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

7/10/85

MEMORANDUM FOR: Jose Calvo
Larry Shao

FROM: Chet Poslusny

SUBJECT: NEW ALLEGATIONS

Attached is a set of allegations which were discussed with TUGCO employees in a meeting in May along with the transcripts of the meeting. Please have them reviewed and identify those which will be handled by your group, the lead reviewer for each, and an estimated closure date. The intimidation items are being looked at by Jim Gagliardo. Please provide feedback by July 26th.

Chet Poslusny
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M. Kline

FOIA-85-59

R21

[redacted]

1. Improper removal and replacement of valve code name plates pg. 9, 14, 15, 17

2. TUGCO avoidance of ANI Review/Inspection p.3-5 - undersided hanger weld page 11. Attempt by TUGCO to dictate what the ANI will or will not inspect.

3. Improper grinding of a valve seat. - P. 22-23

[redacted]

1. Trending Reports on surveillance findings (Startup) not prepared from 1983 through 1985.- p.3

2. Identification of operations problems by surveillance group was ignored/discouraged by TUGCO management specifically in areas of auxiliary operator training and following of procedures. (Intimidation) page 16-32. Also see attached report provided by alleger. Supression of Ops QA finding - p.48

3. Invalid testing of welders - January 1985 - p.33

4. Pressure to stop documenting deficiencies - instead solve in the field. p.38

5. QC failing to identifiy deficiencies. - p.45

6. New organization will place QA surveillance group under an organization over which it is conducting surveillance. - p.46

7. Intimidation -- pg. 46,47,43 also see #2 above.

[redacted]

1. Operations personnel unfamiliar with the operations QA organization and operation - p. 4,5

2. Procedural and training problems were identified by QA Surveillance Team in a report. Operations and Construction management both reacted strongly against report findings. Lead individual on QA surveillance team was given verbal reprimand based on a personnel matter unjustly. P. 6,7,8-10, 44. Investigation by TUGCO management was promised but never done.

3. Authorized nuclear inspector is experiencing problems in exercising his responsibilities. Results engineering group (operations) apparently is bypassing the ANI review and inspection and he, the ANI has had to write them up repeatedly.

   ex. 1 The stellite seat on a class one valve was ground down/machined without giving the documentation to the ANI for review and approval. - p. 15,16

   ex. 2 Air receivers were cut up without review of ANI p. 17

   ex. 3 Weld on on pressure boundary done using unauthorized weld type without engineering approval. - p. 18

4. TUGCO management has an attitude problem regarding QA finding problems, creating a feeling of job insecurity. - p. 20-21

5. Work packages were being issued with drawing numbers but without revision numbers contrary to the procedure in place. When this was brought to the attention of the QA surveillance supervisor he issued a change to the procedure that no longer required the identification of the drawing revision number in the work package. - p.23-27

6. Problems were identified with the laydown areas at the fabrication shop by the NRC. TUGCO wrote a letter to the NRC subsequently stating that all problems had been corrected. A recent surveillance inspection revealed that a significant number of problems still exist.- p. 31,32

7. QA Surveillance inspector has identified an incident where it appears that QC inspectors are literally directing the craft people on how to install electrical conduit. - p. 32,33

8. Brown and Root manges by intimidation. - pg. 36

9. Improper testing of welders - p. 38-39

10. Walkdown in housing areas revealed deficiencies where QC had done an audit only days before - p.44.

[redacted]

1. No surveillances were performed for about 1½ years. - p.5

2. Negative management attitude toward mission of surveillance group - p. 7, 18

3. Deficiency Report written on operations procedures handled improperly by operations management - p. 11

4. Operations Management tries to handle deficiencies in an informal manner - e.g. verbal vs NCR's, fixes without documentation of problems. - p. 12,13,16.

5. There has been poor communications provided to Surveillance group, including Dallas audit group findings - p. 13.
Poor line of communciation with operations QA - p.15.

6. Craft are tending to leave problems uncorrected until they are identified by QC inspectors. Craft management discourages craft communication with QC to minimize problem identification and resulting delays. - p. 18-20

Example - Use of undersized lugs on electrical wire terminators for fire detectors only addressed after problem was taken to Safe Team. - p. 21.

[redacted]

Operators appear to be trained inconsistently or ineffectively - p. 3,4,7,9. Procedural problems. This was written up by QA surveillance inspector but apparently never followed up by the operations side.

[redacted]

There are some problems in effectiveness of operation and maintenance procedures. - p. 5,6,7

[redacted]

Inadequately structured tests were given to inspectors for certification (electrical area) - p. 8,9