April 3, 1987

(2)

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LChandler
SBlack
OIA

Docket Nos. 50-445
and 50-446

MEMORANDUM FOR: The Atomic Safety and Licensing Board for Comanche Peak (P. B. Bloch, W. H. Jordan, K. A. McCollom, E. B. Johnson)

FROM: Christopher I. Grimes, Director
Comanche Peak Project Division
Office of Special Projects

SUBJECT: CORRECTION TO REPORT OF INVESTIGATION BY THE OFFICE OF INSPECTOR AND AUDITOR (BOARD NOTIFICATION NO. 87-06)

On December 11, 1986, we forwarded to the Licensing Board and parties to this proceeding a Report of Investigation by the Office of Inspector and Auditor (OIA) regarding Region IV management actions relative to Comanche Peak (Board Notification No. 86-24).

Since that time, OIA has reported an error to the chart which was contained on pages 34 and 35 of the report. OIA states that this chart did not accurately characterize the analysis of technical issues performed to determine whether Region IV management appropriately downgraded, changed or deleted inspection findings and violations. The complete analysis, which is included in the report, remains unchanged and there is no effect on the conclusions of the report. The corrected chart is enclosed. Areas of change are outlined.

Review of the report and its attachments is still underway and no decision on the release of the complete report (and all attachments) has yet been made. We do, however, expect this decision to be made in the near future, at which time we will issue a further board notification regarding this matter.

(original signed by)

Christopher I. Grimes, Director
Comanche Peak Project Division
Office of Special Projects

Enclosure:
As stated

cc: See next page

*See attached pages for previous concurrences.

*PAD#5:	*OIA	*OGC-Beth	NRR	CPPD
CTrammell:jch	SConnelly	LChandler	SBlack	CGrimes
03/[illegible]/87	03/13/87	03/21/87	3/26/87	4/3/87

3/26/87

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Docket Nos. 50-445
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Comanche Peak Project Division
Office of Special Projects

Enclosure:
As stated

cc: See next page

OIA SKlomelly
3/13/87 with changes

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CTrammell:jch	LChandler	SBlack	CGrimes
3/10/87	/ /87	/ /87	/ /87

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Christopher I. Grimes, Director
Comanche Peak Project Division
Office of Special Projects

Enclosure:
As stated

cc: See next page

*See previous concurrence page.

We no legal objection subject to correction noted

*PAD#5:	*OIA	OGC-Beth	NRR	CPPD:
CTrammell:jch	SConnelly			
&	LChandler	SBlack	CGrimes	
&				
03/10/87	03/11/87	/ /87	/ /87	/ /87

CMT 3/16/87

DISTRIBUTION LIST FOR BOARD NOTIFICATION

Comanche Peak Units 1&2
Docket Nos. 50-445/446

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ACRS(10)

Rev. 03/23/87

PAGES 34 & 35

	[redacted]	[redacted]
Inspection Report 85-07/05		
Concerns 1 and 2 Reactor Vessel Installation	Inconclusive[1]	Inconclusive
Concern 3 Audit of Reactor Vessel Installation	Inconclusive	Inconclusive
Concern 4 Spool Piece Marking	No Violation	Inconclusive
Concern 5 Cement Mixing Blades	Questionable[2] Handling of Violation	No Problem in Handling of Violation
Inspection Report 85-14/11		
Concerns 1, 2, and 3 Records Shipment to Stone and Webster	Questionable	Inconclusive on Concern 1 and 2. Questionable on Concern 3.
Concerns 4 and 5 Records Shipment of CB&I	Inconclusive	Inconclusive
Concern 6 Temporary Storage of Records	Questionable	Inconclusive
Inspection Report 85-16/13		
Concerns 1, 2, and 3 10 CFR 50.55(e)	Questionable	Inconclusive
Concern 4 NAMCO Switches Not Properly Identified	Questionable	Inconclusive
Concern 5 BISCO Seals	Refer to IE; Inconclusive	Refer to IE; Inconclusive

---

[1] Inconclusive - There was insufficient information to determine whether a violation was appropriate.

[2] Questionable - There was sufficient information available to cite a violation.

SUMMARY

	Inconclusive or No Violation	Questionnable	No Problem In Handling Violation
[redacted]	7	9	0
	14	1	1

(4)

OFFICE OF SPECIAL PROJECTS

1. EDO NUMBER
   OSP ACTION NUMBER 87-51
   ACTION NUMBER
   WITS NUMBER
   OTHER NUMBER

2. DATE 5/21/87

3. SUBJECT: Recommendations pursuant to the Comanche Peak Reports questions 1 and 2

4. REQUESTOR Chairman Zech

5. ACTION REQUESTED

6. ASSIGNED TO: CGrimes

7. EXPECTED COMPLETION DATE: 6/5/87

8. "O SLIP ITEM?

9. PRIORITY ISSUES ITEM

10. DOCUMENTATION OF COMPLETION

11. FILE LOCATION:

12. PLEASE RETURN THIS FORM TO DIRECTOR'S SECRETARY WITH COMPLETED ACTION.

memo Keppler to Stello – will incorporate actions into review plan & address in separate SER

E/5

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

April 14, 1987

MEMORANDUM FOR: Chairman Zech

FROM: Victor Stello, Jr.
Executive Director for Operations

SUBJECT: IMPLEMENTATION OF RECOMMENDATIONS OF COMANCHE PEAK REPORT REVIEW GROUP

In November 1986, the Office of the Inspector and Auditor (OIA) issued its Report of Investigation, 86-10, addressing allegations of Region IV management wrongdoing relative to inspection activities regarding the Comanche Peak Steam Electric Station. In broad terms, the OIA Report dealt with three allegations: (1) harassment and intimidation of an inspector in connection with the preparation of inspection reports and the consequent downgrading or deletion of violations; (2) failure of the Region to carry out required inspections of the permittee's quality assurance program; and, (3) deficiencies in the NRC Form 766 reports prepared by inspectors to document inspection activities.

With the approval of the Commission, on January 21, 1987, I established the Comanche Peak Report Review Group (CPRRG) to evaluate the OIA Report. Consistent with the Commission's direction, the CPRRG was charged with providing recommendations on five matters: (1) the safety significance of the 34 issues identified in the OIA Report; (2) whether the issues identified in the OIA Report were appropriately handled in terms of process and disposition; (3) whether the current augmented review and inspection effort at Comanche Peak is sufficient to compensate for any identified weaknesses in Region IV's quality assurance inspection program; (4) the purpose and significance of NRC Form 766; and, (5) whether the issues raised with respect to Comanche Peak have broader implications in Region IV. The CPRRG specifically did not duplicate the OIA investigation nor develop any independent record of testimony (although it did request and receive some additional documentation); it did not address the licensability of the Comanche Peak facility; and, it did not investigate or otherwise inquire into any matters of wrongdoing, misconduct or mismanagement except to the extent that such matters were explicitly identified in the OIA Report and its attachments and then only for the purpose of identifying factors that might have caused or contributed to the matters considered in the OIA Report. However, the CPRRG did perform a complete review of the OIA Report and all the supporting attachments thereto. Copies of the CPRRG Report were provided to the Commission on March 17, 1987. It is apparent that I treated this entire matter very seriously and devoted extensive management and staff effort to the task.

LIMITED DISTRIBUTION

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The CPRRG, in its Report issued to me on March 12, 1987, addressed each of the five issues identified above. To quote the CPRRG's conclusions:

(1) None of the 34 issues identified in OIA Report 86-10 was found to be significant in terms of any direct adverse impact on plant safety.

(2) Region IV's disposition, i.e., classification, of the identified issues was appropriate, and the Region acted within its authority based on the information contained in the inspection reports and on the guidance available for determining the classification of the findings, e.g., violation, unresolved [sic]. Certain issues were not appropriately processed; e.g., inspection findings were in some cases not developed by the inspectors in accordance with agency guidance, and Region IV supervision did not always provide the guidance necessary to properly focus and resolve items.

(3) When measured against the 1986 inspection program requirements, gaps were identified in the total inspection program. The current augmented review and inspection effort at Comanche Peak has, for the most part, compensated for gaps in scope and coverage in Region IV's QA inspection program.

(4) The 766 system, primarily used by IE and little used by the Regions, is not used in making safety decisions. The accuracy, completeness, and timeliness of the data are not adequate for many needs. Overall, the 766 system does not satisfy current agency needs.

(5) The CPRRG's judgment is that broader implications are likely for facilities in Region IV other than Comanche Peak. Additional considerations may influence the significance of these implications. (CPRRG Report at 4-1).

In addition to the foregoing conclusions, both the CPRRG Report and its several Appendices contain numerous recommendations for specific improvements and corrective actions. We have extracted from the CPRRG Report and its Appendices all explicit recommendations and have categorized them as follows:

- Category 1 additional and confirmatory actions and inspection efforts needed to assure complete disposition of the 34 issues in the OIA Report and to compensate for gaps identified in the Comanche Peak QA inspection program;

- Category 2 clarification of inspection philosophy and practices, authority to determine significance level of inspection findings, and documentation requirements and procedures for inspection findings; and,

- Category 3 review of existing data management systems with application to inspection activities, including NRC Form 766, and necessary revisions to enhance the reporting, management and use of the inspection data for both Headquarters and Regional purposes. (CPRRG Report at 5-1, item 4 and Appendix D, Sec.VIII)

In order to carry out the CPRRG Report recommendations in the most timely manner possible and with due recognition of the recent establishment of the Office of Special Projects and the agency-wide reorganization, the above recommendations will be assigned as follows:

- category 1 recommendations apply specifically to the Comanche Peak facility and, accordingly, will be assigned to the Office of Special Projects;

- categories 2 and 3 recommendations, because of their programmatic nature, will be assigned to the Office of Nuclear Reactor Regulation with the assistance of the Office of Administration and Resources Management.

In addition to implementing the CPRRG's explicit recommendations, I am directing these offices to further review the Report to determine whether there are any further actions to be taken based on other statements, implicit recommendations or lessons learned contained therein. Each of the recommendations will be implemented except as approved by me upon adequate justification. Enclosure 1 is a preliminary listing containing those recommendations which are explicitly set out in the CPRRG Report. As noted above, the staff will continue to review the Report to extract other recommendations or suggestions which may be included in the text and elsewhere in the Report.

While concluding that "broader implications are likely for facilities in Region IV other than Comanche Peak" (conclusion (5) above), the CPRRG makes no express recommendations for resolution of this concern. The CPRRC does, however, make several observations regarding the significance of enhanced inspection activities at Comanche Peak and in terms of characterizing the nature of the causes of the events at Comanche Peak, which bear on this issue. These matters, along with a more detailed discussion of the evolution of the NRC's inspection program and other Region IV facilities, is presented in Enclosure 2. In brief, it would not be

unexpected that, if measured against the 1986 inspection program, gaps would be found elsewhere. Moreover, the philosophy of the modularized inspection program is such that each line item need not be "completed" by the inspector. Rather, the inspector is to consider each line item in determining whether the facility is being constructed (or operating) safely. Nevertheless, the operating history of the other facilities, the team and other special inspections and on-site technical audits that were performed by the staff in addition to the various independent and utility-conducted verification efforts, suggest strongly that such gaps as might exist would be few and not of safety concern. Consequently, I have no cause to believe that the reasonable assurance which was previously found to exist with respect to other facilities within Region IV has been eroded. Nevertheless, while I have no reason to conclude that the initiation of an inquiry to determine whether specific gaps in the inspection process exist for other facilities is immediately warranted, I propose to direct NRR to examine in more detail, the inspection records for a facility within Region IV which did not receive as much attention through either NRC- or utility-conducted efforts. If the results of such review require, further staff reviews of other plants will be performed.

Based on the findings and conclusions of the CPRRG Report, in particular those regarding the implementation of the inspection program for Comanche Peak, in terms of process and disposition, I also intend to take appropriate personnel actions to assure that, to the extent possible, the circumstances which culminated in the OIA investigation do not recur. In this regard, I propose to personally write to the principal individuals involved to inform them of the CPRRG Report and provide each with a copy. A draft of my proposed letters is attached as Enclosures 3-6. Further, I intend to meet with each of the principals to inform them of my decisions for resolving the remaining issues and to discuss with them their future roles in the Region. I will also meet with other Region IV and site personnel to explain my actions. I intend to stress the importance to be attached to professionalism, teamwork and the need to be sensitive to the views of others which may not coincide with one's own, within the framework of the inspection process as well as within the agency as a whole. In addition to implementation of CPRRG's programmatic recommendations to provide further clarity, consistency and understanding of the NRC's inspection process, the principal individuals involved, both inspector and management, will also be given specific training to improve their interpersonal skills and communication as appropriate to the individual. The Region-wide training program and guidance initiated by the Regional Administrator, described in his December 17, 1986 memorandum to me, will be continued for all appropriate Region IV personnel.

In addition to the recommendations which are discussed above, the CPRRG Report contains recommendations and observations directed toward improvement in OIA's investigation process. CPRRG Report at 1-3 - 1-4; Appendix F at 17, items 1.7.10 and 1.7.11. The Commission may wish to refer these matters to OIA for its consideration. An additional, related recommendation is in order. The CPRRG Report fundamentally substantiates

the General Counsel's observation, stated in his December 23, 1986 memorandum to the Commissioners, that:

> It is unclear . . . why reliance on the Regional Administrator and adherence to the NRC's longstanding procedures for handling Differing Professional Opinions, as set forth in NRC Manual Chapter, NRC-4125, would not have sufficed to permit a timely and effective resolution of all issues without having the situation escalate at the outset to the point of a full-scale OIA investigation involving charges such as harassment and intimidation. The central issues which gave rise to this matter appear to involve differences in professional views on several matters.

It is my judgment that in this instance, the conduct of this protracted OIA investigation has served only to further polarize the individuals involved and by distracting personnel from their assigned responsibilities, has been detrimental to the agency's mission to protect the health and safety of the public. This suggests the need for the Commission to examine the policy question of requesting an OIA investigation when management-type issues are involved. Perhaps by improvement in the existing procedures for resolving differing professional opinions, the Commission can better provide for the prompt disposition of such issues.

I recommend the release of the CPRRG Report and its Appendices to the public consistent with any limitations determined appropriate by the Commission regarding the release of the OIA Report, Investigation 86-10. I further recommend the public release of this memorandum, except for Enclosures 3-6, upon Commission approval of the actions recommended. Appropriate Congressional Committees will be notified at that time.

The Commission's approval of the foregoing actions is requested.

Original signed by
Victor Stello

Victor Stello, Jr.
Executive Director for Operations

Enclosures:
1. CPRRC Recommended Actions
2. Implications for Other Region IV Facilities
~~3-6. Letters to named Region IV personnel~~ *deleted*

cc w/Enclosures:
Commissioner Roberts
Commissioner Asselstine
Commissioner Bernthal
Commissioner Carr
SECY
OGC
SConnelly, OIA

October 16, 1987

TO: R. Warnick
Fm: H. Shannon Phillips
Subject: Identification of Inspectors Identifying OIA Issues
I have briefly reviewed and marked those responsible.

CPRRG RECOMMENDATIONS

Comanche Peak Actions

Enclosure 1

ID	RECOMMENDATION	ORGANIZATIONS		REFERENCES	
D2	Reinspection of hardware and design during current Commanche Peak re-review. (Explicit recommendations in sequence numbers 22 through 50.)	OSP	Complete Referenced	pg 3-8	
18	Clarify agency guidence: Clear lines of responsibility between the Commanche Peak augmented inspection program and the established licensing, and inspection and enforcement processes were not established or maintained in implementing the inspect. program	OSP	PM Complete	pg 5-1, recommendation #2	pg 3-25
20	Confirmatory NRC action. Perform a detailed review of Westinghouse's engineering evaluation regarding translation of design criteria into installation specifications, procedures and drawings and failure to control deviations regarding Unit 2.	OSP	T Jan 89	pg 5-1, recommendation #1	App A, Table 1, IR 85-07/05 Item 1 (1)
(21)	Confirmatory NRC actions: Perform a visual inspection of the accessible reactor vessel surroundings during or after hot functional test.	OSP	I	pg 5-3, recommendation #1	App A, Table 1, IR 85-07/05, Item 1 (2), AppA pg3-3

Del Norman (D Shannon Phillips *Assisted in 2nd & 3rd inspection as requested by Rita & Arlotta

PN

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS		REFERENCES		
22	Confirmatory NRC action: Perform a detailed review of Westinghouse's engineering evaluation. Failure to maintain tolerance required and failure to report tolerance deviations on an NCR with regard to Unit 2 RV support brackets and shoes.	OSP	T	pg 5-1, recommendation #1	App A, Table 1, IR 85-07/05, Item 2, App A pg 3-3	DN SP
(23)	Confirmatory NRC action: Verify that an adequate quality control procedure exists for QA inspectors to witness the transfer of marking for material that would otherwise lose its traceability when cut into smaller sections.	OSP	I Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-07/05, Item 4 App A pg 3-12	DN SP
24	Confirmatory NRC action: Issue: FSAR 17.1.17 does not describe TU Electric records system. Action: Review the revised NEO procedures upon their completion and verify the implementation. Verify adequacy of applicants corrective action. } include 25-34	OSP	T Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 1 (1), AppA p3-22	Thomas Young (T Y)
25	Confirmatory NRC action: Issue: QA manual does not address ANSI N45.2.9 requirements/commitments. Action: See actions of Sequence Number 24 above.	OSP	T Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 3	Shannon ? (SP

** Assisted NRC inspector by observing the condition, reviewing documentation or reviewing inspectors draft inspection findings. This is in addition to Riv or Arlotta request to inspect.

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
26	Confirmatory NRC Action: Issue: TU Electric failed to have/use procedures to control shipment of design records for piping to Stone and Webster, NY. Action: See Sequence Number (24) above.	OSP	T	Dec 87 referenced	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 3	TY SP * *
27	Confirmatory NRC action: Issue: Original design records shipped in cardboard boxes to Stone and Webster. Action: See Sequence Number (24) above.	OSP	T	Dec 87 referenced	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11 Item 4	TY SP *
28	Confirmatory NRC action: No backup copy of records made for records shipped to Stone and Webster. Action: See Sequence Number (24) above.	OSP	T	Dec 87 referenced	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 5	TY SP *
29	Confirmatory NRC action: Issue: Failure to control and account for QA design records transferred from site to Stone and Webster, NY. TU Electric stated.... Action: See Sequence Number (24) above.	OSP	T	Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 6	TY SP *
30	Confirmatory NRC action: Issue: Site records containment liner and mechanical penetration of Chicago Bridge and Iron shipped to Houston, Texas, in cardboard boxes. Action: See Sequence Number (24) above.	OSP	T	Dec 87 referenced	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 7	DN SP *

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
31	Confirmatory NRC action: Issue: No backup copy of records made for records shipped to Chicago Bridge and Iron. Action: See Sequence number (24) above. referenced	OSP	T	Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 8	DN SP*
32	Confirmatory NRC action: Issue: TU Electric failed to inventory records sent to Chicago Bridge and Iron. Action: See Sequence Number (24) above. referenced	OSP	T	Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 9	DN SP
33	Confirmatory NRC action: Issue: Plant records stand in folders or open binders in open face cabinets at records center. Action: See Sequence Number (24) above. referenced	OSP	T	Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 14	TY SP*
34	Confirmatory NRC action: Issue: Failure to provide temporary or permanent storage facility for records entered into the permanent records center then co-mingled with in-process documents in paper flow group. Action: See Sequence Number (24) above. referenced	OSP	T	Dec 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-14/11, Item 15 App B pg 101	TY SP*
(35)	Confirmatory NRC action. Issue: Failure to develop/implement procedure to demonstrate 50.55(e) deficiencies corrected. Action: Audit the CDR program to verify its adequacy. (Applicant should revise Procedure NEO CS-1.) include 36-39	OSP	I	Jan 88	pg 5-1, recommendation #1	App A, Table 1, IR 85-16/13, Item 1, App Ap 3-28/9	Joseph McCle (JM) SP*

CPRRG RECOMMENDATIONS

Comanche Peak Actions

	ID	RECOMMENDATION	ORGANIZATIONS	REFERENCES
18	(36)	Confirmatory NRC action. Issue: TU Electric failed to revise implementing procedures containing 50.55(e) reporting before corporate NEO Procedure CS-1 was implemented resulting in a conflict with 5 other procedures. Action: See Sequence No. (35) above. referenced	OSP I Jan 88	pg 5-1, recommendation #1 — App. A, Table 1, IR 85-16/13, Item 2.
19	(37)	Confirmatory NRC action. Issue: Failure to maintain retrievable 50.55(e) files (i.e., could not produce record in almost a month). Action: See Sequence Number (35) above. referenced	OSP I Jan 88	pg 5-1, recommendation #1 — App A, Table 1, IR 85-16/13, Item 3.
20	(38)	Confirmatory NRC action. Issue: Failure to report to NRC actual corrective action taken on 50.55(e)s. Action: See Sequence Number (35) above. referenced	OSP I Jan 88	pg 5-1, recommendation #1 — App. A, Table 1, IR 85-16/13, Item 4.
21	(39)	Confirmatory NRC action. Issue: TU Electric's 50.55(e) files not auditable. Action: See Sequence Number (35) above. referenced	OSP I Jan 88	pg 5-1, recommendation #1 — App. A, Table 1, IR 85-16/13, Item 5.
22	40	Additional NRC action. Issue: TU Electric never responded to all aspects of IEB 79-14. Action: Provide applicant with clear & concise written evaluation of actions taken to date & specify additional actions required to close the issue of IEB 79-14.	OSP PM June 88	pg 5-1, recommendation #1 — App. A, Table 1, IR 85-16/13, Item 6 & p. 3-33.

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
(41)	Confirmatory NRC action. Issue: TU Electric's IEB record files were incomplete (1982 & 1985). Action: Evaluate effectiveness of applicants' program through an audit. (Assure that all Bulletins were received, processed, & corrective actions initiated... include 42-44	OSP	I	June 88	pg 5-1, recommendation #1	App. A, Table 1, IR 85-16/13, Item 7 & p. 3-36,37.	JM SP*
(42)	Confirmatory NRC action. Issue: Deficiency in TU procedures to handle IEBs. They do not describe how construction management personnel handle IEBs requiring action, especially hardware repair, replacement & modification. Action: See Sequence No (41). referenced	OSP	I	June 88	pg 5-1, recommendation #1	App. A, Table 1, IR 85-16/13, Item 9 & p. 3-36.	JM SP*
(43)	Confirmatory NRC action. Issue: No focal point in TU Electric to track IEB items. Action: See Sequence Number (41) referenced above.	OSP	I	June 88	pg 5-1, recommendation #1	App. A, Table 1, IR 85-16/13, Item 10.	JM SP*
(44)	Confirmatory NRC action. Issue: TU Electric's internal letter stated that TU Electric would not identify nonconformances on [illegible] 79-14 to NRC. Action: See Sequence Number (41) referenced above.	OSP	I	June 88	pg 5-1, recommendation #1	App. A, Table 1, IR 85-16/13, Item11.	JM SP*

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
45	Confirmatory NRC action. Issue: Insufficient evidence of successful testing of BISCO fire seals - filing of false reports by BISCO, validity of BISCO seal questioned. Action: Verify adequacy of new seal installation.	OSP	I	Nov 87	pg 5-1, recommendation #1	App. A, Table 1, IR 85-16/13, Item 12	TY SP
46	Confirmatory NRC action. Issue: Failure to maintain tolerance and to report tolerance deviations on an NCR re Unit 2 RV support brackets and shoes. Action: Examine traveler and NCR procedures, confirm changes are in plant-specif. design + maintained...	OSP	T		pg 5-1, recommendation #1	App. A, Table 2, IR 85-07/05, Item 2, App A pg 3-6	DJ
47	Confirmatory NRC action. Issue: Failure to perform audits of surveillances of reactor pressure vessel specs, procedures & installation. Action: Monitor applicants' response to staff concerns raised in SSER 11 regarding their audit program.	OSP	T	Dec 87	pg 5-1, recommendation #1	App. A, Table 2, IR 85-07/05, Item 3	DN
48	Confirmatory NRC actions. Issue: No objective evidence (records) that mixing blades had been inspected quarterly since 1977. Action: Review statistical data re uniformity of concrete and review larger sample of concrete compression tests.	OSP	T	Dec 87	pg 5-1, recommendation #1	App. A, Table 2, IR 85-07/05, Item 4, App A p 4-17	SP

CPRRG RECOMMENDATIONS

Comanche Peak Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
49	Confirmatory NRC action. Issue: NAMCO switches IEB 79-28 were not properly identified on installation travelers. Action: Monitor applicants' EQ CAP. Note (3) Applicant actions.lis	OSP	T	Feb 88	pg 5-1, recommendation #1	App A Table 2, IR 85-16/12, Item 8, p3-41,42: pg 3-8	JM SP
50	Confirmatory NRC action: Issue: Insufficient evidence of successful testing of BISCO fire seals, filing of a false report by BISCO---validity. Action: Reinspect seals and certification documentation.	OSP	I	Nov 87	pg 5-1, recommendation #1	App A, Table 1, IR 85-16/13, Item 12 & pg 3-46	TY SP*
51	If spool CVCS spool piece was not marked at the time of inspection, then additional review would be warranted. Resolve uncertainty associated with when the spool piece was marked.	OSP	I	March 88	pg 5-1, recommendation #2	pg 3-10. App B pg 15	DN SP*
52	Inspections included in the 1986 inspection program, but not completed at Unit 1, should be reviewed, and those determined to be necessary to confirm plant quality, should be accomplished.	OSP	PM	May 88	App C, Table 1, pp.10-12		SP

CPRRG RECOMMENDATIONS

Comanche Peak Actions

	ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES	
35	53	The status of the inspection programs for Unit 2 should be monitored with respect to all NRC inspection activities to assure that inspections keep pace with construction and "windows of opportunity" are not lost.	OSP	PM Complete		pg 5-2, pg 3-27/28, recommenda App C pg 4 tion #3	SP
36	(58)	Further review of Operations Traveler criteria, control and effectiveness is warrented if it has not been done as a part of inspection activities completed to date.	OSP	I	Dec 87	App B pg 15	SP
37	(60)	A need to varify the adequacy of Level I QC inspection of RPV installation may exist.	OSP	I		App B pg 15	DN
38	61	Further NRC review of the completness of QC coverage and technical acceptability of the actual inspection criteria for the installation of all the major NSSS components is possibly warranted.	OSP	T		App B pg 15	DN
39	(62)	Inspection of other installed field-fabricated spool pieces should be considered.	OSP	I	March 88	App B pg 15	DN

CPRRG RECOMMENDATIONS

Comanche Peak Actions

	ID	RECOMMENDATION	ORGANIZATIONS		REFERENCES	
40	61	Verify adequate material identification and traceability program for earlier work or review procurement and control program for the bulk piping stock at CPSES with further inspection directed to the checks and balances precluding install. wrong material	OSP	I Dec 87	App B pg 15	DN
41	66	Determine if the Regulatory Guide 1.97 QA commitments have been properly implemented at the CPSES and whether Region IV has monitored such implementation.	OSP	I Dec 87	App B pg 16	
42	67	The adequacy of the licensee's program to update permanent installation documentation when components are changed ~~should~~ or replaced should be reviewed, if not already evaluated in inspections to date.	OSP	I Dec 87	App B pg 16	
43	69	The need to evaluate safety significance and all pertinent aspects of the licensee's QA Program may need to be emphasized.	OSP	I Dec 87	App B pg 17 Rec. # 1.7.9	SP

CPRRG RECOMMENDATIONS

Comanche Peak Actions

	ID	RECOMMENDATION	ORGANIZATIONS	REFERENCES	
44	(72)	Additional inspection by NRC is required to review engineering efforts to close IEB (79-14). reference	OSP I (June 88)	App B pg 4.6-6 Items 28/33	next exercise JM SP
45	73	Region IV selectively review records to see if specific inspection gaps were caused by non-performance. If so, Task group recommends "the Region" (sic) take appropriate action to close those gaps where there remains a clear benefit to...plant quality.	OSP I PM May 88	App C pg 3	SP

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CPRRG RECOMMENDATIONS

General Programmatic Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES		
D4	ANSI N45.2.9 is silent on shipping records. A definitive and documented regulatory position does not exist on controls during transfer between organizations.	NRR	RES		pg 3-18	App B pp 75-77, pg 3-14 two places.	TY SPx
D5	Clarify agency guidence: IE MC 9900 guidence was misinterpreted on applicability of 10 CFR 50, Appendix B criteria to to the requirements of 10 CFR 50.55(e).	NRR			pg 5-1 recommendation 2	pg 3-25, pg 3-18, App B pg 16, App B pg 116	SP TY JM
11	Clarify agency guidence: Philosophical differences ... on two issues: first, to what extent should inspectors focus on "hardware" vs QA "records" second, to what extent should violations be developed prior to issuance.	NRR	NMSS	OE	pg 5-1, recommendation #2	pg 3-24, pg 3-22 App B p 10	SP
64	The philosophical position as stated by Region IV (that although a procedure required blade inspections, it did not require documentation of such (specions) requires careful consideration.	NRR	NMSS		App B pg 16		SP

CPRRG RECOMMENDATIONS

General Programmatic Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES	
65	Consideration should be given to the TRT position that "permanent" records removed from storage for use or revision revert to an "in-process" status, which do not require application of the full ANSI N45.2.9 provisions.	NRR	NMSS	RES	App B pg 16	TY SP CH
75	NRC Headquarters should improve its regional assessment function to require more frequent and timely in-depth evaluations of the region's plant inspection performance and documentation practices.	NRR			App C pg 9	SP
57	Lack of formal discretionary guidance provided to supervisors and management when dealing with non-escalated enforcement. When does a non-compliance become a violation? Expand MC 0400 and 0610 accordingly. Also see Sequence number 68.	OE	NRR	NMSS	App B pp 6-11	App B pg 17 Recommendation #1.7.8
68	Consideration should be given to amplifying MC 0400 and MC 0610 regarding how to develop and document violations of 10 CFR 50, Appendix B Criteria. Also see Sequence number 57.	OE	NRR	NMSS	App B pg 17 Rec. # 1.7.9	

CPRRG RECOMMENDATIONS

General Programmatic Actions

ID	RECOMMENDATION	ORGANIZATIONS			REFERENCES	
D7	No NRC guidence exists on the time permitted a licensee to retrieve a document which is required to be retrievable.	OE	NRR	NMSS	pg 3-23	TY SP #4
12	Clarify agency guidence: Authority of inspectors and supervisors to disposition violations involving isolated matters having minor safety significance and for which the licensee takes immediate, effective corrective action.	OE	NRR	NMSS	pg 5-1, recommendation #2 pg 3-25	
14	Clarify agency guidence: No definitive guidence exists regarding the acceptability of multiple violations for the same underlying cause.	OE	NRR	NMSS	pg 5-1, recommendation #2 pg 3-25	
17	Clarify agency guidence: The FSAR is part of the application for an operating license and enforcement submitted to NRR for review. The role of the FSAR in the inspection process for facilities under construction is unclear (IE MC 9900).	OE	NRR		pg 5-1, recommendation #2 pg 3-25	SP

CPRRG RECOMMENDATIONS

Data Management Improvements

ID	RECOMMENDATION	ORGANIZATIONS		REFERENCES		
54	Develop a more comprehensive, unified 766 System that meets current agency needs. Consider the monitoring of site specific inspection programs, periodic regional monitoring of inspection program status, and Hq overview. Possibly then do Sequs 76 and 77.	NRR	OIRM	pg 5-1; recommendation #4	pp 3-28-32, App C pg 9, App D pg I-2 and pg VIII	SP
76	Establish inspection and enforcement data quality assurance policies and procedures as well as a training program to help assure a consistent, reliable, and timely agency data source. This could be accomplished after Sequence number 54.	NRR	OIRM	App D pg I-2 Rec. # 2	App D pg VIII Rec. #2	
77	Consider collecting all inspection and enforcement staff resource data in RITS. Evaluate the benefits of collecting inspection information by SALP functional area rather by inspection module. This could be accomplished after Sequence number 54.	NRR	OIRM	App D pg I-2 Rec. # 3	App D pg VIII Rec. #3	SP

IMPLICATIONS FOR OTHER REGION IV FACILITIES

With respect to the issue of whether Region IV failed to conduct required activities for Comanche Peak, the principal focus of OIA's investigation was on the inspection of the utility's Quality Assurance Program, mainly at the company's headquarters, pursuant to IE Manual Chapter 2512. (OIA Report at 37-46) The CPRRG, however, expanded this scope and examined the matter from the broader perspective of all required inspection activities called for by the current NRC inspection program.

The CPRRG concluded that ". . . broader implications for other facilities in Region IV cannot be ruled out and are likely to exist." However, while no specific recommendations are made, a number of observations stated by the CPRRG do provide useful guidance. For example, the CPRRG stated that:

> . . . to the extent that limited resources were a factor at Comanche Peak [in terms of deficiencies in Region IV QA inspection activities], some evidence exists that this factor may have affected other plants. Construction programs at Waterford, Comanche Peak, South Texas, Wolf Creek, and River Bend were all under way at the same time. This fact could have aggravated the situation, particularly since Region IV has a relatively small staff. Testimony in the record indicates that inspection activities at Comanche Peak and Waterford were adversely affected as a result of limited regional resources.
>
> Further, some of the factors that apparently lead to the difficulties at Comanche Peak, and ultimately to the OIA investigation, appear to be rather fundamental in nature and may not be limited to one site. In this regard, it is not at all clear that for Comanche Peak there was an established and understood philosophy for the conduct of the inspection program; a commonality of purpose on the part of both inspectors and management; and good communications and interchange in the development and dispositioning of inspection findings. . . .
>
> However, there are factors apparent from the CPRRG review that tend to make it difficult to gauge or assess the significance of such implications. The heart of the Comanche Peak conflict seems to be a dispute between an inspector and his management. This dispute reflected differences in inspection emphasis, enforcement policy, and the role of the inspector in the inspection and enforcement program. . . . Additionally, despite much controversy over the issues reflecting this dispute, the record does not establish that any unsafe condition exists at Comanche Peak. In fact, none of the 34 issues

> raised by the inspectors and included in the OIA report have direct safety significance. Further, the record contains considerable testimony that, for the most part, the Comanche Peak activities were being pursued by individuals attempting to properly discharge their responsibilities as they understood them. These findings suggest that the controversy in this case involves a limited number of individuals and a limited number of issues. (CPRRG Report at 3-3 - 3-4.)

The language quoted above is presented to provide a perspective on the appropriate breadth of actions necessary to assess whether the situation as it existed in regard to Comanche Peak, existed with respect to other facilities within Region IV. It is also necessary, however, to understand the evolution of the NRC's inspection program over the years in order to assess the significance of any gaps that might exist. In fact, the findings of both the OIA and CPRRG Reports with respect to the NRC's inspection program are, in a general sense, consistent with the Commission's own findings, presented in "A Report to Congress, Improving Quality and the Assurance of Quality in the Design and Construction of Nuclear Power Plants," NUREG-1055, May 1984. Through the late-1970's, the inspection program was fundamentally oriented towards a review of a licensee's written quality assurance program and program documentation with little emphasis on observation of work and inspection of hardware. The program, which has always been based on inspections/audits of only a fraction of all such activities, be they construction-related or operation-related, exceeded manpower resources. Such manpower constraints have been magnified from time to time and from Region to Region because of specific Regional manpower shortfalls and/or because of peculiarly heavy inspection demands resulting from the number of facilities within a Region requiring like, manpower-intensive efforts in the same timeframe. In the 1980's, the focus of the program was revised somewhat to put increased emphasis on the inspection and observation of work and less on records review, and to better accommodate resource limitations. At each stage of the evolution of the inspection program, the IE Manual and its inspection modules, which provides guidance to NRC inspectors, have been changed to correspond to the then-current inspection philosophy. It should also be recognized that literal completion of each inspection module is not required. Rather, as the IE Manual makes clear, an inspector is obligated to give consideration to the inspection requirements of each module which, due to facility-specific considerations, may result in any given module not being "completed". Moreover, as a practical matter, completion of all modules has generally not been achieved; completion of the inspection program has ranged from about 60-70% to 90-100%. The foregoing background is discussed at length in Appendix D to the above-mentioned Report to Congress.

Also relevant to the question of broader implications is the implementation of augmented NRC inspection and audit activities (such as CATs, PATs, IDIs and the like) at many sites as well as the implementation of a variety of independent and utility-conducted design, construction and quality assurance verification programs prior to the licensing of all recent plants. While both

of these efforts have tended to focus on selected areas of a facility, they have taken into consideration applicable QA/QC requirements and have been sufficently broad in scope, in terms of the spectrum of structures, systems and components of a plant under scrutiny, to provide a well-rounded retrospective picture of the adequacy and effectiveness of the respective QA program. Both the OIA and CPRRG Reports acknowledge the contribution of such efforts, in the case of Comanche Peak, to compensate for possible gaps in the NRC routine inspection process. The existence of similar undertakings elsewhere, therefore, is of significance in deciding whether measures are warranted to determine whether such gaps in the inspection program as were found at Comanche Peak are of concern at other facilities.

In light of the foregoing, the CPRRG's conclusion regarding broader implications is addressed. As noted by the CPRRG, a number of facilities in Region IV were under construction in generally the same timeframe. Thus, on the one hand, limitations on Region IV resources logically could have had an effect on inspection efforts related to all of them. On the other hand, the Region was fully budgeted for these activities and a variety of special and augmented inspection and audit activities were conducted at several of these facilities which provide confidence that any gaps in the Region IV program would not likely have resulted in the failure to detect deficiencies with safety significance.

For instance, as at Comanche Peak, extensive staff technical audits were undertaken at the Waterford, South Texas, Wolf Creek and River Bend facilities in connection with the staff's operating license reviews. These activities included detailed reviews of the applicants' site records on selected (but widely varied) issues and team inspections on selected important safety systems. As part of these efforts, emphasis was placed on implementation of QA programs related to the matters under review.

Similarly, Fort St. Vrain has been subjected to detailed scrutiny in connection with factors surrounding the extended plant shutdown, compliance with the Commission's environmental qualification requirements and the staff's review of the Chernobyl implications. Although these reviews focused principally on hardware and systems design, related QA elements were implicitly considered in the licensee's overall improvement program. In addition, Region IV conducted an augmented inspection of the licensee's quality programs as a result of a SALP category 3 finding.

The Cooper, Fort Calhoun and Arkansas Nuclear One facilities have been in operation for many years, indeed, prior to the development of the NRC's increased emphasis on construction inspection activities and were not subjected to such detailed audits and inspections. Nonetheless, because their periods of construction preceded by some years some of the evolutionary changes in the inspection process, the uncertainty as to the proper inspection philosophy is likely less than was found to exist in later years when more changes occurred. Furthermore, although the staff did not perform any special or augmented audits or inspections at these plants, their long operational histories strongly suggest that gaps that might be found are of little moment in terms of safety.

As noted above, the CPRRG also observed that the conflict regarding Comanche Peak appears to have at its heart "a dispute between an inspector and his management." This factor, unquantifiable though it may be, could tend to limit the potential for far-reaching implications; we are not aware of similar disputes of such broad scope that have arisen in connection with any other facility in Region IV. Moreover, the CPRRG's found that, in general, Region IV's disposition of each of the 34 items at issue in regard to Comanche Peak was appropriate and that none of these issues was of direct safety significance. The CPRRG Report gives no reason to suspect that such disputes as might have existed in connection with other facilities were not also appropriately dispositioned or that issues of direct safety significance are likely to have been discarded or ignored because of process-related conflicts.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

AUG 31 1987

August 25, 1987

MEMORANDUM FOR: Victor Stello, Jr.
Executive Director for Operations

FROM: James G. Keppler, Director
Office of Special Projects

SUBJECT: CPRRG RECOMMENDATIONS

In response to the Chairman's May 12, 1987 memorandum, we have reviewed all of your Category I recommendations and related aspects of the Comanche Peak Report Review Group (CPRRG) recommendations as specified in your April 14, 1987 memorandum to the Chairman. Enclosure 1 to your memorandum identified 45 recommended actions specifically related to the licensing and inspection activities for the Comanche Peak Steam Electric Station. We agree that these actions are appropriate and sufficient to resolve the 34 issues raised in the OIA Report 86-10. Moreover, we believe that these actions are straightforward and can be accomplished by the Comanche Peak Project Division separately from the Category 2 and 3 programmatic recommendations assigned to NRR and ARM.

We have also reviewed the CPRRG report, as required by item 2 of the Chairman's memorandum, and conclude that there are no additional actions or lessons-learned beyond those identified in your April 14, 1987 memorandum. However, we will continually refer to the report to ensure that the intent of the recommendations is being fulfilled and to reflect on this question.

Many of the assignments evolving from the CPRRG recommendations are closely related to other review and inspection activities being conducted by the Comanche Peak Project Division. We believe it would be impractical and inefficient to attempt to resolve the CPRRG recommendations separate from these other activities. Rather, we intend to incorporate the CPRRG recommendations into our related technical review and inspection activities and will report their resolution separately prior to licensing.

James G. Keppler
James G. Keppler, Director
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Document Name:
MEMO STELLO/KEPPLER

Requestor's ID:
SHERRY

Author's Name:
CIGrimes

Document Comments:
CPRRG recommendations

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