4 Q. But I'm just asking you, based on your
5 knowledge of where you were at that point in
6 time, on September the 20th, is it probable,
7 since we don't know, is it probable that a Q-1
8 supervisor reviewed [REDACTED] work?

9 MR. SILBERG: I think we are
10 just speculating.

11 A. It depends on what time he did the
12 work.

13 Q. (By Mr. Griffin) Somebody is going to
14 have to take responsibility for this program and
15 this paper, and your name is on these
16 investigative reports.

17 A. Is it on that?

18 Q. To the best of my recollection, it's
19 Mr. Scott's.

20 A. Okay. Then, if that is the case, if
21 it was during the time frame that Bob Scott was
22 the supervisor of the investigators, then he
23 would have reviewed that. He should have been
24 satisfied with the end product or made known his
25 dissatisfaction with it.

6,7C47D, Porters

1 Q. So if his signature, and I cannot
2 swear that it is, but if his signature appears
3 on it, like I think it does, that means that he
4 bought off and decided that, interviewing the
5 bad guy, and --

6 A. You have to understand, also, that, if
7 [REDACTED] did this investigation and completed
8 it, prior to the time I or Bob Scott got there,
9 that could have been laying as a backlog, closed
10 out, just had to have everything signed off the
11 front. Okay. You keep track of what open
12 investigation is. [REDACTED] ^{12/70} said, "I'm done with
13 that, and it just has to be typed." It could
14 fall into that category.

15 Q. I will give you this, Chuck. I will
16 agree that the investigative files do not show
17 what took place or when the investigative
18 activity took place. This file only shows one
19 interview, and that is in the face of --

20 A. I'm personally not satisfied with
21 that, okay, if you want my personal observation
22 of that approach.

23 Q. Okay. [REDACTED] Item 2. That is
24 the next one. In this case, a fellow by the
25 name of [REDACTED] ⁶⁻²⁰⁻⁷⁰ alleged that

1 [REDACTED] and [REDACTED] two
2 Q-1 people, I think it was before they became
3 Q-1 people, had discriminated against him. In
4 this case, [REDACTED] interviewed [REDACTED] and
5 [REDACTED] and they said, "No," and so it was
6 listed as unsubstantiated.

7 Now, at the time that this
8 investigation took place, [REDACTED] ^{6,7C,7D} and [REDACTED]
9 were Q-1 investigators, so they are -- you have
10 [REDACTED] ^{6,7C,7D} from my
11 point of view, all buying off on the philosophy
12 that, "You just go talk to the bad guy, and if
13 he says no, then it's unsubstantiated." In this
14 case, the bad guys are two Q-1 investigators.
15 Would you consider that a valid investigation,
16 to determine whether he had been discriminated
17 against?

18 A. Number one, [REDACTED] ^{6,7C+7D} nor [REDACTED]
19 would have not had -- because they were QA
20 people, they would not have had any influence on
21 the extent of the investigation, should not have
22 had, so far as how far you go.

23 Q. Uh-huh.

24 A. I don't think it's wrong for them
25 having been interviewed.

6,7C+7D, portions

1 Q. No. I agree with you there.

2 A. There, again, it would be very
3 subjective for me to say that the investigation
4 was influenced or not influenced by them having
5 been quality first and then having been the ones
6 responsible for this. Again I am not familiar
7 with that particular case.

8 Q. In other words, (6.7C 47B) filed with
9 DOL and won his case, but that doesn't change
10 the affect that the investigation was limited to
11 talking with the bad guys. This is in the same
12 time frame as the other one. This occurred
13 within a -- on the same day as the other one,
14 the concern that was listed, the one that we
15 just got through discussing. Would this one
16 kind of fall in your -- in the limits of your
17 knowledge? Would they be the same as the last
18 one? Yes, Mr. Scott's signatures may appear on
19 there, but you are not familiar with the --

20 A. Yes.

21 Q. -- you are not familiar with his
22 methodology of closure?

23 A. Very well could be the case. Again,
24 the time frame -- if I knew what it was
25 specifically, it would sure be helpful, but I

6.7C 47D, Prnt(m)

1 don't know. I'm trying to think when these
2 people came into the program.

3 Q. On August 15th, you got the concern.
4 On September the 24th, the concern was closed.

5 A. Again, I don't know when [REDACTED]
6 interviewed those people. Were they in quality
7 first when he interviewed them? [REDACTED] would have
8 been. Bob Scott didn't come -- I mean [REDACTED]
9 didn't come over to quality first until about
10 the 1st of September. Again --

11 MR. SILBERG: You also said that
12 this shows that [REDACTED] and [REDACTED] bought off
13 on the one interview approach.

14 MR. GRIFFIN: I'm just saying,
15 these people are -- you are making a valid point
16 there. They are not responsible for the
17 investigation, but they know how the
18 investigation is proceeding, and --

19 MR. SILBERG: They would have no
20 reason to know what else [REDACTED] --

21 Q. (By Mr. Griffen) You have know what
22 this smacks of is not telling on your buddy.
23 They are all in the same group. They cut off an
24 investigation by just talking to the two guys
25 accused, and that is it. It's unsubstantiated.

6, 7C, 47D, Porters

1 A. I think, for the benefit of those
2 people, I don't think [REDACTED] even knew [REDACTED] at
3 that time. He would have known -- he would have
4 known [REDACTED] for -- because [REDACTED] had been there
5 for a short period of time.

6 MR. SILBERG: Your philosophy
7 would then say, "We can't handle this one at
8 all, because he knows them."

9 Q. (By Mr. Griffin) If all you are going
10 to do is go ask him, if he did it, and he says
11 no, and you are going to buy that, then, yeah, I
12 guess that would probably -- I probably would
13 say that maybe you ought to get somebody that
14 would be more --

15 MR. SILBERG: That is why there
16 are multiple other channels. He did go to DOL,
17 obviously. He did have the right to go to the
18 NRC.

19 MR. GRIFFIN: Well, I see which
20 way you are going here, but -- you are right,
21 they do, but what we are trying to do is
22 evaluate the investigative program. I think Mr.
23 Snyder here probably thinks his program had more
24 integrity than just doing one-shot interviews on
25 the bad guy.

6, 7047D, portions

1 A. That's correct.

2 Q. (By Mr. Griffin) I would like to
3 think --

4 A. I don't know that that happened in
5 every case, and evidently it didn't.

6 Q. He found some here --

7 A. Yes.

8 Q. -- and long before I found them, Mr.
9 Driskill found them, and Mr. Ward found them
10 before him.

11 A. Yes.

12 Q. I'm just -- I want to come away from
13 this interview with an understanding that, if
14 you bought off on this, is this acceptable, is
15 this a valid investigation, is this what you
16 want to hang your hat on --

17 A. No.

18 Q. -- as the head of Q-1 investigation?

19 A. It is not, and I think that -- and,
20 just for the record, every time that we have
21 been made aware of a legitimate discrepancy or
22 deficiency, we have taken action to correct
23 that. I think the record will bear that out.

24 MR. SILBERG: You are putting
25 this all in the hindsight mode.

1 MR. GRIFFIN: I'm always working
2 in that mode.

3 MR. SILBERG: I don't think it's
4 quite fair to charge Chuck and KG&E, which was
5 going down a new path that almost no one had
6 ever walked down before, and the -- and there
7 were no guidelines in these programs, and there
8 still aren't, from NRC --

9 MR. GRIFFIN: Correct.

10 MR. SILBERG: -- and they are
11 learning it as they are doing it, and now, three
12 years later, to say, "Gee, you should have done
13 it like we like to do it." You know, that's --

14 MR. GRIFFIN: I'm not trying to
15 beat up on Chuck. I'm trying to discover the
16 methodology that you employed. Just to make a
17 comment, for instance, on some of the more
18 significant technical issues that were
19 identified by Q-1, they did a hell of a job, in
20 getting these things identified, getting them to
21 the people who were going to have to correct
22 them, following through on the close out. The
23 NRC has already given you a big wet kiss for
24 getting these things identified, because the NRC
25 was there on most of the significant close outs

1 on technical issues.

2 THE WITNESS: Uh-huh.

3 MR. GRIFFIN: Our criticisms of
4 Q-1 have to do with things like this. What
5 would have happened if just these few we have
6 gone through here, if each one of these -- okay,
7 you are right. The Department of Labor or the
8 Kansas Human Resources eventually got involved
9 and made a ruling, but the NRC now and in the
10 future, and back then we would have -- it would
11 have been reviewed, September of 1984, by the
12 NRC, although they didn't tell you what their
13 findings were. We would have liked to have seen
14 a little bit more meaningful investigations in
15 these areas.

16 THE WITNESS: So would I.

17 MR. SILBERG: Well, if that is
18 true, you really owed it to us to tell us that
19 in September of 1984 and not to wait until it's
20 all done and then come back.


21 MR. GRIFFIN: Mr. Snyder has
22 been making that point, almost from the first
23 day, and that is a given. The NRC's remaining
24 concerns, the reason the commission asked me to
25 come do this, is not to harass Mr. Snyder, but

1 to try to determine whether the NRC should rely
2 on this program and whether these concerns were
3 suppressed and not adequately investigated.

4 MR. SILBERG: There are really
5 two issues, it seems to me, and the one policy
6 issue is having the NRC rely on utility
7 employees concern programs. Looking only at a
8 limited time frame, and not recognizing the
9 substantial changes that were made after, isn't
10 going to answer that question. It will tell
11 you, you know, maybe in our view, in your view,
12 we haven't relied on how it existed then, and --

13 MR. GRIFFIN: Somebody else may
14 try to use this case or these evaluations and
15 investigations to draw a conclusion like that,
16 Jay, but that is not the purpose for my being
17 here. I'm not going to draw a conclusion like
18 that. That is not what investigators do.

19 MR. SILBERG: Right.

20 Q. (By Mr. Griffin) We gather facts.
21 Here we found a series of -- in some of Mr.
22  work, he made some real tough calls
23 up front, early on in the program, in April and
24 May. He was saying, "Blackball, discrimination,
25 harassment, intimidation," and inexplicably here

G, 7C & 7D, portions

1 we get into the September and October time
2 frame, and all of a sudden he is doing one-shot
3 interviews. You see, I have seen Mr.
4 [REDACTED] work out at legal. He is capable
5 of doing a rather detailed professional job.

6 A. I have never seen his work, so --

7 Q. We want to know whether we -- we
8 wanted to know whether the Q-1 review of, in
9 this case, primarily wrongdoing, was -- whether
10 you all did a valid job or whether you were all
11 just closing these things out.

12 A. Well, it was not just closing them
13 out, for any -- and, here again, the belief that
14 we wanted to do something less than what ought
15 to be done -- that was not the case. Again, if
16 there is anything that was not done, it was
17 through ignorance of -- of primarily knowing
18 what it was expected of us to do in that arena.

19 MR. GRIFFIN: Then, I guess,
20 Jay, an observation. A concern was also
21 reportability. If the NRC was not being -- if
22 you -- if KG&E wasn't using the right criteria
23 for the reportability and would -- and this type
24 of information was coming to KG&E, and then
25 these people were seeking other ways of trying

6, 7C + 7D, Posterns

1 to resolve their concern, and Q-1 already had
2 made a conclusion, "No, you haven't -- your
3 concern is not legitimate." The NRC has a
4 continuing concern with the handling of certain
5 aspects of the program.

6 MR. SILBERG: On reportability,
7 that was something that presumably was looked at
8 by INE folks when they were in here, and that
9 was the same -- I take it the same tests that
10 the project used across the board.

11 MR. GRIFFIN: We have already
12 said this 25 times, but all they have had to
13 rely on is what the file said, and this is a
14 perfect example of where the file says
15 practically nothing. To say that the INE looked
16 at these things or an inspector was on site,
17 everything is okay --

18 MR. SILBERG: I was talking
19 about the two-part test as opposed to its
20 application in specific cases.

21 MR. GRIFFIN: Yes.

22 MR. SILBERG: Obviously the
23 application depends on what is in the file, not
24 the test, itself, which is what Ward's concern
25 was. That is something that presumably was

1 satisfactory or at least was not commented upon
2 by INE.

3 MR. GRIFFIN: I think that is
4 the point. Maybe it wasn't commented upon.
5 "The reason is, absent interviewing Mr.
6 ██████████ and you, I can't make much from the
7 file."

8 Q. (By Mr. Griffin) Let's move out of
9 wrongdoing here for a little while. The next
10 one, one you and I discussed before today,
11 Chuck, to some degree, it has to do with
12 ██████████ Item 11. This was the letter that
13 you wrote to Fouts regarding the concrete
14 expansion anchor bolts. On this one, the letter
15 was to authorize the release of the anchor
16 bolts, so it could be used. Is that right?

17 A. I --

18 Q. That they didn't meet tensile
19 strength.

20 A. Yeah, but again, I don't really
21 understand the issue there, Brooks, the
22 allegation, how -- I don't mind explaining,
23 okay, but --

24 Q. Okay. The concern relative to this
25 issue, Chuck, is that here we have Q-1

G, 7C & 7D, portions

1 investigating an allegation against a guy who
2 authorized the release of some stuff from the
3 warehouse that was not -- I hope -- I hope I use
4 the right words here, but it didn't meet the
5 requirements as far as tensile strength. A
6 letter is written under Foults's signature by
7 you. Then here somebody makes an allegation
8 that this was not proper. So here you are the
9 Q-1 investigator, I mean Q-1 supervisor, and
10 people are saying, "I don't think it's
11 legitimate for Mr. Snyder to be investigating
12 himself."

13 A. Do you know what the allegation was,
14 Brooks?

15 Q. I think I essentially do.

16 A. I thought the allegation was one where
17 there was a retesting required of the imbedded
18 anchors. There had to be another inspection to
19 go around, a total reinspection program. During
20 the total reinspection program, lo and behold
21 somebody found that there had been the
22 authorization for some anchor bolts made years
23 ago, and had they reinspected those, also --
24 again, I have got no problem explaining to you
25 my involvement, but the allegations I recall --

1 Q. I'm sorry, but I'm not trying to redo
2 the allegation.

3 A. No.

4 Q. What I --

5 A. I guess --

6 Q. The allegation that I'm -- or not the
7 allegation, but the concern that was raised to
8 me, by your former subordinates --

9 MR. SILBERG: This is not the
10 concern --

11 MR. GRIFFIN: No.

12 MR. SILBERG: That was looked at
13 by quality purchasing --

14 MR. GRIFFIN: Yes, yes.

15 Q. (By Mr. Griffin) This concern,
16 regarding the letter under Mr. Fouts's
17 signature, was investigated by Q-1.

18 A. As part of the overall investigation?

19 Q. Yes. Of course, since you were the
20 one that wrote the letter, you were one of the
21 interviewees.

22 A. Yes.

23 Q. The allegation or the -- I keep saying
24 "allegation." The problem that some of the Q-1
25 investigators had with this was you were

1 investigating yourself, and some believed that
2 the reason this allegation was eventually
3 reported as unsubstantiated is because you had
4 strong feelings about anybody making conclusions
5 against your entries.

6 A. No. I will be very happy to explain
7 that, again understanding, when I explain it to
8 you, the way the system worked. A design
9 document was developed by Bechtel. The design
10 document was either in the form of a
11 specification or a drawing or both. By
12 "drawing," I mean a design drawing, construction
13 installation drawing. Bechtel specified the use
14 of half-inch Hilti anchor bolts. It appears the
15 reason they specified Hilti was because Hilti
16 had a product that would meet their requirements
17 for this plant. Part of that was the advertised
18 tensile strength on this particular bolt. This
19 one I think in question is a quarter inch size,
20 if I remember correctly. The way the program
21 worked, if a problem was identified to the
22 designer, then the designer had to provide some
23 direction. It's my understanding, going back in
24 that point in time, which was, what, 1981 --
25 Q. 1982.

1 A. -- or 1982, that Hilti had discovered
2 that they had misrepresented their product, Part
3 21, that what they advertised as something of
4 100 kips tensile strength was only 78 in one
5 particular line of theirs. They notified the
6 authorities, which was required. Ultimately
7 Bechtel was aware of it. Then Bechtel had
8 specified the use of this bolt which didn't meet
9 what it was represented to.

10 Now, Daniel originated an FCR, a
11 facility -- or a field change request, FCR,
12 requesting Bechtel to provide some relief. We
13 were shut down on using that particular product,
14 because it didn't meet specs. There were people
15 on the site working for Bechtel. There were
16 people back in Gaithersburg, Maryland. They
17 talked by phone. The paperwork was sent back
18 there. "Look, we are sending you a piece of
19 paper. This is what the problem is. We need to
20 let you know about the problem. Don't wait
21 until the papers get here." Some of it was
22 telecopied. Much of it was mailed.

23 The response back on this particular
24 one or the recommendation by Daniel was, "Let us
25 use this bolt for this one particular drawing

1 application," details on Drawing C31 or
2 something. I forget what it was. It was a
3 civil drawing. All of the anchor bolts were
4 depicted on civil drawings because they were a
5 civil commodity, no matter if they were piping
6 or electrical, hangars, whatever. It was still
7 on a civil drawing, the details. It told you
8 how deep to go in the concrete with it, how far
9 away you had to be from the corner a wall or
10 whatever. Anyhow, Bechtel came back in a -- in
11 an oral response on the telephone that they were
12 going to approve that fuel change request for
13 that application. Daniel wrote a letter to my
14 superior, Gary Fouts, asking permission to use
15 that product in that application based upon
16 Bechtel's verbal commitment that they would
17 authorize its use.

18 Based upon that, I wrote a letter for
19 Fouts's signature, saying, "You, Bechtel, may
20 proceed to use this product in these
21 applications on that drawing, which Bechtel has
22 told us they are going to approve, but you must
23 determine it was not out of certain lots that
24 were determined to have been bad, because we
25 don't know all of them were bad yet. On top of

1 that, you must record all of the locations where
2 you use that product. Specific instructions."

3 Three days later, we got the response
4 back in writing, and Bechtel had changed their
5 mind. They had not given us that broad use.
6 They had limited it to only electrical support
7 applications on that drawing.

8 I conveyed that message to Daniel
9 again. I said, "They have changed their mind.
10 Basically you have seen the correspondence. You
11 now are authorized to use that anchor bolt for
12 these limited applications. Again, you must
13 assure what lot number it came out of, and you
14 must record the location of all those used."

15 I see -- again, I see no connection
16 between that and the allegation. I provided
17 direction in the capacity I had as project
18 construction supervisor to the constructor, who
19 had to have direction. It had nothing to do
20 with me, personally, authorizing using something
21 that wasn't authorized. It was authorized by
22 the designer. I simply was the go-between
23 between Daniel and the designer, because, by
24 project requirements, Daniel did not communicate
25 directly with the designer.

1 Q. So you think that the allegation was
2 substantiated or unsubstantiated?

3 A. I don't know what the allegation
4 really was.

5 Q. These anchor bolts were released from
6 the warehouse, violation of procedure.

7 A. They were not. Procedures are written
8 around drawings.

9 Q. Okay.

10 A. The procedures might have -- let me
11 rephrase that. I see where you are coming
12 from. The procedures might not have been
13 revised, Brooks, but that was not my problem at
14 that time. I was addressing the design
15 application. Daniel should have revised their
16 procedures in some way, to say, "We now have to
17 put these different controls in. We must define
18 where these bolts go, and we must assure they
19 came out or did not come out of certain lot
20 numbers." That should have been the procedure.
21 I don't know if that happened or not. Again, I
22 had one segment of it. Mine was to meet the
23 needs of the designer and the constructor.

24 Q. I understand what you are saying,
25 Chuck. The question here was whether you --

1 some people were saying that you improperly
2 influenced --

3 A. I didn't even know about the
4 allegation or the concern.

5 MR. SILBERG: Wait, wait. Let's
6 get the whole statement.

7 Q. (By Mr. Griffin) -- the conclusion or
8 the course of the investigation.

9 A. Believe me, I knew nothing about
10 this. I heard some stuff about anchor bolts,
11 but until you and I sat down and looked at that
12 file, I had forgotten I even wrote those
13 letters. That's how much knowledge I had of
14 this thing being an allegation.

15 MR. SILBERG: Also, we talked a
16 little bit about this. My notes indicated that
17 the Q-1 investigation showed that this was a
18 substantiated concern.

19 MR. GRIFFIN: That is why I'm
20 sitting here, listening to him, trying to defend
21 why it's not true. I don't have any
22 understanding of it, either.

23 MR. SILBERG: Your concern is
24 that there is some conflict of interest, and I
25 guess the course of -- the result of the

1 investigation --

2 MR. GRIFFIN: I wasn't asking
3 for review of the Q-1 investigation. I was
4 asking -- I wanted to find out whether he
5 believes you unduly influenced --

6 A. No, but I can see what may have
7 happened now, okay, in not noticing the
8 concern. It would have been necessary for
9 Daniel to revise procedure, and it appears from
10 what I'm hearing now that Daniel went ahead with
11 the letter direction we gave without revising
12 their procedures.

13 Q. (By Mr. Griffin) Actually, at that
14 point, my review didn't go far enough to
15 determine how it was ultimately -- it was
16 substantiated, and there were a series of QFARS
17 written, so I presume it was sorted out, but --

18 A. But they didn't revise the
19 procedures. Here, again, that's not my fault,
20 and I didn't influence the investigation.

21 Q. No, but the allegation was made
22 that --

23 A. That I shouldn't have been involved?

24 Q. No, that you violated procedures by
25 writing the letter.

1 A. No. That is false. That was not the
2 allegation. The allegation was that Daniel
3 probably put a product in out of procedure.

4 Q. Okay. I will read the allegation.

5 A. Okay.

6 MR. SILBERG: This is the
7 original concern or the allegation by the --

8 MR. GRIFFIN: The original
9 concern.

10 A. The original concern is what I have an
11 interest in.

12 Q. (By Mr. Griffin) It says "One quarter
13 inch concrete expansion anchors were required to
14 meet 100 kip anchors, only about 78 kip.
15 Letters from Fouts allowed installations."

16 A. Then that was absolutely correct. I
17 think you will find, when the investigation went
18 out further, they didn't change the procedures
19 to indicate that, and that was a lower tier
20 document. The procedures do not take precedence
21 over the design documents. What I wrote was a
22 change in the design documents, which was
23 absolutely legitimate and called for, but I
24 think Daniel failed to proceduralize it, so they
25 were guilty of violation of procedures. I think

1 that is where it started out in --

2 MR. SILBERG: The allegation
3 comes from the ex-investigators that he somehow
4 influenced the quality first and --

5 MR. GRIFFIN: Was attempting to
6 adversely influence the outcome, as a Q-1
7 supervisor.

8 A. It's odd, because I didn't even know
9 anything about the allegation.

10 Q. (By Mr. Griffin) Okay. That is your
11 testimony.

12 A. I can explain all day to you how these
13 things happened to you, if you want.

14 Q. I want to move on to another issue.
15 One of the investigators that did a rather
16 substantial investigation for Q-1 that caused a
17 lot of controversy was Mr. [REDACTED] and he handled
18 [REDACTED] and I think it was Item 1. Were you
19 involved in the ongoing supervision of Mr. [REDACTED]
20 or did you get caught up in this issue, as he
21 went through this lengthy investigative process?

22 A. Well, to Mr. [REDACTED] work product, I
23 have no knowledge of what he was assigned, what
24 he performed, what he didn't perform. My only
25 knowledge is that his work product was

70 Portions

1 unsatisfactory to his supervisor.

2 Q. When did you make that determination?
3 After it was ended? After he had finished his
4 investigation? Or were you involved in
5 counseling Mr. [REDACTED] beforehand?

6 A. I was not involved in counseling at
7 all.

8 Q. So you found out about the situation
9 after he had finished his work?

10 A. What I found out was what Bob Scott
11 brought to me, his supervisor, saying that his
12 work product was unacceptable. He had on
13 several occasions gone back and reviewed and
14 re-reviewed with him his assignment, and he was
15 unable to complete the assignment
16 satisfactorily.

17 Q. But, in fact, he did complete it to
18 his satisfaction?

19 A. Again, I --

20 Q. You turned in a Q-1 investigative
21 report.

22 A. That's what I understand. Yes.
23 Again, my action was in support of my
24 supervisor, who was capable of determining
25 whether or not a man was meeting the needs of

70 Antine

1 the program. By that I mean he was given
2 direction to perform investigations, and I was
3 told that he was unable to complete that
4 assignment.

5 Q. But, in fact, he did complete it.

6 A. Again, I was given words by my
7 supervisor, who I supported. I felt he had
8 knowledge and was capable of directing people
9 and knowing what he was going to --

10 Q. Let me approach it a different way,
11 rather than us just saying that same sequence
12 back and forth.

13 What do you do when a Q-1 investigator
14 submits a report? Do you sometimes accept it,
15 and sometimes you throw it away?

16 MR. SILBERG: When you say
17 "you," you mean --

18 Q. (By Mr. Griffin) "You," meaning you,
19 Snyder.

20 A. I do not review all of the
21 investigative reports to make sure --

22 Q. I wasn't asking about all of the
23 investigative reports. This was a situation
24 that kind of developed and was kind of -- it was
25 a pretty high profile, because you, you or one

1 of your supervisors, at least, terminated the
2 Q-1 investigator. Not only did you not accept
3 his report, you terminated him, and you said his
4 work was unsatisfactory. Then, when I came to
5 review the Q-1 files, his investigative -- his
6 investigative report is not part of the file.
7 If I understand what you are saying, Chuck, you
8 relied upon your supervisor's, Mr. Scott's,
9 judgment, and you did not accept the man's work,
10 and you terminated him. Is that accurate?

11 A. I concurred with his termination,
12 yes.

13 MR. SILBERG: Are you saying
14 that -- are you asking Chuck whether he reviewed
15 [REDACTED] report?

16 MR. GRIFFIN: I think his
17 testimony is --

18 THE WITNESS: I did not.

19 MR. GRIFFIN: -- that he didn't,
20 he relied on Mr. Scott.

21 MR. SILBERG: Okay.

22 Q. (By Mr. Griffin) You did terminate
23 him?

24 A. I concurred with the request for
25 termination. It was made by Bob Scott, to me,

J.D. Porters

1 to request my concurrence to terminate the man.
2 I concurred with his request to terminate the
3 man. The man never came to me and talked about
4 the issue, by the way.

5 Q. Did he ask to?

6 A. No.

7 Q. Did he ask anybody else if he could
8 talk to you about it?

9 A. To the best of my knowledge, he did
10 not. He hadn't -- he came in and talked to me
11 before about some other issues. The door wasn't
12 closed. He had been in there several times
13 before on other issues.

14 Q. Fortunately, as we discovered during
15 my case review, even though Q-1 doesn't have Mr.
16 [REDACTED] report, fortunately legal did, and we
17 were able to get a copy of it, and we reviewed
18 it, and we think Mr. [REDACTED] had some very sound
19 concerns. Apparently Q-1 ^{disagrees} ~~agrees~~. Is that
20 right?

21 A. Whatever he produced for his
22 supervisor was, the way he was giving it to me,
23 was not acceptable to his supervisor.

24 Q. I want to approach this, again, from a
25 little different angle. Do you think it's

- - - [Signature]

1 legitimate for Q-1 supervisors, because they
2 don't like the findings, to dispose of Q-1
3 investigative reports as a result of --

4 A. To answer that question, I would say
5 no.

6 MR. SILBERG: What do you mean,
7 "dispose"?

8 MR. GRIFFIN: As in take out of
9 the file, throw away.

10 Q. (By Mr. Griffin) I may be wrong about
11 this, Chuck, but I don't think anybody down here
12 on site knew that that report still existed. I
13 may be wrong about that.

14 A. Well, I think I conveyed to you
15 earlier that I gave instruction for -- since the
16 allegation was against me -- that is the way it
17 was given to me, this allegation. Anything
18 relative to that, I could not be a part of. I
19 was not going to be mixed up in me investigating
20 myself. I gave instructions for legal to do the
21 investigation.

22 Q. Okay. Well, somehow the -- not only
23 were Mr. [REDACTED] findings not accepted, his
24 report was not accepted, and it was not placed
25 in the files, and the criticism here is, do you

7D, Rations

1 think this is a -- or do you think this is a
2 valid approach and within the authority of you,
3 as a Q-1 investigator, to take, whatever this
4 was, five or six weeks of investigative work by
5 a Q-1 investigator, because you don't, not you,
6 meaning your supervisor, does not like the
7 findings, and you don't evaluate the findings.
8 As the head of Q-1, do you think it's valid to
9 discard the report?

10 A. You are drawing a conclusion. Bob
11 Scott never said he didn't like the findings.
12 You are saying that. Bob Scott said he wasn't
13 doing acceptable work product.

14 Q. From the testimony I have taken from
15 the other investigators here, they said you
16 could hear the discussions between Mr. [REDACTED] and
17 Mr. Scott out in the work areas, so Mr. [REDACTED]
18 ongoing investigation, as he was pursuing this,
19 was under periodic -- based -- I'm relying on
20 the testimony of the other people there,
21 periodic review by Mr. Scott, and when he
22 eventually and finally, after whatever it was,
23 five or six weeks, turned in his findings, which
24 only, I guess, he knew in sufficient detail to
25 either validate or invalidate, whatever

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1 conclusions he arrived at, this was not accepted
2 by Mr. Scott. Is that your understanding?

3 A. That is my understanding, that his
4 work product -- in other words, the product of
5 his efforts, for whatever period of time, was
6 not acceptable.

7 Q. Do you think it's valid to discard his
8 work product as an investigative unit, I mean as
9 Q-1?

10 A. No, it's not valid to discard his work
11 product, and I think you will find it's not
12 discarded.

13 Q. It was discarded --

14 A. The only thing I can say is [REDACTED]
15 the interviewer, when he left, when he departed,
16 he lodged an allegation against me personally.
17 I had no choice but to give instructions for
18 that allegation to be transferred to legal so
19 they could perform an investigation.

20 Q. Here is what happened. The allegation
21 was reassigned to Mr. [REDACTED] who --

22 MR. SILBERG: You are talking
23 about the initial allegation?

24 MR. GRIFFIN: Yes. I'm not
25 talking about the KG&E investigation.

b, 7C & 7D, Porters

1 MR. SILBERG: The underlying
2 investigation.

3 Q. (By Mr. Griffin) I don't think Mr.
4 [REDACTED] -- did he make an allegation to Q-1?

5 A. Yes, absolutely. That is the reason
6 the file went to legal.

7 Q. Okay. Mr. [REDACTED] was reassigned
8 the investigation which narrowed the scope
9 tremendously.

10 A. I understand he was reassigned the
11 responsibility. I recognize that.

12 Q. He narrowed the scope, and then he
13 arrived at the same basic conclusion as Mr. [REDACTED]
14 but on a much more narrow scale. The reason I'm
15 exploring this with you, Chuck, is the NRC has
16 the obvious concerns here. Is it valid to throw
17 away or remove from the investigative files the
18 investigative --

19 A. But you have to agree, obtainable --

20 Q. Well, I'm not --

21 MR. SILBERG: I'm sorry?

22 Q. (By Mr. Griffin) They weren't
23 obtainable to people, NRC, who came through
24 here. They didn't know it was in the files.
25 All we had up to that point was the testimony of

6,7C & 7D, Porters

1 Q-1 management that it was not accepted. I was
2 frankly surprised to find it in the KG&E files.

3 A. I was, too, when you made me aware of
4 it.

5 Q. The former NRC people who have already
6 looked at these didn't know it existed.

7 MR. SILBERG: You also were
8 saying that the underlying concern, when it was
9 turned over to [REDACTED] was dramatically
10 restricted.

11 MR. GRIFFIN: Narrowed in
12 scope.

13 MR. SILBERG: It's my
14 understanding, and you can confirm this or not,
15 Chuck, that the concern that [REDACTED]
16 investigated was the concern that was in fact
17 raised, and that [REDACTED] was embarking on a much
18 broader investigation, which at least some
19 people believed [REDACTED] felt went well beyond
20 the scope of the incoming concern.

21 THE WITNESS: As a general
22 understanding, I would agree that is -- that is
23 probably what my understanding is, but that is
24 only since we discussed the issue here a couple
25 weeks ago.

6,7C47D, Portman's

1 Q. (By Mr. Griffin) I heard that point,
2 too. Like I say, I talked to enough former Q-1
3 investigators to know that Mr. [REDACTED] and Mr.
4 Scott had some rather loud, extended discussions
5 on his pursuit of this subject before he turned
6 in his ultimate report.

7 A. They may have had.

8 Q. The idea of discarding -- Q-1 to
9 discard and not accept his report, whether you
10 as the manager agree with it or not, I just want
11 to know whether you think that is an acceptable
12 approach, whether you think you have the
13 authority to just disregard an investigative
14 finding, whether you agree with it or not.

15 A. "Discard" is what bothers me.

16 Q. Pick any word you want. Throw away,
17 trash. Whatever.

18 A. It was never thrown away. I tried to
19 offer an explanation. I gave an instruction, an
20 allegation against me, and that was evidently
21 part of whatever would have been the allegation
22 against me, is all I can perceive it to be.

23 Q. You told me awhile ago you didn't know
24 the file was in existence any more than -- you
25 didn't know it went to legal. It's not in the

7D. Portions

1 file. It may have been one thing to make a copy
2 and send it to legal, let the NRC come in look
3 at this thing and say, well, they didn't like
4 it, and we either don't like it or not.

5 A. To answer your question, if they came
6 to me and said, what do we do with the records,
7 would I have said discard them, would I agree to
8 discard them? There is no way. I didn't even
9 know records existed.

10 Q. Do you know if Mr. Scott -- did Mr.
11 Scott ever tell you that Mr. [REDACTED] had submitted
12 a report?

13 A. To the best of my knowledge, no. He
14 just said his work product was unacceptable.

15 Q. I see. I guess I will have to talk to
16 Mr. Scott and find out, because Q-1 file, which
17 is what the NRC is relying on here to some
18 degree, if an investigator does a report, we
19 assume it's his report, we assume that if he
20 signed it, it's his signature. There are a lot
21 of assumptions we are making there. But what
22 the concern is, do you think it's a valid
23 approach, to remove or be unwilling to accept
24 investigative findings that you don't agree
25 with? Not you, but your organization doesn't

7D, portions

1 agree with.

2 A. I can't answer that. I don't know for
3 what reason they would be unacceptable to him.

4 MR. SILBERG: I could conceive
5 of circumstances where, if a guy was just -- you
6 know, the concern is X, and this guy is
7 investigating Y.

8 MR. GRIFFIN: We have some of
9 those, and we are going to get to them.

10 MR. SILBERG: Right. That that
11 would be -- it's so far beyond the realm of the
12 concern that you wouldn't keep that in the
13 quality first file.

14 MR. GRIFFIN: Well, in this one,
15 the man worked for six weeks on a very, very
16 difficult issue, looked at an enormous amount of
17 material, and the perceptions of the Q-1
18 investigators and the person terminating, not
19 all of them, but those that commented about it,
20 believe that he was terminated because the Q-1
21 management did not like his investigative
22 findings. Then, when they -- when we couldn't
23 find his report, we found out just how much they
24 didn't like it. It wasn't there.

25 A. I haven't looked at his report. I

1 didn't know he had a report.

2 Q. (By Mr. Griffin) Now that I have had
3 one of our QC -- I mean investigative staff
4 people look at it, they think he has got some
5 legitimate findings, and his former -- the
6 former Q-1 investigators, who looked at it,
7 thought he had investigative findings. Now, I
8 just -- what I'm looking for from you is very
9 simple, Chuck. Do you think this is a
10 legitimate approach, to the handling of
11 investigative conclusions? Do you think you can
12 discard the report or --

13 A. You can't discard the report.

14 Q. Well, can you discard it down to
15 legal, where nobody knows where it is, and can
16 you take -- is it valid for Q-1 to release its
17 reports and -- with an indication that they
18 don't exist, and is it valid to terminate
19 employees for reporting concerns that Q-1
20 management doesn't like the findings?

21 MR. SILBERG: That is about a
22 17-part question.

23 MR. GRIFFIN: Since we have been
24 on this for ten minutes, I think Chuck has a
25 fairly rounded understanding of what I'm trying

1 to get an answer from him for.

2 Q. (By Mr. Griffin) If you say, Chuck --

3 A. Do you want me to speak for management
4 for Q-1?

5 Q. Yes.

6 A. From that standpoint?

7 Q. Yes.

8 A. Okay. No, it is not right to discard
9 reports. No, it is not right to terminate
10 someone because he gives us words we don't want
11 to hear.

12 Q. That is what I have been trying to get
13 from you.

14 A. Okay. But, in this case, I don't see
15 where we get either one.

16 Q. Well --

17 A. Particularly, when you questioned me,
18 because -- I had no knowledge of what he had
19 developed.

20 Q. Well --

21 A. All I know is assignment.

22 Q. Can you answer this question: Why, in
23 the midst of all of this, were you -- I mean,
24 you got deeply involved in a lot of less
25 important cases than this, but on this one you

1 chose not to explore it or to involve yourself
2 in the issue, itself. You merely relied on Mr.
3 Scott and said, "Okay, we are terminating this
4 guy. I don't want to look at his report." Yet,
5 in my contact with you, you have gotten deeply
6 involved in a lot of issues.

7 MR. SILBERG: He didn't know
8 there was a report.

9 A. I did not get deeply involved in
10 this. The man came to me, Mr. Scott, and said,
11 "I have worked with this man for, and I forget
12 how many weeks it was, "and on many different
13 times I have reviewed his approach on this
14 thing, his work product, and it's unacceptable.
15 He will not follow my direction. He does not
16 give me anything that I can use. I want to
17 terminate the man." I said, "Fine, terminate
18 the man."

19 Q. (By Mr. Griffin) So Bob Scott never
20 told you that he had completed --

21 A. That's right.

22 Q. -- his report?

23 A. Okay.

24 Q. I think we have --

25 A. I did not know there was anything in

1 the file on it, again. When I gave instruction,
2 an allegation against me, to be sent to Wichita,
3 I did not know that that went to Wichita with
4 it --

5 Q. Okay.

6 A. -- if existed. In both of those
7 cases, and it isn't two cases, it's one, I know
8 that there was some assumptions made. Dick
9 Denise came over and talked to me about that
10 issue. He went to the NRC, also.

11 Q. I understand your testimony. Let's
12 move on to another subject, Chuck. A lot of the
13 people that I have interviewed out here describe
14 a process whereby they inherited cases from
15 employees that left. Some stayed longer than
16 others. Some investigators would, as I say,
17 inherit incomplete cases. Some of the hostility
18 that remains, Q-1 investigators, has to do with
19 incomplete cases where they think they had
20 already documented substantial findings, that
21 they ultimately heard back. Of course, they
22 could not rely on that investigation. That the
23 investigations were closed as unsubstantiated,
24 because the people that had inherited the cases
25 had not interpreted what was available or left

1 for them to interpret in the same way the
2 original investigators had. Did you ever hear
3 any complaints like that from any of the Q-1
4 people?

5 A. Not specifically. Would you define
6 "cases"?

7 Q. Q-1 investigations.

8 A. Concerns or files?

9 Q. Concerns, investigations on concerns.

10 A. Concerns. Okay. Just so I understand
11 what you are talking about there. Many files,
12 you know, had many people in them. No one has
13 ever come to me and told me that they were
14 unhappy because they inherited something from
15 somebody else or that something was taken away
16 from them and given to somebody else. When I
17 look at people who left for whatever reason,
18 there were some things that people inherited,
19 but it was because somebody had left.

20 Q. Well, it's not like they had just
21 left. They were laid off. Right?

22 A. No. I disagree with that. To the
23 best of my knowledge, I do not know about having
24 laid off one person who was in the middle of an
25 investigating concern.

1 Q. Well --

2 A. In fact, we made -- we went to great
3 pains to make sure we didn't lay somebody else
4 off, somebody off, because they were in the
5 middle of an investigation.

6 Q. Well, for instance, Mr. [REDACTED] I know,
7 was -- you know, people had come -- had to come
8 and finalize some of his stuff.

9 A. Only the verification of corrective
10 action. Mr. [REDACTED] was not terminated from his
11 job, by that I mean laid off, in the middle of
12 performing an investigation. He completed
13 whatever investigation he was assigned to, of
14 whatever concern, before he was terminated.
15 There was correction action verification that
16 had to take place.

17 Q. So you are talking about just that
18 final sign-off?

19 A. Absolutely. That is not even good
20 business.

21 Q. I want to cover briefly an allegation
22 coming the other way.

23 A. Okay.

24 Q. Some of the people I interviewed said
25 that they thought that, in the early stages of

7D, postures

1 the Q-1 program, that some of the exiting
2 employees were improperly pumped for information
3 and were made to give -- or ultimately it seemed
4 that they were making allegations that they
5 never really intended to make. Did you ever
6 review any interviews or attend anything or come
7 across any information to indicate to you that
8 this was going on?

9 A. A personal opinion, I would say, in
10 general, I -- before I had occasion to look -- I
11 have not looked at all of the files. I haven't
12 had occasion to go back and look at all of
13 them. The ones I have looked at, there are some
14 indications to me that it's more than an
15 interview about the concerns a person has when
16 they came in. It's an expansion of -- of
17 whatever concerns they had. But that is a
18 personal opinion again, and I took no action on
19 this. There was no action taken on my part for
20 people to change the methodology or reduce or
21 discard certain things.

22 Q. Let's move on to another case. There
23 was -- this [REDACTED] Item 2, this is the one
24 that had to do with the valves being
25 disassembled. I think there were actually two

1 Q-1 cases on this. There was a -- in the first
2 case, it addressed the bag and tag aspect of
3 this. I'm not so much interested in that one.
4 This relates to the validity of the sampling
5 process that went on to -- that took place, to
6 determine whether the valves were -- what is it
7 called. If MMP or MPP-1 data was still
8 accurate. In other words, were the heat numbers
9 matching and all of that.

10 A. The code data reports.

11 Q. Yes. In this investigation, there was
12 a -- part of the allegation was that the -- that
13 the original -- that there was an original
14 sampling and that the number of deficiencies
15 identified in this relatively small sample were
16 greater than the accepted for deficiencies,
17 given the sample size. So the sample was
18 expanded. Then, when the resampling was done,
19 in the in-between time, somehow the deficiencies
20 identified in the first sample had somehow been
21 corrected.

22 My question to you is, did this
23 apparent -- or this evidence that existed, did
24 it indicate that the sampling was being tampered
25 with -- did it ever come to your attention?

1 A. To the best of my knowledge, that was
2 never raised. I have no knowledge of that
3 particular allegation you are saying, that the
4 sampling was tampered with.

5 Q. In this instance, the investigator
6 reported this, and I have read -- I have looked
7 at the Q-1 file. The way it states it, it is
8 kind of in understated tones, but what he is
9 doing is he is expressing disbelief that these
10 things magically found their way back into the
11 right valves, these parts that had previously
12 been the incorrect number, because they hadn't
13 used a bag and tag system. Now they magically
14 appeared back in the right valves for the
15 second sample. Now, in addition to this
16 concern, they -- there is no evidence that it
17 was picked up as a separate issue. As far as
18 you know, was there -- was it put on
19 observation, or was it assigned to somebody else
20 to investigate?

21 A. This particular concern, if my memory
22 serves me correct, was written up in the quality
23 program deviation documents, the QPV.

24 Q. You are talking just for the bag and
25 tag aspect?

1 A. No, this was for programmatic
2 deficiency. The tag and bag was a specific
3 hardware application.

4 Q. But this improper sampling process was
5 picked up?

6 A. Yes, to the best of my knowledge, it
7 was picked up in the QPV. When you say
8 "improper sampling," that is based upon
9 somebody's supposition that it was improper.
10 Okay? My knowledge of the case, and that is all
11 there is to it, in generalities, is that the QPV
12 addressed the programmatic application, and that
13 was the sampling. The determination, again, of
14 the sampling was done, if my memory serves me
15 correctly. By our quality assurance
16 organization.

17 Q. Okay.

18 A. It was their option to do it whatever
19 way they wanted to do it.

20 Q. Here is the essence of my question.
21 Here you have your own Q-1 investigator that
22 says, "I found somebody here getting sneaky with
23 us." What they are doing is, they are -- they
24 held the sample, and they didn't report that
25 sample, so they expanded the sample, and then

1 somebody, craft or somebody, went out there and
2 reinstalled hardware. This is your Q-1
3 investigator telling you this. And he writes it
4 in his report.

5 What I'm trying to find out is whether
6 Q-1 walked away from this issue, if that was the
7 end of it, or whether it was picked up by
8 somebody else, or whether it was picked up as
9 another Q-1 investigation, or whether it was
10 handled separately by somebody else.

11 A. The best of my knowledge, we walked
12 away from it, because the QPV was a project
13 direction relative to how to fix a condition,
14 that was a determined sampling, and --

15 Q. But craft is out there sneaking around
16 at night, and I'm using that phrasing just to
17 make it sound as ominous as possible, but if
18 they are out there trying to blow something by
19 QC or QA, isn't that something, and maybe I'm
20 drawing a --

21 A. I don't recall seeing that --

22 Q. -- conclusion here, that that would be
23 something that Q-1 would be best suited to
24 investigate?

25 A. Yes, but I don't recall that having

1 been a concern.

2 Q. It wasn't the original concern, but it
3 was reported by the Q-1 investigator.

4 A. There, again, I don't recall having
5 seen that, and it wasn't brought to my attention
6 that way, if that is the way it existed.

7 MR. SILBERG: That also gets
8 back to the philosophical design of the program,
9 which is that things that turned up, which were
10 not part of the concern, would be turned over to
11 the other appropriate organizations.

12 MR. GRIFFIN: Right.

13 MR. SILBERG: I understand that
14 this QPV did that.

15 THE WITNESS: The QPV addressed
16 the sampling. That was the direction of the
17 sampling, the methodology. That was the
18 corrective action prescribed.

19 MR. SILBERG: I haven't looked
20 at this file, I'm just listening to the
21 discussion, and it seems to me, based on my
22 understanding of the programmatic philosophy, of
23 quality first, that normally if something like
24 that turned up --

25 MR. GRIFFIN: There is no QPV on

1 this one.

2 MR. SILBERG: -- this would turn
3 that over to --

4 THE WITNESS: I don't know which
5 one of the two it's in, but in one particular
6 file there is a QPV we have in the record.

7 Q. (By Mr. Griffin) We don't need to
8 cover this area again, but do you fix the
9 hardware and ignore the wrongdoing? In this
10 case, you have some evidence of some sneaky
11 business going on.

12 A. I don't recall having heard that.

13 Q. Okay. Well, to expand upon this,
14 the -- when the Q-1 investigator reported this,
15 Chuck Mason comes over to you and -- and decides
16 that maybe -- that maybe -- there is a series of
17 discussions, and let's move up the date of this
18 Q-1 investigation, and he's writing the report
19 that says this.

20 A. Move up the what?

21 MR. SILBERG: Move up what?

22 MR. GRIFFIN: Move up the date
23 of his departure.

24 A. That is a falsehood. Chuck Mason
25 never discussed with me when I would have a man

1 depart this site.

2 Q. (By Mr. Griffin) Let me amend my
3 statement to you. It was not Mr. Mason. It was
4 Mr. Patrick and Rudolph.

5 A. Those individuals have had no
6 influence on the quality first program since
7 Rudolph got out of it.

8 Q. This particular investigator
9 indicated -- because of the language, Patrick
10 Rudolph made a couple of visits to Snyder's
11 office to discuss technical qualifications and
12 whether he should be fired. You don't recall
13 anything like that?

14 A. No. There were no meetings like
15 that. That again is a falsehood. Absolutely.
16 Those people, how -- recognize our -- I reported
17 to Kent Brown. Those folks reported, Patrick to
18 Rudolph, to Grant, to Koester, to Brown. The
19 reason I had the independence is so I didn't
20 have to put up with crap like that.

21 MR. SILBERG: The allegation is
22 that they were -- that they had visited Chuck to
23 complain about the technical qualifications or
24 to urge --

25 MR. GRIFFIN: Well, that's a

1 euphemism, to see -- to get the Q-1 investigator
2 fired.

3 MR. SILBERG: Fired? Okay.

4 THE WITNESS: Shoot the
5 messenger, if you don't like the message, is
6 what I'm hearing.

7 MR. SILBERG: You are saying
8 that never happened?

9 THE WITNESS: That's absolutely
10 false. The only influence they had was an
11 explanation of the reason they wrote the QPV to
12 start with, and they made a determination to
13 sampling. That was a project commitment.

14 Q. (By Mr. Griffin) You are talking
15 about somebody else's investigation. You are
16 talking about -- I'm talking about one
17 investigator, one investigation, this aspect of
18 it. I have read his file, and although it
19 indicates -- he doesn't state it in the language
20 I would prefer you use when somebody does
21 something underhanded, but he wrote another
22 statement, and he said that this led to these
23 visits regarding his technical qualifications
24 and whether he should be retained. But you have
25 no recollection of that occurring?

1 A. No, sir. There is only one man I
2 recall having investigated that issue, and if
3 there was more than one man, I don't remember
4 the names very well.

5 Q. Okay.

6 MR. SILBERG: Would it help to
7 identify the individual to see if you are
8 talking about the same thing?

9 MR. GRIFFIN: Well, I think
10 that, if somebody would come in, going after one
11 of your people, I would like to think you would
12 remember that, so rather than identify a
13 particular individual -- by the way, most of
14 these people have requested confidentiality, and
15 it's the interest of the NRC. Obviously --

16 MR. SILBERG: It just puts us in
17 a difficult position.

18 MR. GRIFFIN: I'm willing to
19 drop it at that point.

20 A. It's untrue.

21 Q. (By Mr. Griffin) Okay.

22 A. Unequivocally.

23 Q. Chuck, was there ever a time while you
24 were -- after you took over Q-1 that Q-1
25 investigation reports were not signed by Q-1

1 investigators? Was that ever part of the
2 procedure or was that ever part of your
3 operational policy?

4 MR. SILBERG: You are talking
5 about investigational reports?

6 MR. GRIFFIN: Yes.

7 A. I think they are just initialed, and
8 I --

9 Q. (By Mr. Griffin) I mean where they
10 had no review of the final product.

11 A. To the best of my knowledge, no. In
12 fact, that is one of the things I put into
13 place, was the fact that I had to know what
14 their input was. It had to be recorded as
15 theirs.

16 Q. I had one allegation that was made
17 that you were closing -- that you were closing
18 out your reports without sending it back, and
19 when he --

20 A. I don't know what "sending back"
21 meant.

22 Q. Well, sending back for the review --
23 for the review and --

24 A. , Because I --

25 Q. -- signature of the investigator or --

1 A. Bob Scott signed the review space on
2 that report, not me.

3 Q. Did Q-1 investigators sign those
4 reports?

5 A. They initialed them, as best I can
6 recall.

7 Q. Okay. They saw what the final product
8 was?

9 A. Yes.

10 Q. This person said that you had changed
11 that and, after discussions with some of the
12 people, you changed back again.

13 A. To the best of my knowledge, no. That
14 wasn't the case.

15 Q. After Q-1 was taken out from under QA,
16 in other words you took over from ^{Rudolph}~~Brunhoff~~ (ph),
17 those things that QA addressed, did Q-1 receive
18 feedback from QA?

19 A. QA wasn't addressing anything. QPV
20 and QPD were the documents utilized. They were
21 QA documents. QA was not responsible for
22 verification of action. Quality first -- we
23 segregated them. Even though they were their
24 documents, we had the numbers, we had the
25 subject matters, so it was up to quality first

1 to verify corrective action.

2 Q. One of the more common themes that I
3 heard from the former Q-1 investigators was that
4 on numerous occasions they were closed for lack
5 of specificity. As an investigator, myself, I
6 know that it is not unusual for this to occur,
7 but along the same lines, or the same theme, of
8 some of these cases being closed on one
9 interview investigation, do you remember any
10 appreciable number of cases being closed?

11 A. Not appreciable, and I would like to
12 comment on that. There were -- specificity
13 probably is applicable to ones where we had a
14 very generalization of an allegation without any
15 detail and no way to gain any more detail. In
16 that case, there were probably some that were
17 closed out because of lack of specificity,
18 although there was an attempt made to see if
19 there were any other concerns that we had in the
20 file that might be relative to -- to shed some
21 light on it, to see if there were any
22 connections.

23 Q. I will give you an example of one.
24 [REDACTED] Item 14. [REDACTED] had an
25 investigation. The allegation is on the master

6.7c+7D, Fortens

1 list. "Piping preheat and weld records are
2 falsified, bought off after the fact by
3 inspectors who never leave their desk." In this
4 case, relying on the case file, there were six
5 topics selected at some point earlier in time,
6 generally discussed with 19 QC inspectors across
7 the whole spectrum of QC on the site. This
8 particular allegation, about buying off work
9 without leaving your desk, was not one of those
10 six topics. However, these six topic
11 discussions, with 19 across the board, you know,
12 electrical, mechanical, whatever, all kinds of
13 QC inspectors, was used to close several
14 investigations. This is just one of them. Some
15 of the investigations of this broad shotgun
16 approach was used on, one of the six topics was
17 in one way or another linked with the
18 allegation. In this case, from my review of it,
19 the six topics, and I don't remember what the
20 six topics were, didn't have anything to do with
21 the allegation whatsoever, and yet this vehicle
22 was used to close the investigation, and there
23 was no evidence of any other investigative
24 activity.

25 Now, without belaboring the point

1 again, assuming that Mr. [REDACTED] got some kind of
2 supervisory review, as head of Q-1, would you
3 generally endorse an allegation or an
4 investigation into an allegation of wrongdoing
5 by using an approach which doesn't even speak to
6 the allegation, itself?

7 A. Generally I would not support or
8 condone that approach, but here again, without
9 knowing the specifics --

10 Q. This one, I saw those six topics, and
11 I -- and also bear in mind that there is no
12 information whatsoever as to what those 19
13 inspectors said about those six topics. It's
14 just -- this was just an approach used to close
15 a certain number of cases. I was a bit
16 surprised to see this approach used by somebody
17 who has the credentials that Mr. [REDACTED] does.

18 A. Yes, because [REDACTED] is a good
19 hand. Again --

20 Q. The six topics, 19 -- you have some
21 guy here that doesn't have anything to do with
22 it, and you are talking electrical, and you are
23 talking with some QC inspector over here that is
24 doing materials acceptance, and it doesn't have
25 a lot of impact that --

6.7C97D, Porters

1 A. To me, I -- I would have to look at
2 the file to really comment on it.

3 Q. Since I only looked at a few of them,
4 I don't know how many times this approach was
5 used, how many investigations were closed, but
6 it was more than two. I hope it wasn't a great
7 deal more than two.

8 A. Again, I would have to look at that
9 specific one. But I do not agree with the
10 methodology, if that is what you are asking.

11 MR. SILBERG: That sounded very
12 much like a "When did you stop beating your
13 methodology" question.

14 Q. (By Mr. Griffin) Actually, I feel
15 like a lot of these things, like that one,
16 probably, was -- that is probably one of those
17 cases that Driskill looked at and said, "I can't
18 believe this," and you have already had --

19 (Whereupon, a discussion was
20 held off the record.)

21 Q. (By Mr. Griffin) Back on the record.
22 We have taken a little refreshment break here.
23 I have a follow-up question for you, Chuck,
24 about the ceasing to use tape recorders. One of
25 the reasons that was put forth was -- that

1 recorders were no longer used was that Mr.
2 Koester had seen a transcript of the allegation
3 taken from the lady who alleged sex
4 discrimination against [REDACTED]
5 and the amount of specificity of the language
6 and acts that allegedly had occurred was such
7 that he didn't want to see that any more, and
8 that that had ultimately led to the tape
9 recorders being removed. Do you have any
10 information about that?

11 A. The only thing I can offer, it was
12 following that interview process, immediately
13 following, that he gave me direction to remove
14 all of the tape recorders. That is all I can
15 offer.

16 Q. So he never said that was the reason?

17 A. That's correct.

18 Q. I want to get your comments on a
19 couple of observations from what you might say
20 are advocates of the program. One was the -- a
21 lot of people discussed the different
22 philosophies between you and Mr. Thero. One
23 line of thought that I heard from several was
24 that a QA mentality and -- that it was difficult
25 for them to draw conclusions or arrive at

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1 conclusions, some of the investigators heard --
2 that were hired under Thero's regime. Do you
3 have any feelings on that subject, based on the
4 fact that you did inherit a lot of these people?

5 A. Just to reiterate a general statement
6 I made awhile ago, that in my opinion QA
7 auditors are not good quality first
8 investigators.

9 Q. Who do you think are good?

10 A. The type of people I ultimately put in
11 those positions, people who have some knowledge
12 of the product. If it's construction, people
13 who have been involved in construction
14 activities. If it's start-up, people who have
15 been involved in start-up activities. If it's
16 operational, people who have been involved in
17 operational activities.

18 Q. Do you think it's legitimate to use
19 people that were in construction on this site,
20 on operations on this site, to fill those roles?

21 A. I don't see why not.

22 Q. You don't think it would be a problem
23 with objectivity or fairness or keeping
24 personalities out of it?

25 A. I, personally, don't think so.

1 Q. Another line of thought that --

2 A. May I go back, please?

3 Q. Yes.

4 A. Another question. You were leading
5 somewhere. Could you explain why you --

6 Q. No, I just like to cover both sides
7 of these issues. It's not all one way. It's
8 not all "Snyder is a bad guy." There is some
9 criticism going the other way, too. That is
10 all --

11 A. The reason I say, I only know of one
12 man in the program, who had anything on this,
13 would be Owen, himself, in the quality first
14 program.

15 Q. You held that position at the time
16 that Mr. ⁶⁷⁰⁴⁷⁰ [REDACTED] did and --

17 A. Mr. ⁶⁷⁰⁴⁷⁰ [REDACTED] is the one I think that
18 really comes to mind. He moved over from an
19 organization into quality first organization.

20 Q. That was more your philosophy, the
21 manager who was directing these activities --

22 A. We were talking about abilities,
23 though, not philosophies, in the question.

24 Q. Another thing that I heard repeated by
25 some of the people I interviewed was that you

1 had hired engineers because, you know, they were
2 able to make calls, that they thought that, if
3 things had continued in the same vein, that
4 these allegations would not have been closed and
5 might have been an impediment to fuel load, and
6 that, by bringing in people who were able to
7 make these calls, you could get resolution for
8 these things, and the fuel load would not be
9 unnecessarily delayed.

10 A. It's difficult for me to give you
11 any response. What should I have done in lieu
12 of that? What would I have done better? I
13 guess I -- let me rephrase that. If I was going
14 to manage a program and do my very best to meet
15 the obligation of this project, I should have
16 looked at the best way of doing it. I guess
17 what I'm hearing is that, at least from what you
18 are saying, that, if I had not done that, some
19 people are saying I would not have resolved the
20 issues as quickly as I did? Is that right?

21 Q. No, these are -- as I prefaced my
22 statements awhile ago, there were certain
23 advocates of your supervision who said, "The
24 reason we needed to get these engineers in here
25 is to get these people who can't arrive at

1 conclusions out of the way, get some people who
2 can make some hard decisions, get these cases
3 closed, and support fuel load date."

4 A. That, I believe, is a good statement.

5 Q. The reverse of that is, some people
6 believe that you come from a construction
7 background, and you brought people in that were
8 from a construction background, that relate to
9 hardware issues. Sure, they are technically
10 competent, and they can go right to the heart of
11 the matter. When you start getting into some of
12 these other issues, like wrongdoing or scoping
13 or root cause, these people have no interest in
14 it. They just say, "Fix the hardware, close the
15 case." So you have got two camps --

16 A. I would disagree with everything
17 except the wrongdoing issue, relative to today.
18 The others, no. Any man who I brought in who
19 was not of a QA background was as well qualified
20 or better to even look at the QA interests.

21 MR. SILBERG: I guess the
22 question was, would a QA person be any more
23 likely to be facile in dealing with wrongdoing
24 issues than an engineer.

25 THE WITNESS: Or even

1 objectives.

2 MR. SILBERG: I guess that is
3 not intuitively obvious, that QA people would be
4 more at home on wrongdoing than engineers
5 would.

6 Q. (By Mr. Griffin) I will make an
7 observation that the -- I'm not well qualified
8 to make this observation, but after four years
9 now with NRC, NRC inspectors function more
10 closely akin to QA people, although most of
11 them, in their hearts, are construction, but the
12 type of objectivity you maintain, when you go
13 out to address an issue or do an inspection, we
14 run along the lines of going in and, like I say,
15 properly scoping the things, seeing how big the
16 problem is, and then giving it a fair review,
17 whether it's good or whether it's bad, then also
18 doing a thorough report to show the basis of our
19 conclusions.

20 Here you have these two -- what a lot
21 of people have described to me as two camps.
22 You have got the contractors, and you have got
23 the QA people. The people say, when you get
24 into this, the philosophies -- the different
25 philosophies are paramount, that this is a

1 difference in personalities more than it is a
2 difference in conduct of the program. The
3 effect on the program is just as closely related
4 to the differing philosophies. I'm telling you
5 this, as the NRC, we have to factor that out.
6 This is not a personality or a beauty contest or
7 anything like that. We need to know if you gave
8 these allegations a respectable look/see.

9 A. I think we did.

10 Q. I touched on this awhile ago, but I
11 didn't specifically question you about it. I
12 have a number of the former Q-1 investigators
13 say that Mr. Patrick in QA had a pile of Q-1
14 documents that he kept in a drawer over there,
15 and several people heard him make comments about
16 how, "No, we aren't going to be getting to these
17 until after fuel load." Did you ever hear of
18 that?

19 A. No.

20 Q. Have you ever heard any discussions
21 with Mr. Patrick which led you to believe that
22 the documents they were receiving from Q-1 would
23 not be reviewed before fuel loading?

24 A. They never received any documents from
25 Q-1.

1 Q. How about observations?

2 A. QA did not -- I will rephrase that.
3 QA was not on the receivership of QFOs. QA had
4 a responsibility to sometime during scheduled
5 audits and surveillance to verify that action
6 was taken pursuant to a particular weakness that
7 we have identified. That --

8 Q. Do you think these are the documents
9 that these several --

10 A. No, that is not the issue.

11 Q. What documents --

12 A. There is a priority log that was
13 maintained by Q and A. That is what they are
14 talking about.

15 Q. A six-inch priority log?

16 A. It wasn't six inches. It was so many
17 pages.

18 MR. SILBERG: This may be
19 something else.

20 Q. (By Mr. Griffin) Your employees said
21 that these people had QA action-type documents,
22 and I don't know whether they were QFOs and a
23 mix of other things --

24 A. No.

25 Q. I heard this from more than three

1 sources.

2 MR. SILBERG: This is QA action
3 documents or quality first action documents?

4 MR. GRIFFIN: Did I say QA?

5 Q-1. I'm sorry.

6 A. They had no Q-1 action documents. The
7 only involvement that QA had with quality first
8 was verification of action on QFOs. You know
9 how many QFOs there were.

10 Q. (By Mr. Griffin) Yes.

11 MR. SILBERG: I don't. Is that
12 a six-inch stack?

13 A. What, 22 of them?

14 THE WITNESS: There were 22
15 QFOs, which are one or two pages apiece.

16 A. Mr. Patrick was brought in, because
17 Mr. Patrick was responsible for the priority
18 log.

19 Q. (By Mr. Griffin) I want to just
20 touch, lightly touch, on the Diss-alvo tape
21 issue, because you and I talked about it at
22 length during my last document review here. I
23 really don't have very many questions about it.

24 One thing I would like to ask you
25 about is that, when Mr. Thero left the Q-1

1 program, he wrote a letter, and he had a lot of
2 strong feeling about what he thought it would
3 take to resolve the Diss-alvo tape issue. He
4 apparently felt that it was something that was
5 detrimental to the condition that the plant was
6 going to be in once they got into HOT functional
7 testing. He wrote out a laundry list of things
8 that he thought must be resolved before you guys
9 got the pipes dirty. Did you see Mr. Thero's
10 letter when
11 he --

12 A. I'm sure I did. Like I say, I gave
13 you a copy of it. I couldn't tell you what is
14 on it to this day. I obviously saw it. I would
15 have had to have seen it.

16 Q. Do you know if any action was taken or
17 whether his thoughts or his feelings or his
18 concerns were ever relayed to those responsible
19 for the pipe cleanliness?

20 A. I don't know that they were, but
21 knowing his philosophy, I doubt if they were.

22 Q. I mean, he submitted the letter to
23 you.

24 A. * Yes.

25 Q. Did you turn it over to him?

1 A. No, I did not. You asked me if he had
2 ever made it known. I did not.

3 Q. As we have discussed before this
4 interview today, there was a great deal of
5 effort put in at this site to hydrolyze --
6 disassemble and hydrolyze pipe that had been
7 potentially contaminated with this tape and
8 clear the chloride concentrations that could
9 lead to stressed corrosion cracking. Were you
10 content that this hydrolyzing process, combined
11 with the flush process, was going to resolve
12 this issue?

13 A. This is a personal opinion again,
14 remember. I was not the manufacturer of the
15 equipment or anything else. From my knowledge
16 of the equipment, I would be satisfied that a
17 hydrolyzer application would in fact remove any
18 contamination inside a piece of pipe it was
19 passed through.

20 Q. Okay. Now, the one remaining concern
21 I have, Chuck, is that late in the program, as
22 flushing was proceeding, and they were finding
23 large amounts of the -- of this residue tape,
24 which was -- which had been discolored, I guess,
25 by the heat --

1 to the NRC relative to this issue is that,
2 because of your background in the pipe cleaning,
3 this program, your responsibility when you were
4 on the construction site, and your participation
5 in trying to achieve resolution on how this
6 issue was going to ultimately be resolved, years
7 ago, adversely affected your objectivity
8 relative to these new allegations and that you
9 simply referenced the old CARS -- or I guess
10 it's one CAR --

11 A. NCR.

12 Q. NCR. -- and that you effectively kept
13 these allegations from being addressed
14 separately.

15 A. That's untrue. As you and I discussed
16 earlier, the pipe cleanliness issue was
17 addressed on an NCR. That NCR addressed all
18 types of things contrary to cleaning pipe,
19 whether it was Diss-alvo tape, two-by-fours,
20 whatever. Any allegation that was offered
21 relative to pipe cleanliness problems
22 automatically fell under the corrective action
23 associated with that NCR, except that, if one
24 were specific and that specificity fell within
25 the confines of the letter which I gave you a

1 copy of, which engineering developed, which
2 said, "Ye, verily, if you find Diss-alvo tape in
3 these pipes, you wouldn't just flush them, you
4 must hydrolyze them" -- that is the bottom
5 line. That is the project director. Now, what
6 I suspect has happened, people wanted everything
7 flushed, just because they found tape. They did
8 not pay attention to project directive. This
9 project functions on a project directive.

10 Q. Well, the tape appeared on the screens
11 until there was no more tape on the screens.

12 A. Which is --

13 Q. Which is proper.

14 A. That's the way it's supposed to be.

15 Q. But the idea was that the -- that the
16 flushes were of multiple systems and that the
17 implication was that some of the systems
18 contained stainless steel.

19 A. I think your technical associate the
20 other day disproved that. He had documents
21 there that showed the flush path. They were
22 numbered. They had the --

23 Q. I'm just repeating the concerns.

24 A. I know.

25 Q. I'm repeating the concerns. The

1 question is your objectivity. Were you willing
2 to take any new concerns, and there were
3 concerns made to Q-1, related to pipe
4 cleanliness, or as the construction supervisor,
5 were you unwilling to allow your Q-1
6 investigators to make any investigative effort
7 relative to new allegations in this area?

8 A. The Q-1 investigators were free to
9 make new investigations into any investigation,
10 old investigations, or whatever you want to call
11 them.

12 Q. But you guys ^{assigned} ~~signed~~ the
13 investigations, didn't you?

14 A. What?

15 Q. Q-1 management ^{assigned} ~~signed~~ the
16 investigations. The implication is that these
17 things were not investigated, that they were not
18 addressed as new issues, that they were simply
19 dumped into the big NCR in the sky on this issue
20 and nobody took a lot to see if there was a new
21 wrinkle or some other aspect of it.

22 A. I disagree with that. The only
23 wrinkle would have been, and it was not a new
24 wrinkle, is did that allegation address pipe
25 that was addressed by engineering as requiring

1 hydrolyzing. If it did not, it automatically
2 went to the NCR, which was a pipe cleanliness
3 issue, which was addressed generically.

4 Q. Test me here, but the allegation that
5 I heard, that I was made aware of, is that
6 multiple systems were flushed, Diss-alvo tape
7 was appearing from the multiple system flushes,
8 showing that the Diss-alvo tape was present
9 somewhere, and they couldn't tell which systems
10 it had come from. Now, technically speaking,
11 even if there was stainless steel involved in a
12 multiple flush, the hydrolyzing process would
13 have removed the type of residue that would have
14 been detrimental to the pipe in a pressurized
15 condition. Is that right?

16 A. It all depends on the size of the
17 pipe. I can't -- you know, I can't say a
18 three-inch pipe is -- you couldn't use one on a
19 three-inch -- I don't know if you can -- an
20 18-inch pipe might be very difficult. For a
21 pipe size where it was appropriate to use a
22 hydrolyzer, yes, I believe a hydrolyzer would
23 have cleaned them.

24 Q. In the master list here where you have
25 the QFAR numbers and so on there are references

1 periodically to CAR 19 and I believe to this
2 NCR. Some people thought you lost your
3 objectivity on the subject.

4 A. CAR 19? I don't understand the
5 relationship to CAR 19.

6 Q. No, CAR 19 is steel.

7 A. That is AWS.

8 Q. What I'm saying, there were a couple
9 of items that you guys dumped -- if an
10 allegation came in at or near this, you threw it
11 in that pile and never addressed it as a
12 separate concern. The implication and the
13 allegation to the NRC is that there may have
14 been new aspects to pipe cleanliness and
15 structural steel that were not evaluated by Q-1,
16 merely get rid of these issues, and tossed them
17 into the big pile, and they were never
18 investigated.

19 A. I disagree with that. I'm sitting
20 here trying to think ahead, what application
21 there might be, that could be categorized that
22 way. Again, the pipe cleanliness issue, if it
23 was not specifically Diss-alvo tape, deemed to
24 be present in any of those systems that
25 engineering says, you must remove it from, it

1 was a pipe cleanliness allegation, which had to
2 be treated the same as any other pipe
3 cleanliness violation in that NCR. That was a
4 generic application. It said, "You must do
5 something to this."

6 Q. What you are saying is, based on your
7 technical knowledge, there couldn't be any new
8 wrinkle related to pipe cleanliness that the
9 existing program would not --

10 A. There was none identified, no new
11 technical issue identified, in an allegation.

12 Q. I want to ask you about [REDACTED] I
13 think the heading is "Vague walk-down
14 procedures." This was one that I think you and
15 I talked about before in our interview. I
16 believe you became -- you got involved with Mr.
17 Reeves --

18 A. Glen Reeves.

19 Q. -- on some findings by Mr. [REDACTED]

20 A. Yes, okay.

21 Q. Apparently you got in the middle of
22 that, and Mr. Reeves was reluctant to accept the
23 investigative findings, and you were interceding
24 on behalf of your investigator.

25 A. I was influencing Mr. Reeves to

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1 respond to our needs.

2 Q. Okay. On this issue, I think the NRC
3 eventually, somewhere, in the process, got
4 involved and stopped the process. Was that
5 before or after -- are you familiar with that?

6 A. No, because this was all over with
7 when I came in. They had done this -- this KG&E
8 walk-down, where they had taken from Daniel the
9 responsibility and --

10 Q. So that preceded this investigation.

11 A. Yeah.

12 Q. Okay. My question to you is, when I
13 reviewed this case file, I expected to see an
14 appreciable amount of work in there by Mr. [REDACTED]
15 but the Q-1 file only contains information
16 placed in there by a fellow by the name of
17 [REDACTED] I don't even know his first name.

18 A. [REDACTED]

19 Q. [REDACTED] concluded that there were no
20 problems related to this issue. However, Mr.
21 [REDACTED] had made, wherever his investigation --
22 I mean, his investigation report is, or
23 wherever -- whatever he documented, the form of
24 these conclusions that he was trying to convey
25 to Mr. Reeves, are not present in that file. Do

6,7C + 7D, Partens

1 you know why only Mr. ^{6.7C47D} [REDACTED] work, showing that
2 this is of no concern, that there are no adverse
3 findings --

4 A. No. I'm going back, thinking, that
5 the -- [REDACTED] came to me and asked me to
6 work with Glen Reeves, if I would, to make it
7 known to him the need to respond to these. I'm
8 trying to think here of ever having seen
9 anything in the file, even.

10 Q. As described, there was a great deal
11 of work put in on this by Mr. Reeves. I mean by
12 Mr. [REDACTED] There is no evidence of any of his
13 work, though, that I can see in the file.

14 A. I seriously doubt if there was a great
15 amount of work put in there by him, and the
16 reason I say that is because he didn't come into
17 the organization until just the time I did or
18 until after I did.

19 Q. Well, if he was relying on Mr. [REDACTED] ^{al 2017}
20 work, then nothing was done. Apparently he had
21 a lot of concerns about this and a lot of
22 findings that he was trying to convey, and you
23 were helping him --

24 A. I was simply trying to get the
25 response back that he needed to close out the

6.7C47D, Porters

1 QPVs and the QPDs. That is the only involvement
2 I had in it. Whatever was developed had already
3 been developed, and the deficiencies were
4 identified, and the recommended corrective
5 action was transmitted, and we were waiting for
6 the commitment to corrective action. Without
7 looking at that file right in front of you,
8 there is no way I can discuss the content. Like
9 I say, I remember the application and my role in
10 it. To the best of my knowledge, [REDACTED] was
11 very happy to see me making an effort to try to
12 get responses.

13 Q. Yes. That is the way it was imparted
14 to me, too. It's just that I can't find any
15 evidence of what the problem was, because the
16 file didn't indicate.

17 A. The only thing I knew about, Glen
18 Reeves was bowing his back and simply was not
19 responding. That is the only problem I was
20 aware of, and I corrected that.

21 Q. So this list is a list that is
22 unsubstantiated?

23 A. I beg your pardon?

24 Q. This issue was listed as
25 unsubstantiated? It was your understanding, in

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1 your discussions with Mr. [REDACTED] and your
2 involvement with Mr. Reeves, that this
3 particular issue was unsubstantiated?

4 A. No, no, no. It was substantiated
5 findings. They were documented on QPVs and
6 QPDs. You do not issue QPDs and QPVs unless you
7 have substantiated something.

8 Q. That was my understanding, too. It's
9 unsubstantiated. There is a QFO and a
10 surveillance report.

11 A. On what issue?

12 Q. [REDACTED] Item 5, vague walk-down
13 criteria, which is --

14 A. We are talking only about one
15 concern. I thought we were talking about a
16 program.

17 Q. I was talking about Mr. [REDACTED]
18 investigation, that he was arguing with Mr.
19 Reeves about. You were thinking in terms of a
20 whole file, and I'm thinking in terms of the
21 particular part of that file that Mr. [REDACTED]
22 handled.

23 A. One particular concern. That is so
24 vague I don't even know. I'm relating back
25 again to the whole issue, as it were, rather

AD [REDACTED]

1 than a specific concern.

2 MR. SILBERG: If it was
3 unsubstantiated, why would Chuck have come to
4 Reeves to get corrective action?

5 MR. GRIFFIN: That is a good
6 point.

7 Q. (By Mr. Griffin) The file doesn't
8 contain evidence of work, and that is really the
9 question here. I'm just looking for an
10 explanation.

11 A. I can hazard a response, as long as
12 it's recognized that way.

13 Q. Okay.

14 A. The criteria established for that
15 walk-down effort, which Glen Reeves was
16 responsible for, was defined by the quality
17 assurance organization. He responded to their
18 direction. He said, "Look, in order to assure
19 ourselves that we in fact comply, you shall
20 sample," and so on and so forth.

21 I'm hazarding a guess, the issue might
22 have been that [REDACTED] was unhappy with QA's
23 direction to Glen Reeves, thinking Reeves should
24 have done more. That is the only thing I can
25 hazard a guess about. If that is what the

70 notes

1 allegation was, then it was found to be
2 unsubstantiated, because QA again provided the
3 project director --

4 Q. Mr. [REDACTED] is the one that called it
5 unsubstantiated. Mr. [REDACTED] of course thinks it's
6 very substantiated.

7 A. [REDACTED] was an investigator at that time
8 in your organization before I took it over.

9 Q. When you took over Q-1, there was a
10 verification for corrective action, but hadn't
11 you deleted the requirement that Q-1 accept the
12 corrective action? Was that a distinction that
13 had been made?

14 A. Say that again.

15 Q. I know that, under your -- in your
16 format that you used in your investigative
17 reports, you have a verification by Mr. [REDACTED]
18 signed on most -- the majority of them.

19 A. Okay.

20 Q. Earlier in the program, before you
21 arrived, Q and A wrote, accepting the validity
22 of corrective action. Did this end when you
23 took over the program?

24 A. No. In fact, I would say that it --
25 that I was responsible for putting in place

6,7047D porters

1 meaningful verification of corrective action
2 relative to the concerns as expressed.

3 Q. Okay. Did this verification extend to
4 the point of having to accept it or not accept
5 it under your supervision?

6 A. I had the authority to reject
7 corrective action. I might add, my rejected
8 correction action resulted in direction to
9 people, that they provide corrective action
10 acceptable to me.

11 Q. So they had to go back and do
12 additional work?

13 A. That's correct.

14 MR. SILBERG: So you did on
15 occasion reject corrective action?

16 THE WITNESS: Yes, definitely.

17 MR. SILBERG: The allegation is
18 that he could not -- he could not go beyond the
19 fact that someone said corrective action was
20 taken? Once someone said correction action
21 taken, that is all he could do, would be just to
22 check that box?

23 MR. GRIFFIN: If I understand
24 the concern, it was that, under Thero, Q-1 had
25 to accept corrective action, but some people

1 believed that, under Chuck, it was a rubber
2 stamp, just merely a verification that it
3 occurred, that there was not a true acceptance,
4 where they approached Q-1, and say, "Look at
5 this, see if you will buy off on this."

6 A. Go look at the files. Talk to the
7 people who dealt with me, and see how hardnosed
8 I have been. That's new on me.

9 THE WITNESS: That's the first I
10 have been accused of being liberal, Jay.

11 Q. (By Mr. Griffin) Chuck, I have
12 already asked [REDACTED] this, but was
13 [REDACTED] ever assigned to document control
14 allegations?

15 A. I honestly don't know. I would like
16 to reiterate something relative to that. There
17 have been as many as two and maybe three
18 document control activities on this site, and I
19 think what you are leading to is if he was at
20 one time involved in some of that, and was he
21 then assigned to investigate in that.

22 Q. Yes.

23 A. To the best of my knowledge, no. He
24 has investigated the other side of the house,
25 the document control in the plant, but the other

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1 side, not to my knowledge.

2 Q. Thank you.

3 MR. SILBERG: While you are
4 looking, let me clarify something. When you are
5 talking about Diss-alvo tape before, I will
6 bring this up, and you referenced the letter
7 from Owen Thero, listing the whole number of
8 concerns, did I understand you to say that you
9 did nothing with that letter?

10 THE WITNESS: I cannot remember
11 anything specif'ally that I did with it. It
12 was kind of like a reminder from Owen, that,
13 "These are issues that I think really need to be
14 looked at."

15 MR. SILBERG: Okay.

16 THE WITNESS: I guess what I'm
17 saying, and maybe I'm saying it in a -- in some
18 way that may be misinterpreted. I knew what had
19 to be done with this project, relative to the
20 quality concern files. I did not have to
21 necessarily respond. I had no accountability to
22 Owen's list. That's why I can't really say, "I
23 took every item and made somebody aware of
24 this." I inherited all of that. I took care
25 of seeing that it was ultimately involved,

1 whatever issue that came to quality first. I
2 didn't need to respond to every issue from
3 Owen. I know I did not, from that list, just
4 because that list -- go talk to anybody, because
5 I knew what the program needed.

6 MR. SILBERG: So the --

7 Q. (By Mr. Griffin) We don't really need
8 to revisit this a great deal, but fundamentally
9 you and Owen disagreed about this issue? He
10 felt there was an ongoing concern, as the
11 construction supervisor, who had been intimately
12 involved in this, and you obviously, and based
13 on our lengthy, lengthy discussions, you already
14 had very strong feelings that it was resolved,
15 that the -- that everything was in place that
16 needed to be in place, and then the other aspect
17 is other individual people have said, "Chuck is
18 not objective about this at all. He is saying
19 he's the construction supervisor. He will not
20 accept any new information on this subject
21 because he was the construction --

22 A. That's the --

23 Q. Mr. Thero wrote out quite a few
24 things. I'm not in a position to evaluate
25 them. I don't think he invited the magic words,

1 like I don't want to make a quality first
2 allegation, but he certainly -- it wasn't a
3 reminder list. It was more like, "These things
4 must be done before you go to HOT functional."

5 A. It was like a threat. Okay? Let's
6 say what it was. If the letter were ever
7 surfaced, it could be a threat for me to follow
8 what he wanted to have done. If that is the way
9 he intended it, you know, I don't know, but I
10 did not respond to his letter. There is no
11 requirement for me to, no need for me to. The
12 man was very, very incapable when it came to
13 knowing the real issues.

14 MR. SILBERG: But the reason
15 that you didn't --

16 THE WITNESS: I had to --

17 MR. SILBERG: -- respond to it
18 is because of your belief that the current
19 project procedures were taking care of the
20 issues that he raised in his letter?

21 THE WITNESS: That's correct.

22 MR. SILBERG: Okay.

23 Q. (By Mr. Griffin) I would like to make
24 an observation and have you respond to it,
25 Chuck. You are so adamant on this subject that

1 you do not display much objectivity on this
2 subject, either in my conversation with you and
3 apparently in these others. Are you really that
4 sure?

5 A. Yes, I am sure, and unless someone can
6 show me, which they haven't shown me to date, a
7 new pipe cleanliness issue --

8 Q. Are there any other aspects of the
9 construction at this site that you are so sure
10 of that you can determine that no investigation
11 or no additional investigative activity needs to
12 take place?

13 A. We are talking about the issue.
14 Okay? I have seen no new pipe cleanliness
15 issues.

16 Q. There were 92 issues that --

17 A. No.

18 Q. You seem totally intractable, and
19 that's what you are -- that is what I hear from
20 you, before, and today, too.

21 MR. SILBERG: I think it's not
22 that he is so sure of the substance of the
23 matter. As I hear what is being said, you had a
24 project procedure in the NCA, whatever it is
25 called, which, in essence, was global. It

1 covered everything having to do with pipe
2 cleanliness. As I understand the concept of the
3 quality first program, if such a procedure
4 existed, and specific concerns that fell within
5 the scope of that procedure were transferred
6 under the umbrella of that procedure and would
7 be investigated and closed out as part of that
8 NCR process. I think what I hear Chuck saying
9 is that what Owen Thero was identifying in his
10 letter were things that were covered by that
11 NCR. Therefore, there was no need to do
12 anything more, because it was already dealt
13 with. That is what I hear. Is that --

14 THE WITNESS: There was a --

15 Q. (By Mr. Griffin) I'm just saying some
16 people have been critical of you for wearing two
17 hats. Did the construction supervisor, who was
18 not accepting new allegations, in an area where
19 there is an ^{NCR} ~~NCA~~ or a CAR, and saying that is not
20 his job, his job is --

21 A. That is not accepting them. We
22 accepted them, Brooks. We accepted them. I
23 think you would agree. There is a record that
24 we accepted them. We did not do an individual,
25 isolated investigation.

1 Q. Okay. The reason, because there was a
2 higher tiered document?

3 A. That's right, that already covered
4 that.

5 Q. Okay.

6 A. Again, I qualified that. The only
7 difference that was, if those particular
8 systems, or whatever the allegation was, fell
9 under that umbrella, of the letter that I gave
10 you, which said something additionally must have
11 been done, that was the only difference. Then,
12 again, I know the project. It was not a matter
13 of me being the project supervisor, project
14 construction supervisor. I knew the documents
15 in the project.

16 Q. You know, obviously, if Mr. Thero were
17 here, you would argue to no avail, because he
18 would continue to insist, but before HOT
19 functional testing, certain things must occur.
20 He has certain credentials. You have certain
21 credentials. You would never agree. Yet it's
22 not going to be long before any kind of
23 arbitration is --

24 A. I know, but just for the sake of one
25 last argument on my part, whether or not you

1 would accept this --

2 Q. If it's going to be technical, you are
3 wasting your time.

4 A. It's only technical to this degree.
5 Do you believe what I showed you, that there was
6 a generic NCR, dealing with pipe cleanliness?

7 Q. Yes.

8 A. You believe the letter that I gave you
9 that addressed, if it's in these systems, you
10 find Diss-alvo tapes, and the words are very
11 specific, you must hydrolyze or approve
12 mechanical means --

13 Q. Here is the part where I, as a layman,
14 still have problems. The allegation was that
15 there were multiple system flushes occurring at
16 the same time, and Diss-alvo tape was
17 appearing. These systems involved stainless
18 steel. From a layman's point of view, that is
19 telling me that chloride is being reintroduced
20 to the stainless steel. Assuming you moved to
21 HOT functional testing, as a layman, I think, do
22 you have a continuing problem? Maybe the person
23 that made the allegation looked at it from that
24 point of view. Maybe Mr. Thero -- I don't
25 know. He knows a lot more about this than I

1 do. Maybe he looked at it from that point of
2 view. But whether that is valid or not --

3 A. Okay.

4 Q. -- it is certainly -- you were
5 unwilling to address that as a possibility.

6 A. Let me address just that one issue
7 again. Let's get back to what the
8 Diss-alvo tape issue was, Diss-alvo tape
9 adhering.

10 (Whereupon, a discussion was
11 held off the record.)

12 Q. (By Mr. Griffin) Let me break in,
13 Chuck. I am relying on the inspector that came
14 out here. You really don't have to pitch a case
15 as to -- or you don't have to try to convince me
16 that it is technically correct. I'm not
17 revisiting that issue. I think we will leave
18 that to Jay.

19 MR. SILBERG: I would like to
20 get on the transcript, though, the response to
21 this multiple system flush allegation, that
22 somehow that was leaving unremoved chlorides on
23 stainless steel. I assume there is a response
24 to that. I don't know what it is. I'm just --

25 THE WITNESS: I don't know if

1 that was even an allegation made to us. I don't
2 know that.

3 Q. (By Mr. Griffin) I believe that there
4 were several allegations, during flushing, about
5 Diss-alvo tape, and they weren't investigated,
6 it was my understanding. The reason they
7 weren't is because of --

8 MR. SILBERG: Is there a
9 technical response to this allegation that there
10 were multiple flushes which somehow --

11 THE WITNESS: There is a
12 technical expansion I would like to offer.

13 Q. (By Mr. Griffin) But there is not a
14 Q-1 investigation of this issue.

15 A. No.

16 Q. From some people's point of view,
17 this was a separate new issue that Q-1, if
18 they behaved objectively and responsibly,
19 would have picked up. You know, it's very
20 subjective for me, because I don't know
21 technically whether it was reasonable to link
22 this with others or not. But there are several
23 people, as I have repeated, who disagree with
24 you vehemently and --

25 MR. SILBERG: They believe that

1 that was separate from the NCR?

2 MR. GRIFFIN: Yes.

3 THE WITNESS: See, these people
4 have no qualifications whatsoever to even know
5 what Diss-alvo tape was.

6 A. That is the sad part. That is the
7 truth. You can go check the resumes, if you
8 would like, on that.

9 Q. (By Mr. Griffin) Yes.

10 A. The only point I'm trying to make, in
11 finalizing this thing, relative to that issue,
12 if in fact they had multiple loops coming
13 together, and there was evidence of
14 Diss-alvo tape coming through the screens, and
15 it was picked up from one place and brought to
16 another, is what I'm getting, that makes no
17 difference. The only detriment associated with
18 Diss-alvo tape is what of the residue from the
19 tape adheres to the pipe wall, where it was
20 applied, not what pipe it ran through.

21 Q. I know. As little as I know, I know
22 that much.

23 A. That is a detrimental part, and that
24 is what engineering addressed, a project
25 commitment. We are bound to that.

1 Engineering. The design authorities said only,
2 if you find evidence of it in these systems, you
3 must you go clean it with a hydrolyzer, and
4 otherwise --

5 Q. If you turn around and recontaminate
6 the systems --

7 A. It doesn't adhere. The tape has to be
8 placed on the wall.

9 Q. So the chloride that is in suspension
10 during the flushing cannot adhere to the wall?

11 A. That's correct.

12 Q. Even though that water may sit in
13 those pipes for weeks?

14 A. That's correct. That's correct.

15 Q. It will not come out of suspension?

16 A. That is the engineering justification
17 I have received.

18 Q. Well, that just shows you how us
19 laymen get tangled up, because if I pour Coke on
20 my leg, I expect it to stick to my pants, and
21 that is just as surely as I see it.

22 A. It's suspended. Once it's in water,
23 it's suspended.

24 Q. Okay. I think we have covered it.
25 I'm sure you are the most technically competent

1 around to address this.

2 (Whereupon, a discussion was
3 held off the record.)

4 Q. (By Mr. Griffin) One of the
5 recurring themes in the interviews were Mr.
6 [REDACTED] and Mr. [REDACTED] primarily Mr. [REDACTED]
7 singled out for -- as having closed the most
8 cases with the least amount of work. He was
9 essentially pencil whipping investigative
10 reports. Did you ever evaluate any of Mr.
11 [REDACTED] investigative reports or investigative
12 work?

13 A. I don't know that I would say
14 "evaluated." I recognized what he was involved
15 in, what part of it. I knew basically what his
16 assignments were, primarily in the start-up
17 area. I do know that he closed out a lot of
18 concerns. The close-out does not necessarily
19 mean he investigated them.

20 Q. I'm not talking about closeout. I'm
21 talking about ones that he is on the books for
22 for having conducted the investigation.

23 A. That is conceivable, that there --
24 particularly if they were in the start-up
25 arena. He was the most qualified instructor in

1 having some 20 to 30 years' experience in it.

2 Q. Are you saying that Mr. [REDACTED] then,
3 as a Q-1 investigator, was drawing upon his
4 knowledge of the start-up rather than verifying
5 allegations through document reviews or
6 interviews?

7 A. No. I'm saying that he had the
8 knowledge to know where to go and what ought to
9 be expected. He had an intricate and -- I
10 should say an in-depth knowledge of the
11 requirements, regulatory requirements, anything
12 relative to starting up a plant. He was
13 probably the most qualified on this job site
14 when it came to knowledge of the methodology.

15 Q. One of the things, and this is
16 consistent with the testimony I have received,
17 particularly about Mr. [REDACTED] and I have
18 informed Mr. [REDACTED] that he has had a
19 substantial amount of allegations made against
20 him in this arena, and that is that he has
21 extensive experience, and I know you respect his
22 work a great deal, and -- but that he was in
23 fact drawing upon this rather than conducting an
24 investigation and that essentially you have
25 somebody who is a start-up man and not a Q-1

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1 investigator. This is in the same vein as we
2 were just discussing this Diss-alvo tape, the
3 unwillingness of a man who knows his area so
4 well, "This is the way we did it at Arkansas.
5 This is not a valid concern. I'm not going to
6 investigate it. It's closed."

7 A. I have never heard that.

8 Q. This is not the type of objectivity
9 that is consistent with an independent
10 investigative program.

11 A. I would disagree with him having made
12 that statement. I have never heard it made. In
13 fact --

14 Q. Having heard these people making
15 the statement about Mr. [REDACTED] you would
16 disagree --

17 A. No, I have not. People involved in
18 the start-up program here, and I can't remember
19 now, but going back and getting the list of
20 names, get the list of people that he
21 communicated with, in the --

22 Q. I'm talking about former Q-1
23 investigators.

24 A. Former Q-1 investigators didn't know
25 the man.

6,7C 47D, Porters

1 Q. I mean people he was working in the
2 same offices with.

3 A. The ones he was working with, in the
4 same office, I think you will find the problem
5 is he was more knowledgeable about the programs,
6 in general, than they were, so they construed it
7 the way they construed it. The real proof of
8 that is to talk with the individuals he
9 interfaced with in the start-up organization.

10 Q. What I did instead is that I looked at
11 investigative files --

12 A. Okay.

13 Q. -- which contained very little
14 information, which leads me to believe that Mr.
15 [REDACTED] either was doing one of two things.
16 Either he was not documenting the efforts he was
17 expending or he was drawing on his years of
18 experience to close these issues out. I don't
19 know which is the case, because I cannot tell
20 from the files. I have the testimony of the
21 people who worked with him and around him, and
22 have the files, and I have interviewed him, and
23 he can't even answer the question. When I
24 asked him which ones he did, he said, "I think
25 my file -- I think the files will bear up to

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1 your scrutiny." I have looked at the files, and
2 they don't have any evidence of any
3 investigation of any import or any consequence
4 or any substantial period of time. Then I did a
5 case count for Mr. [REDACTED] and everybody else,
6 too, and he was closing them, like I say, an
7 issue a day. It leads me to be suspicious, as
8 an investigator, that Mr. [REDACTED] may have been
9 drawing largely upon his knowledge.

10 A. No. There is the other possibility
11 with having closed so many, that one was
12 received that had been addressed somewhere else
13 and --

14 Q. I factored that in, Chuck. I know
15 that Mr. [REDACTED] was -- you and him were working
16 to link things. Like I say, you don't have to
17 reinvent the wheel everywhere, and obviously
18 that makes good sense, assuming they are closely
19 enough linked that you are not dropping out some
20 aspect. Mr. [REDACTED] is the one that was
21 employing that six topic 19 interview
22 questionnaire, so --

23 A. I'm not --

24 Q. This is not consistent with --

25 A. The specific one, I'm not familiar

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1 with. If what you say is true, I guess I
2 would -- I would not be agreeable to that
3 methodology, either.

4 Q. What I'm hearing from you today,
5 Chuck, is that you didn't spend a great deal of
6 time in reviewing the investigators' work as a
7 matter of your day-to-day activities.

8 A. That's correct.

9 Q. I want to go through just a list of
10 general allegations, and this is a laundry list
11 of general allegations, and you star in all or
12 most of these. I would like to you comment.
13 Some of them we have already covered. Basically
14 the form, and these allegations -- I call them
15 allegations. They are things that I have taken
16 from the -- from my interviews with your former
17 Q-1 investigators as ways in which they believe
18 you changed the Q-1 program to make it have less
19 integrity, to not -- to ultimately --

20 A. In their opinion?

21 Q. Yes. -- to ultimately result in these
22 issues not being adequately investigated, and
23 that they -- having been closed without adequate
24 investigation, for the sole purpose of getting
25 them off the books.

1 The first one, we have already
2 discussed this, your initial meeting, so we
3 don't have to cover that again.

4 A. Initial meeting?

5 Q. Yes, the initial meeting with your
6 staff, once you took over Q-1. Do you remember,
7 I questioned you about --

8 MR. SILBERG: Setting goals
9 versus mandates.

10 A. Oh, okay. An initial meeting. But
11 I'm sure there were other meetings in addition
12 to that. That's fine, as long as I know what
13 you are talking about.

14 Q. (By Mr. Griffin) It was alleged that,
15 "As the December target fuel date approached,
16 significant Q-1 findings referred to the
17 affected --" it says, "As the December 1984
18 target fuel date approached, significant Q-1
19 findings referred to the affected organizations
20 still did not receive corrective action. Some
21 of these findings received no corrective action
22 before fuel load."

23 A. That is a false statement. Every
24 corrective action request that was generated by
25 quality first was responded to, was responded to

1 with effective verified corrective action prior
2 to us loading fuel at this site.

3 Q. Let me ask you about this, Chuck. Is
4 it possible that, since so many of the Q-1
5 investigators performed the bulk of this work,
6 in late 1984, and then the contracts ended and
7 everything, and they were gone -- is it likely
8 that most of the corrective action that took
9 place probably took place after they had already
10 exited?

11 A. The verification of it most probably
12 had.

13 Q. What was being said? "I have turned
14 in investigative reports, and I'm still here a
15 month later, and I'm still here a month and a
16 half later." There is no corrective action.
17 There is no evidence of corrective action.

18 A. Well, you have to understand this. I
19 think maybe this will explain it. When an
20 investigator completed the investigation, he put
21 all of the papers together, the need for
22 corrective action. He was out of it. Many of
23 them would like to stick that in a desk drawer
24 and wait, and see what happened on down the road,
25 but that was not their job. Their job was as an

1 investigator. They or somebody else may have
2 verified corrective action.

3 Q. These people had continuing contact
4 with some of the people that had been involved
5 in their original investigations --

6 A. Uh-huh.

7 Q. -- and as their contract came to a
8 close.

9 A. Yes.

10 Q. Some of them had the interests to see
11 whether anything meaningful had been done. A
12 common complaint was that no corrective action
13 had taken place. Some of the amount of
14 corrective action that people anticipated they
15 didn't think could be fulfilled or completed
16 before fuel load, which occurred just a few
17 months later.

18 A. Again, it was something we stasured
19 continually.

20 Q. You are saying that all corrective
21 action on these findings was completed?

22 A. Absolutely.

23 Q. Okay.

24 A. I might mention that the NRC verified
25 that they took place, because they were open

1 items, affecting fuel close.

2 Q. Let me repeat something I said
3 before. One thing that was particularly
4 gratifying to me, once I got into some of the
5 more important concerns that Q-1 investigated on
6 technical issues, in almost every case, not only
7 did the Q-1, no matter how, it eventually got
8 the affected organizations very involved, and
9 even more gratifying to me was the fact that the
10 NRC, in almost every major instance, was there,
11 verifying the closeout, before fuel load. I had
12 not -- I was not aware of that when I started
13 this investigation.

14 A. If I could interject, the NRC was
15 instrumental, even involved, when we went to
16 prioritization, because we understood, both of
17 us, me and the NRC, the need to resolve these
18 issues before we considered loading the fuel.
19 That was what prioritization was all about, so
20 you could put the resources where you wanted to
21 put them.

22 Q. Some of these I'm not going to
23 revisit. We have already touched on them.

24 . One other concern that some of the Q-1
25 investigators had is that they were

1 substantiating an allegation, only to have the
2 Q-1 supervisor make a call that it had no merit,
3 a call in contrast to their belief. Was this no
4 merit call, was that something that was normally
5 made by the supervisor, or was it normally made
6 by the investigator?

7 MR. SILBERG: No merit, meaning
8 something was unsubstantiated --

9 MR. GRIFFIN: No merit.

10 MR. SILBERG: Finding it
11 substantiated by --

12 MR. GRIFFIN: Yes.

13 A. I don't understand the significance,
14 whether it was indicated it did or didn't,
15 anyhow.

16 Q. (By Mr. Griffin) If the investigator
17 substantiated it, and he thought it was
18 important --

19 A. Yes.

20 Q. -- and somebody else came along and
21 said that it had no merit, and therefore there
22 is no action --

23 A. No, no. In any case, if something is
24 substantiated, there has to be some
25 explanation. Either it's substantiated and no

1 longer is in effect, the need --

2 Q. Take a look at this one down at the
3 bottom. I haven't even read what the issue is.
4 Well, it's a crazy issue.

5 A. A lot of them substantiated were crazy
6 issues with no merit. There was one allegation
7 that Daniel couldn't even build bird baths.
8 What was I supposed to do with that? I may
9 substantiate that, but that wasn't --

10 Q. Okay. Let me find another example
11 having to do with 300-watt bulbs. Okay. Here
12 is one. "NCRs generated by operations QC are
13 not adequately maintained." That one is listed
14 as substantiated without merit. Now, I --

15 A. Just a brief statement, "are not
16 adequately maintained," that is somebody --
17 somebody's definition of "adequately
18 maintained." Now, what we could have found was,
19 "Ye, verily, we investigated this, but in the
20 course of the investigation they recognized
21 their shortcomings, and they put together a
22 system." Now, "without merit" generally
23 indicates no corrective action was necessary.
24 Something is already done. It's no longer a
25 requirement or it's been changed. Now, what I'm

1 hearing is, they might not have been satisfied
2 with the corrective action that was in process
3 or taking place. That is what I hear.

4 Q. Well, who wrote -- who made the call
5 that something had no merit?

6 A. I do not know whether that was the
7 investigator, the investigative supervisor, or a
8 combination of the two of them.

9 Q. Well, according to the Q-1
10 investigators, it was the Q-1 supervisors that
11 were making those calls.

12 A. It could have been. Here, again, I
13 wouldn't swear to that.

14 Q. Chuck, what would you say were the
15 primary changes you made in the procedures when
16 you took over Q-1? What were the more memorable
17 ones?

18 A. Changing the documents -- and, again,
19 the reason for that was to eliminate any
20 semblance of having involvement with QA, where
21 we had our own processes. The exhibits,
22 attachments to procedure, use of forms.
23 Uniformity, again, I think was of great
24 benefit. Despite what some people think, I
25 believe, looking at the allegation and trying to

1 determine what resources we have, that can best
2 do the job, which there was no evidence of
3 having happened before, trying to match the
4 allegation of the resource as best we could.

5 Q. But that wasn't part of a procedural
6 type of --

7 A. Well, procedurally it was, that the
8 investigative supervisor would review it and --
9 before he assigned a person to it. That was --
10 it was unwritten, possibly, but that was one of
11 the reasons for it. You just didn't go from --
12 from the interview group, say, "Here, give this
13 to this investigator." It was reviewed first to
14 determine the content, and then who it would be
15 assigned to. It was not automatic, is what I'm
16 saying.

17 Q. Okay.

18 A. The requirement, as it were, and you
19 saw a letter went out, that they questioned me
20 about, relative to constructions of the project,
21 about the QPV, QPD, and the -- all of those
22 vehicles. I think you can read in there that
23 there was some direction that we would get
24 responses. I think it was conveyed through that
25 and through the procedures, themselves, that we

1 did have project support to do our job. Whether
2 or not you call that a change or not, I don't
3 know, but it was a positive writing, I guess,
4 that, if there was any doubt in anyone's mind,
5 the way procedures were written, but that we
6 would have a workable procedure. All you had to
7 do was read the procedure, the second time it
8 was written, in a positive manner, I believe.
9 Other procedural changes. We established -- we
10 put in guidelines. There were no guidelines
11 before I took over. It was just whatever
12 someone told someone else, "This is the way you
13 do business," but we did establish that. Even
14 to the point of administrative guidelines. So
15 there was no doubt about who handled the paper,
16 what way, and thereby you eliminated loss or
17 misplacement and that sort of thing, confusion.
18 Procedurally we attempted to minimize
19 confusion.

20 Q. Let me ask you another question on a
21 different subject. There were a number of cases
22 transferred to legal, and from what I could tell
23 Q-1 investigative activity essentially ended
24 when one transfer was made to legal.

25 A. That's generally true.

1 Q. This same thing seemed to occur when
2 there were, like I say, these higher-tiered
3 documents. Is that correct? Do you agree with
4 that?

5 A. Procedurally, that is the way it was
6 designed. Once we transferred, we were out of
7 it. There again, that is one of the changes
8 that I made of significance later on. But it
9 was after the time frame we are talking about
10 when we made these changes.

11 Q. During the various reviews you made,
12 conducted by the NRC, you have been given high
13 marks in technical areas, and otherwise it's
14 been uniformly critical of the handling of
15 wrongdoing issues. Do you think OI's criticisms
16 that they have specified in Ward's report and
17 Driskill's report are valid?

18 A. To a degree, I think some of them are,
19 have some merit.

20 Q. Is there any parts of the criticisms
21 that you have received that you disagree with?

22 A. If you want specifics, yes. I
23 disagree with what qualifications there ought to
24 be for investigators, because -- and the reason
25 I say that is, us folks are accustomed to

1 dealing with inspectors and criminal
2 investigators. Our perception was not dealing
3 with criminal analysis. Ours was
4 investigating. That, I guess, is my biggest
5 difference, philosophically.

6 Q. Who do you think is best equipped to
7 deal with lying, cheating, and --

8 A. A qualified investigator, but I don't
9 know that they have to be a criminal
10 investigator. Trained, yes. I agree with
11 that. In fact, I have asked the NRC to assist
12 me. "What would you advocate training for
13 people?"

14 MR. SILBERG: Did you get any
15 response?

16 THE WITNESS: Someday they are
17 going to tell me. After all this is over, they
18 are going to come visit me and --

19 Q. (By Mr. Griffin) Can you think of
20 anything else that you have been criticized by
21 OI that you specifically disagree with about
22 their criticisms of your handling of wrongdoing
23 allegations? Does anything else come to mind?

24 A. , That I would disagree with?

25 Q. Yes. There have been some strong

1 conclusions.

2 A. In general, yes. There is one item in
3 general. That is, I -- and I have to -- it's a
4 perception on my part, that every time you guys
5 do an investigation, it's a new investigation.
6 We were dealing with a project. We knew
7 people. We knew issues. We knew
8 circumstances. A lot of this was already in our
9 minds. So that is one of my excuses for not
10 having revalidated or recorded. It may be a
11 weak excuse, but it's a taken. It's a given to
12 start with, that you start out differently than
13 we do. The issue, though, of not having
14 adequate documentation, if it's a philosophical
15 thing or methodology, I can see the value of
16 having more than what we have, particularly for
17 someone from the outside, coming in and looking,
18 being able to catch on where you are going.

19 Q. I think the point I was trying to
20 make, four hours ago, or whenever we were on
21 that subject, was you, during our interview
22 today, said you have relied on document -- on
23 file reviews, personally, and of course the NRC
24 did, too. We don't have the people to talk to
25 any more, and they aren't very well documented,

1 from my perspective. Well, there are a few that
2 were. but many of them aren't. We have no way
3 of recovering how little or how much those
4 people did. Some of them may have done
5 exhaustive reviews. I just don't know.
6 Particularly the wrongdoing, the ones I looked
7 at, there seems to be very little objective
8 effort put into resolving some of these issues,
9 almost to the point of, "Oh, well, old John over
10 here, he can't harass or intimidate. It's just
11 his management style. He has been kicking
12 people in the tail for years." That is not a
13 legitimate approach to it, a harassment or
14 intimidation thing.

15 A. I would make one other comment,
16 though.

17 Q. Sure.

18 A. I believe, from what I have seen, and
19 you are questioning me, how we would disagree
20 with what OI has written --

21 Q. Yes.

22 A. -- and I get the feeling that OI
23 functioned as the advocate for the alleged.

24 Q. What we do is, we start it by
25 assuming -- unless what is being alleged is

1 physically impossible, we start out by assuming
2 that the allegation may have merit. Then we try
3 to do a thorough investigation, which involves
4 following all of the logical leads, not every
5 lead, but all logical leads, for resolution,
6 and fully documenting what we have done, so that
7 the -- so that my supervisor can look at what I
8 have done and draw an independent conclusion.
9 So, in that sense, we are not -- we haven't --
10 we look at each one with new eyes, and that is
11 good or bad, depending on your perspective.

12 MR. SILBERG: OI has a very
13 different role, and there is just a qualitative
14 difference between what OI tries to do and has
15 to do and what an employee concerns program like
16 this has to -- I mean, you are responsible to
17 several layers higher up within and without your
18 agency. You are responsible to the
19 commissioners. You are responsible not only to
20 your own supervision but to the commissioners,
21 themselves. You are responsible to the
22 Department of Justice, if there is a referral
23 out, to U. S. attorneys. Whoever may use this.
24 That really isn't the same, and that isn't true,
25 and I don't think it was within people's

1 contemplation, when this program was set up.
2 This was an internal program. I honestly don't
3 think that, when they set it up, it was ever
4 anticipated that you would be in here today,
5 having spent months looking through all of the
6 files and trying to reconstruct what was done
7 three years ago. You know, if we were starting
8 off, 1984, knowing that this was going to
9 happen, I'm sure we all would have done things
10 differently.

11 MR. GRIFFIN: Maybe so, and I
12 agree with many of the things you are saying
13 here. The thing is, I don't know what the
14 future holds for the individual licensees in the
15 internal programs, but in this one the NRC still
16 has regulatory authority to reach back in time
17 and have a say as to the validity of this
18 program and how it was conducted during this
19 period of time. They -- I presume they wouldn't
20 have been asked to come up here and investigate
21 this if they didn't want to revisit this issue
22 one more time, because Mr. Ward's review was an
23 evaluation of and Mr. Driskill's was an
24 evaluation of the files.

25 I have taken a completely different

1 approach. I have talked to the people that were
2 in the program, and the majority of them, and I
3 don't think it was a valid program, and they
4 don't agree with the methodology of drawing a
5 conclusion that is unsupported and saying
6 "Everything is okay," because this program was
7 set up to -- it's -- you take the allegations,
8 you say what you are going to do, your
9 procedures, indicate the same objectivity that
10 any investigative program would -- whether it's
11 a federal agency or a police or anybody that
12 conducts investigations is likely to come back
13 with a true answer, based on the available
14 information. But, in fact, I agree with you to
15 a certain degree, Jay. The way this program
16 functions, as far as documentation, some of the
17 things I'm seeing, is that it's a cross between
18 an investigation and inspection. A greater
19 reliance is placed upon the individual doing the
20 investigation and his judgment. He doesn't have
21 to support his conclusion to the degree
22 generally you do in investigations, because --

23 THE WITNESS: Your
24 investigations.

25 MR. GRIFFIN: An inspector goes

1 out, looks at it, and he comes back and he
2 reports. I'm talking about ^{the NRC} ~~an~~ NRC. He comes
3 back and says "I looked at the system" or "I
4 looked at the program" or whatever, and the NRC
5 is willing to accept that and make decisions
6 based upon that. The investigative process,
7 it's completely different. You go out and you
8 gather the evidence, and you present the facts
9 in a way, and you may or may not draw a
10 conclusion based upon -- others can draw the
11 conclusion, because you have already gathered
12 the facts. The frustration here is that what is
13 available, particularly in the wrongdoing, there
14 is not much to review. There is not much to
15 draw on. The facts seem unsupported. The
16 conclusions, in some places, seem wholesale.
17 I don't know what use it's going to be to me,
18 of this investigation, the investigative
19 findings that result from what I'm doing here,
20 but it's --

21 MR. SILBERG: There is a pending
22 rule motion, pending by Mr. Thero, that every
23 utility be required to adopt just such a
24 program..

25 MR. GRIFFIN: If they did, it

1 would be different than the way it was at Wolf
2 Creek in 1984.

3 MR. SILBERG: That's right.

4 Q. (By Mr. Griffin) Chuck, have I
5 threatened you or your representative here in
6 any manner or offered you any rewards in return
7 for this statement?

8 A. You have not.

9 Q. Have you given this statement freely
10 and voluntarily?

11 A. Yes, I have.

12 Q. Is there anything, and this is a big
13 issue, anything related to this whole episode,
14 any comment you would like to make, relative to
15 this, before we close out the record?

16 A. Yes. I believe the allegations you
17 have in general have been voiced by people who
18 have suffered monetarily at the hands of this
19 project, or if not monetarily, possibly even
20 pride, at the hands of this project, and are
21 seeking retribution.

22 Q. I will give you the last word. Thank
23 you.

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CERTIFICATE

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I, William J. Jennings, a Certified
Shorthand Reporter in and for the State of
Kansas, do hereby certify that I appeared at the
time and place first hereinbefore set forth,
that I took down in shorthand the entire
proceedings had at said time and place, and that
the foregoing constitutes a true, correct, and
complete transcript of my said shorthand notes.

Wm J Jennings

WILLIAM J. JENNINGS, CSR