NUREG–1517

Report of the South Texas Project Allegations Review Team

Docket Nos. 50–498 and 50–499

Houston Lighting and Power Company, et al.

U.S. Nuclear Regulatory Commission

Office of Nuclear Reactor Regulation
Office of Investigations

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L. Kokajko, D. Skay, H. Wang/NRR
D. Murphy/OI

Office of Nuclear Reactor Regulation

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ABSTRACT

This report provides the results of the South Texas Project Allegations Review Team of the U.S. Nuclear Regulatory Commission. This team was formed to obtain and review allegations from individuals represented by three attorneys who had contacted Congressional staff members. The allegers were employed in various capacities at South Texas Project Electric Generating Station, licensed by Houston Lighting and Power Company, et al.; therefore, the allegations are confined to this site. The South Texas Project Allegations Review Team reviewed, referred, and dispositioned concerns related to discriminatory issues (harassment and intimidation), falsification of records and omission of information, and various technical issues. The team was able to substantiate certain technical issues of minor safety significance or regulatory concern at the South Texas Project facility, but it did not find widespread discriminatory practices such as harassment and intimidation.

EXECUTIVE SUMMARY

This report presents the results of the South Texas Project Allegations Review Team (ART) of the U.S. Nuclear Regulatory Commission (NRC). This team was formed to obtain and review old and current allegations from known allegers and new allegers at the Houston Lighting and Power Company's, et al. (the licensee), South Texas Project (STP) Electric Generating Station, Units 1 and 2 (Docket Nos. 50-498 and 50-499).

In 1994, Congressional staff members of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce contacted the NRC about concerns at the South Texas Project. The Congressional staff members expressed such concerns as: discriminatory practices may have occurred at the facility, some technical issues may not have been adequately addressed by the licensee, and some aspects of the NRC inspection program may not have been effectively implemented at the South Texas Project. After the second of two introductory briefings on the facility and NRC regulatory oversight, NRC management proposed to the Congressional staff that a special NRC staff team would be formed to obtain and review allegations concerning STP.

The Congressional staff informed the NRC that they had been in contact with attorneys representing clients who had concerns about the construction and operation of STP. The team received allegations primarily from clients represented by two of three attorneys; a third attorney did not provide access to the clients. The team did not supplant the normal allegations management or inspection processes in the NRC Region IV office, nor did it supplant the investigative process of the Office of Investigations Field Office in Region IV.

The South Texas Project ART interviewed eight individuals and took transcribed statements. In addition, the team contacted two additional individuals based on information received from interviewees. Material was provided that identified two other individuals who supported a previously interviewed alleger. The team reviewed the transcripts and documents provided by the allegers, including material provided anonymously. Based on this review, the ART sent a letter to each interviewed alleger listing the concerns as understood by the team. A total of 49 concerns were received relating to discriminatory issues, falsification of records, and various technical issues.

The team referred the discrimination allegations to the Office of Investigations. Some of the allegations of discrimination were already being investigated in ongoing OI cases. Some new OI cases were opened as a result of the team's interviews. Although the majority of discrimination allegations were not substantiated, OI did identify two examples of discriminatory behavior, and is continuing to investigate another allegation of potential discrimination. The team did not uncover widespread discriminatory practices.

Of the 49 concerns the team received, 40 allegations concerned technical and falsification issues. The team found that nearly all of these concerns had been previously identified by the NRC, the licensee, or by a previous allegation. Therefore, the team was able to close these allegations based on NRC inspection reports, closed allegation files, consultation with the NRC technical staff, and the licensee's corrective actions. Fifteen technical allegations were substantiated, at least in part. These allegations were of minor safety significance and the licensee had taken steps to correct the deficient conditions identified. Twenty-five technical allegations were not substantiated. The team referred some items to the NRC Region IV office for follow-up action.

While some of the technical issues were substantiated and isolated examples of discriminatory behavior were identified, the team concluded that those substantiated allegations did not affect the safe operation of the plant.

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ACKNOWLEDGEMENTS

The South Texas Project Allegations Review Team offers its sincere appreciation to Eileen S. Peyton, Licensing Assistant, for her efforts in preparation of this report. Additionally, the team wants to thank Arthur T. Howell and Edward B. Tomlinson who significantly aided and contributed to this effort.

Finally, the team would like to thank the Office of Nuclear Reactor Regulation technical divisions and branches for their invaluable assistance in reviewing applicable portions of the report. We would also like to thank the Office of Enforcement and the Office of Investigations for their time spent assisting in this effort.

1 INTRODUCTION AND BACKGROUND

1.1 General Background

The South Texas Project (STP) Electric Generating Station is a two-unit, Westinghouse pressurized-water reactor facility, located in Matagorda County, Texas. The facility is co-owned by Houston Lighting and Power Company (HL&P), the City Public Service Board of San Antonio, Central Power and Light Company, and the City of Austin, Texas. Houston Lighting and Power Company is authorized to act for the other co-owners, and has exclusive responsibility and control over the physical construction, operation, and maintenance of the facility. Each unit is rated at 3800 megawatts (thermal).

Both units at the STP were shut down for an extended period in February 1993 because of technical (hardware) issues involving the operation of the auxiliary feedwater system. During this time, U.S. Nuclear Regulatory Commission (NRC) oversight of the facility began to increase significantly, and the NRC placed both units under a Confirmatory Action Letter (CAL) on February 5, 1993.

Because of increased concern about the operational problems, the NRC decided to further increase oversight and assessment of the facility, and initiated a Diagnostic Evaluation Team (DET) review in April 1993, under auspices of the NRC Office of Analysis and Evaluation of Operational Data (AEOD). The problems with the facility, as noted by the NRC, were grouped into three broad areas, namely material condition and housekeeping, human performance, and managerial and organization performance. The DET report, issued on June 10, 1993, identified performance deficiencies in the areas of operations, maintenance and testing, and engineering support, and found that management weaknesses had contributed to these deficiencies. The facility was placed on the NRC "watch list" in June 1993.

The licensee initiated various corrective actions, including generation of an Operational Readiness Plan (August 28, 1993) and Business Plan (October 15, 1993) to ensure nuclear safety, track and correct identified deficiencies, and improve operational performance. Together, these plans constituted the licensee's response to the NRC's DET report, and outlined those actions and resource allocations necessary to effect near-term and long-term improvements in station performance.

To verify that the licensee had corrected deficiencies to improve operational performance, the NRC Region IV Regional Administrator chartered the STP Review Panel on March 11, 1993, to provide oversight of the facility. Subsequently, this panel became the NRC Restart Panel, which was formed on April 12, 1993, in accordance with Manual Chapter 0350, "Staff Guidelines for Restart Approval." The STP Restart Panel was comprised of regional and headquarters personnel charged with coordinating the NRC oversight of the facility,

preparing a restart action plan, and tracking the licensee's progress from the time the units were shut down until each unit restarted. The Restart Panel initiated action to supplement the CAL on two occasions (May 7, 1993, and October 15, 1993), and directed various inspections by the Region IV office and by the Operational Readiness Assessment Teams (ORATs). The NRC staff conducted ORAT inspections before the restart of each unit to verify that the licensee had taken the necessary corrective actions.

After being assured that the licensee had addressed the weaknesses that led to previous concerns, the NRC lifted the supplemented CAL and allowed the units to restart. STP Unit 1 restarted on February 18, 1994, and STP Unit 2 restarted on May 22, 1994. Each unit has performed satisfactorily since restart, as evidenced by only two reactor trips on STP Unit 1, and one trip on STP Unit 2, and few equipment problems. As a result, NRC concern decreased toward the end of 1994, and STP was removed from the NRC "watch list" of problem facilities on February 1, 1995.

1.2 Allegation Review Team Formation

Shortly after restart of STP Unit 1 from the extended shutdown, Congressional staff members from the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce requested a briefing on the status of the facility. Various NRC staff members from the Office of Nuclear Reactor Regulation (NRR), the Office of Investigations (OI), and Region IV met with the Congressional staff on March 31, 1994, and April 29, 1994.[1] The Congressional staff expressed various concerns about the construction and operation of the STP facility, and about discriminatory actions in the form of harassment and intimidation at the site. Additionally, the Congressional staff expressed concern that the various employee concerns programs at the site had been ineffective, and that the NRC staff, particularly Region IV, had not identified problems and had not ensured proper

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[1] Congress had previously expressed interest in the South Texas Project facility. The Subcommittee on Oversight and Investigations of the House of Representatives' Committee on Interstate and Foreign Commerce held a hearing on the regulation and construction of nuclear power plants (specifically, South Texas Project) on September 23, 1980 (Serial No. 96-223). During this hearing, construction deficiencies, harassment and intimidation of quality control inspectors by construction personnel, and lack of management support for quality assurance functions were addressed. In addition, the subsequent investigation/inspection (Inspection Report 79-19), order, violation, and civil penalty (dated April 30, 1980), which were designed to remedy problems at the facility, were discussed. Moreover, Congressional staff briefings were held after the completion of NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2" (see footnote 3).

corrective action. The Congressional staff stated that they had spoken with past and current allegers at the site, and had reviewed information that led them to think that significant regulatory and safety issues existed at STP.

As a result of the April 29, 1994, meeting with the Congressional staff, Mr. James L. Milhoan, Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations, and Research (DEDO) in the Office of the Executive Director for Operations, initiated two headquarters-led teams. On May 6, 1994, the DEDO directed that a team be formed to review allegations regarding STP. On June 30, 1994, the DEDO directed that a team be formed to review the effectiveness of implementation of the inspection program at STP. Finally, the DEDO initiated another important, although limited, review of alleged South Texas Project record falsification issues, which provided useful information to the aforementioned special teams.[2]

This report primarily concerns the findings of the Commission's STP Allegations Review Team (ART). As a result of the May 6, 1994, memorandum from the DEDO, an ART charter encompassing NRR and OI was sent to the DEDO on May 23, 1994, and approved on May 31, 1994. The primary purpose of this team was to obtain and review allegations from individuals represented by three attorneys who had contacted the Congressional staff. This report also addresses the review of alleged STP record falsification issues, which was begun by the third DEDO initiative (see Section 5 of this report). The ART coordinated with the STP Inspection Program and Implementation Effectiveness Review Team, whose charter was approved July 8, 1994, and with the Region IV office. Appendix A contains various memoranda, which give specific information regarding the details of the charter and changes to the charter over time.[3]

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[2] Separately, the NRC Office of the Inspector General (OIG) began an investigation of alleged failure by the NRC to address safety concerns, as well as an audit of the NRC inspection program. Additionally, although unrelated to NRC staff activities, the U.S. General Accounting Office (GAO), the investigative arm of the U.S. Congress, began a review of the NRC power reactor inspection program, paying particular attention to NRC inspection and oversight of STP (GAO Code No. 302122) as a result of a Congressional request. Memoranda regarding the initiation, scope, and depth of the GAO efforts are located in Appendix E.

[3] From a historical perspective, it should be noted that there have been other significant NRC review efforts that have reviewed construction and operational concerns at STP, in addition to routine regional and headquarters oversight. The first significant effort resulted from the licensee's internal contractor report, known as the "Quadrex Report," which documented construction and design issues. The NRC staff subsequently reviewed this report, documenting its findings in NUREG-0948 (Inspection Report 82-12) entitled, "Special Inspection Report of the Quadrex Corporation Report on Design Review of Brown and Root Engineering Work for the South Texas Project, Units 1 and 2." This report identified various follow-up NRC staff actions, which were reviewed and evaluated in NUREG-0781, as supplemented, entitled,

The STP ART began gathering preparatory material and background information in May and June 1994. Since the Congressional staff had identified attorneys representing clients with concerns about STP construction and operation, contact with these attorneys began shortly after approval of the charter. The team received and reviewed allegations primarily from clients represented by these attorneys, although other allegers were subsequently identified. The STP ART began interviewing allegers and reviewing allegations in July 1994.

It should be noted that the activities of this team were in addition to those the NRC headquarters and regional office normally perform. While the STP ART was functioning, this team did not try to supplant the normal allegations management process or inspection process in the NRC Region IV office, nor did it try to supplant the normal investigative process of the Office of Investigations Field Office in Region IV. Indeed, the NRC Region IV office continued to receive and review allegations, and inspect all aspects regarding the operation of the facility. In addition, the OI Region IV Field Office continued to investigate wrong-doing matters concerning the facility.

"Safety Evaluation Report Related to the Operation of South Texas Project, Units 1 and 2," and NRC inspection reports (most notably, Inspection Reports 84-11 and 86-03). The second significant effort resulted from allegations arising from the Government Accountability Project (GAP) just before initial licensing of South Texas Project, Unit 1. This review, led by headquarters personnel, examined allegations at STP, and generated NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2." Also known as the "Calvo Report," this report documented NRC staff review and evaluation of various allegations at the facility. It is of interest that some of the allegations raised during this period were similar to the ones raised with regard to the current STP Allegation Review Team.

2 ALLEGATION REVIEW TEAM PROCESS AND OVERVIEW OF RESULTS

2.1 Process Established by the STP ART Charter

The STP ART obtained and reviewed allegations arising from the construction and operation of the STP in response to Congressional concerns. Congressional staff identified two attorneys who had knowledge of individuals that had expressed concerns about STP construction and operation. Subsequently, a third attorney associated in the same law firm as one of the Congressionally identified attorneys, also contacted the team. The team received and reviewed allegations primarily from clients represented by these three attorneys. The charter for this team encompassed a variety of activities, both within OI and NRR, or some combination thereof. Some of the items in the charter were modified over the course of the project, and some clarifying information was provided. It should be noted that the team did not supplant the normal allegations management process or inspection process in the NRC Region IV office, nor did it supplant the investigative process of the Office of Investigations Field Office in Region IV.

The STP ART obtained a list of complaints filed with the U.S. Department of Labor (DOL) by whistleblowers at STP, and determined the disposition of each of the cases and the safety concerns raised to identify what "protected activity" the individuals had engaged in. The NRC Office of the Inspector General (OIG) was contacted to obtain a list of names and addresses of individuals they had interviewed regarding allegations at STP. Although this list was not obtained because of confidentiality concerns, OIG had already referred any STP-related health and safety allegations to the appropriate office for review. Therefore, the team believed that the identification of these people was not necessary. The team contacted the Congressional subcommittee staff, and obtained a list of the attorneys who represented clients involved with allegations at STP. These attorneys provided a list of people who had made allegations at STP, some of which were known allegers and some new allegers. From these initial sources, the team established a list of potential interviewees.

Once the list was compiled, the team determined which allegers had previously submitted allegations to the NRC, and how those allegations had been dispositioned. In addition, the team obtained and reviewed copies of transcripts, interview reports, sworn statements, and other documents outlining the various concerns. This included a review of any inspection report or OI investigative report that resulted from these allegations in an attempt to determine if the allegations were substantiated and, if so, what actions were taken by the NRC or the licensee to address or remedy the

allegations. Also, an attempt was made by OI to determine, without disclosing the identity of the individual, if an allegation was made through the licensee's Speakout (employee concerns) Program, and to determine the disposition of that allegation. Further, the team reviewed records of the major NRC inspections and NRR/Region IV allegations for the years since NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2," dated March 1988 (also known as the Calvo Report), to determine if allegations by any of the potential interviewees were previously addressed by the inspection process or allegation review.

Arrangements to conduct interviews were generally made through an alleger's attorney. Interviews were transcribed and under oath. (As noted in Section 2.3, not all allegers agreed to be interviewed.) Interviews were conducted at the alleger's attorney's office (in Texas) to allow the alleger to openly discuss concerns. One interviewed alleger provided written material that indicated two other individuals supported the alleger's claim of discrimination. These two individuals were treated as allegers. During (and after) the interviews, the team obtained, reviewed, and filed documents that might help substantiate allegations, for use in the team's allegation management process. Some of this material was provided to the team anonymously. A file was generated for each alleger and allegation. From this information, the team attempted to determine which allegations were new and not previously addressed by the NRC. (Moreover, if new information was obtained regarding an old allegation which might change the final determination of that allegation, the team further reviewed the allegation.) During the review and evaluation of the allegations, the team compared the allegations to concerns raised in NUREG-0948, "Special Inspection Report of the Quadrex Corporation Report on Design Review of Brown and Root Engineering Work for the South Texas Project, Units 1 and 2" (Inspection Report 82-12, dated December 1982), NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2," (Calvo Report, dated March 1988), and the STP Diagnostic Evaluation Team Report (dated June 10, 1993). This comparison was done to identify common problems between the reports and the recently received allegations.

Each alleger was sent a letter (first sample letter in Appendix D) expressing appreciation for informing the NRC of their concerns. Each letter also summarized the major concerns expressed in the interview, and requested that the allegers contact the team if the concerns were not adequately represented. (The team sent initial response letters to 10 allegers; however, response letters were not sent to the 2 people identified by material that supported another alleger.)

Allegations were presented to the NRR Allegations Review Board (ARB). As discussed in Section 2.3, the board approved a process for allegations management in accordance with the team's charter and the board's process. Status reports were provided to appropriate management on a routine basis throughout the review process. Members of the team maintained a chronology of activities. (A chronology of major team activities is included as Appendix H). A database of the allegations was maintained, but separate from the

Allegation Management System (AMS). The NRR Office Allegations Coordinator received the material generated by the team. In order to complete the evaluation, the team was allowed to assess resource needs, transmit requests for additional information to the licensee, or conduct onsite inspections or investigations, as appropriate.

At the end of the team's activities, a second letter (third sample letter in Appendix D) will be sent to the allegers to provide the results of the team's evaluation as noted in this report.

Any lessons learned were identified at the conclusion of the evaluation (see Section 7).

Finally, the team was to plan and schedule an inspection of the current STP employee concerns program. (This was later removed from the STP ART charter, and transferred to the STP Inspection Program and Implementation Effectiveness Review Team, as noted in a memorandum from Kokajko/Murphy to Russell, dated October 19, 1994, as shown in Appendix A.)[4]

2.2 Process Established by the Allegations Review Board

The NRR ARB met on September 9, 1994, to discuss multiple technical issues, harassment and intimidation (H&I), potential wrong-doing by the licensee, and potential OIG issues raised by the allegers who were interviewed. The ARB determined that the allegations were of potential safety significance. Since this material had been previously assigned by the Deputy Executive Director to a special review team, the ARB allowed the team to generate a process for handling these allegations, which was subsequently approved by the ARB chairman (as shown in Appendix A). The process approved by the ARB was similar to that of the ART charter, but it clarified certain aspects of the charter and added new requirements. This section is limited to the clarified aspects and new requirements.

The ARB approved the team's process whereby, in the initial letter to the allegers, the team would inform the allegers of the limitations on the protection of their identity as outlined in the J. Taylor, NRC Executive Director for Operations, memorandum dated August 22, 1994 (first sample letter in Appendix D). The process provided for a transfer of the technical allegations to the appropriate technical review branch if the allegations could not be handled by the team members. Allegations of discrimination, falsification, or other wrong-doing would be referred to OI, which utilized

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[4]Guidance to review employee concerns programs is being developed by the Office of Nuclear Reactor Regulation and will undergo trial inspections at selected plants. South Texas Project may be selected to receive one of the trial reviews. Limited guidance currently exists regarding the review of licensee handling of employee concerns in NRC Inspection Procedure 40500, "Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems."

personnel from the Region IV Office of Investigations. Finally, the process provided for referrals of NRC staff wrong-doing to the NRC OIG.

After the ARB was initially informed about the allegations received by the team, in the conduct of further interviews many of the same allegations were repeated, or additional information was provided. As a result, the team did not return to the ARB with these allegations, but instead continued to review the allegations in accordance with the approved charter. The team's final meeting with the ARB is discussed in Section 2.4.

2.3 Overview of Results[5]

The STP ART obtained allegations from 12 individuals. Of these, eight allegers were interviewed under oath. Transcripts of the interviews were taken. Two allegers were interviewed via telephone after indicating that they did not agree to a transcribed interview. Response letters were sent to these individuals outlining the team's understanding of their concerns (sample letter appears in Appendix D). In addition, the team received written material indicating that two other people expressed a concern in support of one of the previously interviewed allegers. While each of these two people was treated as an alleger, the team did not send a response letter to them.

The STP ART received nine allegations of discriminatory behavior (e.g., harassment and intimidation).

- Two allegations were already the subject of ongoing OI investigations. These two OI investigations are represented in DOL filings. The OI cases were administratively closed, but the NRC is continuing to monitor the progress of the DOL cases. Two written documents obtained by the ART that supported one of the ongoing investigations were counted as two separate allegations.

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[5]Although unrelated to the receipt of allegations, the Congressional staff stated they had been informed that ex-resident inspectors had expressed concerns about the STP facility, and urged the NRC to investigate this source of information. As a result, the ART decided to interview ex-resident inspectors who were at STP during the late construction and early operational time periods. The ART obtained information during interviews (not transcribed) of four NRC Region IV inspectors who were employed as resident inspectors or senior resident inspectors at STP, who are still employed by the NRC. Those inspectors interviewed were former senior resident inspector Joseph I. Tapia, and former resident inspectors Robert J. Evans, Claude E. Johnson, and Terrance Reis. These individuals did not indicate that they thought widespread discrimination (e.g., H&I) existed at STP. The inspectors did note that various routine technical issues arose during the late construction and early operational periods, but that routine issues of this type were not unexpected. The ART concluded that no further review was warranted as a result of the interviews with the NRC ex-resident inspectors. Additionally, attempts to contact ex-NRC employees, who were resident inspectors assigned to STP during construction, were unsuccessful.

OI later opened a case to investigate one of these allegations, since the alleger contacted Region IV directly.

- Three allegations resulted in three new OI cases being opened. Another allegation consisted of a supporting statement for one of the new OI cases, and this was consolidated into that case. This particular case was also the subject of a DOL filing, and is being monitored by the NRC. The two remaining cases were closed based on OI's conclusion that the allegations of discrimination were unsubstantiated.

- One allegation was general in nature and involved a "request for information" tracking form that was apparently disseminated at the facility. The team considered this an allegation and, in conjunction with the Office of Enforcement (OE), took action to correct the situation.

In addition to the nine allegations, the team considered one individual's concern regarding discriminatory behavior. Upon further review, the team discovered that the individual did not specifically allege a discrimination issue. The team concluded that if the individual were to have actually had a discrimination concern, there appeared to be no basis to claim discrimination (an adverse action taken against the individual). Therefore, the team did not consider it an allegation, and this item was not counted in the tally of discrimination allegations.

Finally, the team addressed the Congressional subcommittee staff's general statement that discriminatory practices were occurring at STP. The team considered this concern, but did not count it as an allegation for purposes of this report.

The team received 40 allegations concerning technical and related falsification issues. It should be noted that approximately half of these allegations came from one individual. Fifteen technical allegations were substantiated (at least in part), but could be closed because either the issue was not safety-related or the licensee had identified the issue and had taken adequate corrective action. Twenty-five technical allegations were not substantiated.

Specific information on how the team dispositioned each of these allegations may be found in Sections 3 and 4 of this report. While some items are under review, in particular the ongoing OI investigation and monitoring of the DOL filings, the technical concerns are fully addressed. Some inspection follow-up activity is required. In order to ensure that commitments and corrective actions initiated by licensee personnel are fulfilled, a letter (Appendix G) was sent to the licensee outlining those areas that will require confirmation by follow-up NRC inspection. A similar tasking memorandum will be sent to the Region IV office, and the results of the subsequent regional inspections will be provided to the NRR Office Allegations Coordinator.

2.4 Miscellaneous Team Activities

The ART completed the activities as noted in Sections 2.1 and 2.2 above. Initial contact letters were sent to the allegers, and subsequent follow-up letters will be sent to the allegers (after this report is published). In a final meeting, held on February 2, 1995, ARB accepted the disposition of these allegations (see Appendix A). Additional information, primarily closure of OI cases, was obtained after the date of the ARB meeting, and is reflected in this report.

In accordance with its charter (Appendix A), the STP ART dispatched letters to each of the allegers that were directly contacted (transcribed interview or telephone contact). Each letter was designed to ensure that the allegations identified in the interviews were accurately delineated. Only one alleger contacted the staff to identify a concern that was inadvertently omitted from the response letter. As noted above, written information which identified two apparent allegers was not responded to by the ART, although the information was included as an allegation. (As noted in Sections 3.7 and 3.8, Region IV OI reviewed these allegations separately from the activities of the ART. As a result, Region IV OI will follow its procedures to ensure that the allegers are informed of the status of the review.)

Additionally, fourteen individuals who had H&I and technical concerns were identified through DOL filings and had not been in recent contact (approximately one year) with the NRC staff. To the team's knowledge, these fourteen individuals were not associated with any of the three attorneys who had contacted the Congressional staff. These individuals were sent letters to ask if they would like to talk with the NRC staff (second sample letter in Appendix D). Since the team believed that previous NRC or licensee action had corrected or remedied any problem, it was thought that these individuals would not raise any additional concerns. Eight letters were returned because the recipients were no longer at the residence of record. Three people stated that they were not satisfied with the results of previous reviews, but did not request an interview or provide additional information for review. Three letters were not returned.

In addition to these, seven individuals identified in the initial list of potential interviewees were currently involved in ongoing OI investigations. To the team's knowledge, these seven individuals were not associated with any of the three attorneys who had contacted the Congressional staff. As noted in the charter revision, the team informed the appropriate personnel that they should not limit their interviews to the investigation at-hand. Instead, the investigators should ensure that the interviews are broad enough to capture other salient aspects of any allegations that may shed light on the construction and operation of STP. (NRC Headquarters OI will continue to monitor these cases.)

As noted in the process approved by the ARB, the team would refer allegations of NRC staff wrong-doing to the OIG. One such allegation was received by the team and presented to the Allegations Review Board, which suggested that this allegation be brought to the attention of the OIG. This allegation was

referred to the OIG in a memorandum dated September 13, 1994. Since this allegation is under the cognizance of OIG, it was not counted for purposes of this report, as it is beyond the scope of the ART's activities.

2.5 Access to Allegers

As noted above, the names of two attorneys were provided to the team by the Congressional staff, who had information and access to past and current allegers at the facility. A third attorney subsequently contacted the team. Since the formation of this team was designed to obtain the allegations from the clients represented by these attorneys, the NRC was interested in obtaining and reviewing these concerns as soon as practical. Two of these three attorneys provided access. The clients of these attorneys cooperated and identified additional people to be contacted.

The third attorney was reluctant to provide access to clients. Attempts were made to contact the attorney by telephone and make arrangements for interviews with the clients.

The team made a visit to this attorney's law offices on October 20, 1994, for the purposes of discussing access to the potential allegers. At this meeting, it was suggested that access to the clients might be obtained if certain conditions were met, which included reimbursement of the cost of travel and lodging of the clients to a point closer to the attorney, so that the attorney could be present. By letter dated October 26, 1994, the attorney formally requested these conditions. The NRC responded in a letter dated November 23, 1994, which agreed to the conditions of the attorney's letter, but with some modifications and clarifications.

Verbal acceptance by the attorney was obtained on December 7, 1994, and formal acceptance and a schedule was agreed to be provided by December 23, 1994. This was not provided to the NRC. The NRC sent another letter dated January 4, 1995, which provided an additional opportunity to agree to the conditions of interview and provide a schedule to interview the potential allegers. The NRC requested that the attorney respond by January 18, 1995.

The attorney responded on January 4, 1995, which corresponded to the date of the NRC's letter. In this letter, the attorney did not agree to the conditions of interview and did not provide a schedule of interviews. To clarify the matter, the NRC sent another letter dated January 10, 1995. This letter requested that the attorney formally agree to the conditions of interview and provide a schedule of interview. The attorney did respond on January 18, 1995, but was unresponsive to the NRC's request. By letter dated January 30, 1995, the NRC informed the attorney that the special offer, as noted in the conditions of interview in the NRC letter dated November 23, 1994, had expired. (Appendix B provides the correspondence regarding this matter.)

The team believed that individuals to whom the team might be granted access would have been previously interviewed during the Safety Significance Assessment Team (NUREG-1306 (Calvo Report); see footnote 3, Section 1.2 of

this report), would have been interviewed by the NRC in some other matter, would have made a court statement that was reviewed by the NRC staff, or would have made a DOL appearance where any contentious issue would have been identified and recorded. However, in anticipation that new information might exist, the NRC informed the attorney in its January 30, 1995, letter that the attorney and associated clients could contact designated NRC staff members if they wished to provide allegations to the NRC.

3 REVIEW OF DISCRIMINATION ALLEGATIONS

3.1 Introduction

Section 50.7, "Employee Protection" of Title 10 of the Code of Federal Regulations, states, "Discrimination by a Commission licensee, an applicant for a Commission license, or a contractor or subcontractor of a Commission licensee or applicant against an employee for engaging in certain protected activities is prohibited. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, or privileges of employment." The protected activities are established in section 211 (formerly section 210) of the Energy Reorganization Act. It is generally assumed that harassment and intimidation falls within the scope of the discriminatory conduct prohibited under 10 CFR 50.7. The NRC does not provide a remedy to people who are the subject of discrimination; only the Department of Labor provides a remedy for discrimination complaints. The NRC may, however, take enforcement action against the licensee and/or contractors of the licensee if the NRC determines that discrimination has occurred.

The STP ART received nine allegations regarding potential discriminatory conduct by the licensee or its contractors. One "potential" allegation was considered, and the Congressional staff assertion regarding a hostile work environment at STP was considered (but these were not counted in the tally of allegations). Some of these allegations had been received by the NRC previously and were already under investigation. Others were first received during the ART's interviews. To the extent possible, information regarding these allegations is provided below. Most individuals alleged technical issues as well, which are addressed in Section 4 of this report.

3.2 Discrimination Allegation #1

3.2.1 Characterization of Allegation

It was alleged that an STP employee was the subject of continuous harassment and intimidation in the form of demotions and a hostile work environment for identifying safety concerns. In addition, it was alleged that an HL&P attorney made threatening or harassing remarks to the alleger about being included in a planned reduction in force at STP.

3.2.2 Details

OI had previously opened this allegation under case number 4-92-005 in March 1992. During the interview with the ART, the alleger repeated some of the original concerns and supplied additional information. In April 1993, the NRC had requested that HL&P provide the basis for employment actions taken regarding the alleger. HL&P responded and denied taking actions against the alleger as a result of identifying safety concerns. On September 12, 1994, the alleger provided two written statements from other individuals that supported the alleger's claim of discrimination. These statements were considered as separate allegations and are discussed in Sections 3.7 and 3.8 of this report.

The alleger filed a complaint with the DOL in February 1992. In October 1992, the DOL Area Director decided that discrimination was a factor in employment actions against the alleger. This decision was appealed by HL&P and was presented to an Administrative Law Judge (ALJ), whose decision is pending. OE is monitoring the DOL process.

The alleger contacted the ART on September 12, 1994, and expressed an additional concern that an attorney employed by HL&P had made threatening remarks to the alleger. OI contacted the alleger by telephone on October 6, 1994, to obtain additional information. It was alleged that on September 6, 1994, during a telephone conversation with the DOL ALJ to discuss a possible settlement, an HL&P attorney stated that older people, poor performers, whistleblowers, and people who had gone to the employee concerns program, were going to be laid off from STP. Allegedly, the attorney stated that the alleger, based on past performance, would fall into one of those categories. OI interviewed the alleger's attorney, who was present during the September 6, 1994, conversation. The alleger's attorney stated that the HL&P attorney did not threaten the alleger. OI also interviewed a law clerk in the ALJ's office, who had spoken with the ALJ regarding the allegation. The law clerk stated that the ALJ had no memory of the statement being made.

3.2.3 Conclusion

OI administratively closed this case on February 8, 1995. The NRC is holding possible further action in abeyance pending the decision and order of the DOL ALJ. The allegation regarding threatening remarks made by the HL&P attorney was not substantiated.

3.2.4 Recommended Action

OE will monitor the status of the DOL process and take appropriate enforcement action upon issuance of a decision by the DOL ALJ. If at a future date, information is received from the ALJ, or is developed from other sources that additional investigation is warranted, OI will reevaluate the matter.

3.3 Discrimination Allegation #2

3.3.1 Characterization of Allegation

It was alleged that a former contractor employee who was laid off in December 1993, was not rehired at STP due to an alleged contact with the NRC. It was alleged that HL&P sent a letter to the contractor relating that they did not want this individual working at STP.

3.3.2 Details

This allegation was first received by the NRC during the interview with the ART. OI investigated this new allegation under case number 4-94-044. OI initiated an investigation on October 20, 1994. The evidence developed and reviewed during the investigation did not substantiate the allegation that the alleger was not rehired due to an alleged contact with the NRC. This case was closed on January 17, 1995.

3.3.3 Conclusion

This allegation was not substantiated.

3.3.4 Recommended Action

None.

3.4 Discrimination Allegation #3

3.4.1 Characterization of Allegation

This case involves two individuals. It was alleged that these individuals' employment at STP was terminated due to their previous reporting of security concerns to the NRC.

3.4.2 Details

The NRC Office of the Inspector General (OIG) had previously opened case number 9249I for this allegation in May 1992 and closed the case in February 1993. OIG found that the evidence presented indicates that the allegers did engage in a protected activity, that their management had knowledge of their engaging in a protected activity, and that the process used to justify their terminations was conducted in a manner prejudicial to the individuals. This finding was forwarded to the NRC OE, and Demands for Information were issued to the licensee and one individual. During the interview with the ART, the allegers provided no new information that the NRC had not previously considered.

A DOL complaint was filed. In November 1992, the DOL Area Director determined that discrimination had been a factor in the termination of the allegers. The licensee appealed this decision to the ALJ. OI had opened case number 4-92-012 in May 1992 to monitor the OIG investigation and DOL proceedings.

3.4.3 Conclusion

OIG concluded that the process used to justify the allegers' terminations was conducted in a manner prejudicial to the individuals. OI administratively closed this case on February 6, 1995, based on the conclusions of the OIG report. The NRC is holding possible further action in abeyance pending the decision and order of the DOL ALJ.

3.4.4 Recommended Action

OE will monitor the DOL process and take appropriate enforcement action upon issuance of a decision by the DOL ALJ. If at a future date, information is received from the ALJ, or is developed from other sources that additional investigation is warranted, OI will reevaluate the matter.

3.5 Discrimination Allegation #4

3.5.1 Characterization of Allegation

It was alleged that a former STP employee was the subject of discrimination, harassment, and intimidation for refusing to falsify documents in early 1994. The discrimination included being forced to take a drug test while a visitor at STP, and allegedly failing a second drug test taken as part of the employment process.

3.5.2 Details

This allegation was first received by the NRC during the interview with the ART. OI opened a new investigation under case number 4-94-037. OI conducted interviews of the alleger and other individuals. A DOL complaint was filed in September 1994. Although the DOL Area Director found in favor of the licensee, OI has yet to dismiss that discrimination was a factor in some of the actions taken against the alleger. This case is still open.

3.5.3 Conclusion

This case is being pursued by OI.

3.5.4 Recommended Action

If OI makes a finding of discrimination, it may refer this case to the Department of Justice (DOJ). OI will inform the alleger upon closure of its investigation. OE will review the OI findings to determine if enforcement action is warranted pending any referral to DOJ. OE will continue to monitor any DOL proceedings to determine if additional evidence is uncovered that might warrant NRC action.

3.6 Discrimination Allegation #5

3.6.1 Characterization of Allegation

It was alleged that this individual perceived that he was the subject of harassment and intimidation for supporting the alleger discussed in Section 3.5 of this report.

3.6.2 Details

This allegation was first received by the NRC during an interview with the ART. The NRC has not found evidence that adverse actions have been taken against this individual to pursue an individual investigation of discrimination. However, since this alleger's statement supports another alleger's case, OI is reviewing the information provided by this alleger as part of the investigation discussed in Section 3.5.

3.6.3 Conclusion

This allegation has been consolidated into OI case number 4-94-037, which is under review by OI.

3.6.4 Recommended Action

None.

3.7 Discrimination Allegation #6

3.7.1 Characterization of Allegation

It was alleged that this individual and others were alienated for supporting the alleger discussed in Section 3.2 of this report.

3.7.2 Details

Written material dated September 1994, was provided by the alleger noted in Section 3.2 of this report. This material identified an apparent alleger who had expressed support of the alleger discussed in Section 3.2. This material contained apparent examples of discrimination for supporting the alleger discussed in Section 3.2.

The alleger later contacted the Region IV staff alleging that the licensee's hiring practices may be discriminatory. The alleger also stated that he had brought this concern to the Speakout program. Region IV OI opened case number 4-94-057 to investigate this allegation. Subsequently, Region IV OI interviewed the alleger who stated that he was satisfied with HL&P's resolution of the concerns, and consequently withdrew the allegation.

3.7.3 Conclusion

Based on the limited information available, the withdrawal of the allegation by the alleger, and no apparent violation of NRC rules and regulations, this case was closed on January 9, 1995. If at a future date, information is developed which indicates there has been a violation of NRC requirements, OI will reevaluate the matter.

3.7.4 Recommended Action

None.

3.8 Discrimination Allegation #7

3.8.1 Characterization of Allegation

It was alleged that this individual and others were consistently turned down for jobs because they supported another alleger.

3.8.2 Details

A written log (apparently a personal chronology of the time period of July to September 1994) was provided by the alleger noted in Section 3.2 of this report that details an apparent alleger's attempts to obtain a new position. The log indicates that several persons who supported the alleger discussed in Section 3.2 were turned down for jobs. Due to the supporting nature of this allegation, it was consolidated into the OI investigation discussed in Section 3.2.

When contacted by OI, the individual stated that the problems with obtaining a new job were a result of HL&P's general restructuring which began in June 1994. Although the individual was interviewed by Speakout in 1991 or 1992 regarding the alleger discussed in Section 3.2, the individual did not believe that adverse action had been taken as a result. The individual also stated that others who had supported the alleger were turned down for jobs, but that other factors were involved.

3.8.3 Conclusion

Because this individual did not allege discrimination, this allegation is closed. If at a future date, information is developed which indicates there has been a violation of NRC requirements, OI will reevaluate the matter.

3.8.4 Recommended Action

None.

3.9 Discrimination Allegation #8

3.9.1 Characterization of Allegation

A former contractor employee at STP alleged that a chilling effect existed at STP that prevented employees from bringing concerns to the licensee or to the NRC. He also alleged that documentation was falsified and that if employees challenged this practice, they would be subject to termination. These practices allegedly occurred during construction of STP.

3.9.2 Details

This allegation was first received by the NRC during an ART interview. The ART noted that the alleged discriminatory actions would have occurred during construction. OI opened a new investigation under case number 4-94-043. To date, the NRC has not found evidence of an adverse action taken against this individual to pursue an investigation of discrimination. OI administratively closed this case on February 9, 1995, based on the ART's review of and failure to substantiate the alleger's technical concerns, lack of specificity provided by the alleger, and a determination that the investigation is of low priority. If at a future date, information is developed which raises the priority of this case, OI will reevaluate.

3.9.3 Conclusion

This allegation was not substantiated.

3.9.4 Recommended Action

None.

3.10 Distributing Whistleblowers' Names

3.10.1 Characterization of Allegation

It was alleged that the licensee had developed a database that listed several individuals as whistleblowers, and that this list was widely distributed throughout the site.

3.10.2 Details

The alleger provided a copy of a database printout that was given to him by another employee who claimed that he found it in a conference room. The printout was titled "STP RFI Tracking System," and was dated June 30, 1994. It consisted of a list of requests for information. From a perusal of this document, it appeared that this tracking system monitored, among other things, activities on information requests associated with current litigation between the licensee and other entities. It was not clear that this document was intended to be restricted in its distribution as there was no clear indication on the document itself that distribution was in any way controlled.

Request number 51 in the document refers to "...potential liabilities associated with 'whistleblower' claims made by, or the administrative or court proceeding involving, the following South Texas Project 'whistleblower'." The tracking system entry then proceeds to name 11 individuals that have apparently filed complaints with the Department of Labor; and as such, the individuals' complaints against the licensee would be public information.

The NRC was concerned because it was not clear that this document was intended to be restricted in its distribution by the licensee. Permitting this document to be available to HL&P employees could result in the perception that these individuals are viewed in a negative manner, and could cause other employees to avoid raising safety concerns out of fear that they will be labeled as "whistleblowers." In a letter dated October 6, 1994, James Lieberman, the Director of NRC's Office of Enforcement, informed the licensee and its co-owners of the NRC staff's concerns.

HL&P responded by letter dated November 1, 1994, stating that the document was used in litigation (discovery) activities to assist its staff in responding to legal matters. The licensee's letter stated what the NRC independently determined--that the individuals had filed complaints against HL&P with the DOL, which is a public proceeding.

However, in order to address NRC staff concerns, HL&P committed to have renewed instructions that "...personnel participating in responding to discovery requests take care that the materials they handle be safeguarded from access by anyone who does not have a need to review or respond to those matters." Additionally, HL&P warned its co-owners of the NRC staff concerns and their responsibilities in a letter dated November 1, 1994, which was attached to its November 1, 1994, response to the NRC. (Appendix C contains the correspondence related to this matter.)

3.10.3 Conclusion

The ART determined that this allegation was substantiated. However, the reasons given by the licensee for maintaining such a database are reasonable. The ART finds the licensee's response to this concern acceptable.

3.10.4 Recommended Action

None.

3.11 Allegation of Potential Discriminatory Action

3.11.1 Characterization of Allegation

This subsection is provided for completeness purposes only, since the potential alleger did not specifically allege a discrimination issue. An alleger identified an individual who was thought to have information regarding certain technical allegations, and may have been the subject of discriminatory action. Based on this information, the team contacted this individual and, for all practical purposes, treated this person as an alleger, including the dispatching of an initial contact letter.

3.11.2 Details

When contacted by telephone (on several occasions), the individual did not allege any technical issue, but did provide insights into some of the technical allegations that had been previously received. If anything, the individual indicated that certain concerns were being evaluated already, and did not express concern about any technical issue. Moreover, the individual was asked about discriminatory action taken, since the team had heard that this had occurred. The individual, in fact, did not state that discriminatory action had been taken. However, given his concerns about a recent performance appraisal and HL&P's announcement of future layoffs, the team inferred that this was so, and asked him about this. Subsequently, the individual in question agreed to provide written material (previous performance appraisals) for OI's evaluation of the inferred concern. This material was obtained and reviewed by OI (Headquarters) in December 1994.

3.11.3 Conclusion

OI (Headquarters) concluded that if the individual were to have actually had this discrimination concern, there appeared to be no basis for a claim of discrimination (for no adverse action had been taken against the individual). Additionally, the ART concluded that no allegation had, in fact, been made, and no further action was warranted. If information is later received that investigation is warranted, OI will reevaluate the matter.

3.11.4 Recommended Action

None.

3.12 Conclusion Regarding the Work Environment at STP

As noted earlier, Congressional subcommittee staff indicated to the NRC that, based on information supplied by the allegers associated with the attorneys who had contacted them, it suspected discriminatory practices had occurred at STP. The statements made by the attorneys contacted by the ART and the individuals interviewed would suggest that discriminatory practices (such as harassment and intimidation) had occurred at STP, and that employees could not raise safety concerns without fear of retaliation. The relatively few allegations received by the team does not suggest this.

The Department of Labor is the only agency which can provide compensation to an individual as a result of discrimination. Therefore, filings of complaints of discrimination with DOL can be an indication that employees perceive a problem with discrimination. The ART found that DOL received 19 cases of alleged discrimination from STP employees or contractors since STP was licensed (1988 - 1994); during which time, an average of 3,000 persons were employed at STP.

Any single case of employee discrimination is unacceptable. However, the limited number of alleged cases of harassment and intimidation referred to DOL for the period 1988 - 1994, compared with the relatively large workforce, would not suggest that widespread discriminatory practices were occurring at STP. Therefore, the general allegation of widespread discriminatory practices, such as harassment and intimidation, at STP is unsubstantiated.

To support this conclusion, the NRC had conducted two inspections of the STP employee concerns program (ECP) in December 1993 (IR 93-52 dated January 24, 1994) and May 1994 (IR 94-21 dated June 6, 1994). In May 1994, the inspectors interviewed 30 STP employees, with emphasis on employees who had previously submitted nuclear safety concerns to the ECP, and found that virtually all would submit nuclear safety concerns either to their supervisor or to the ECP. During a meeting with the NRC on January 9, 1995, the licensee presented the conclusions of an independent assessment of employee attitudes. The survey of employees indicated improved confidence in the ECP program and indicated that employees would report a nuclear safety concern. This is supported by an increase since December 1993 in the number of walk-in concerns brought to the ECP from 24 percent to 41 percent and a decrease in the number of concerns received anonymously from 36 percent to 15.4 percent.

Although the team did not perform an in-depth evaluation of the work environment at STP, the previous NRC inspections and efforts by the licensee support the team's conclusion that widespread discrimination does not exist. In a letter to HL&P dated February 1, 1995, the NRC stated that STP was removed from the NRC watch list of problem plants, based in part, on its improvements in the ECP. The letter stated, "Recent management actions to ensure an open, positive climate for employees to raise safety concerns were noted and the restructured employee concerns program appears to be well-received by the plant staff."

4 REVIEW OF TECHNICAL ALLEGATIONS, INCLUDING FALSIFICATION AND OMISSION

4.1 Introduction

Technical allegations, including allegations of falsification and omission of information, were reviewed and evaluated by the STP ART. The team took the view that a determination of the safety and regulatory significance of the issue in question was necessary. Subsequently, the team's objective was to ensure that the allegation, if substantiated, was being adequately addressed.

Of the technical allegations, 15 were substantiated (at least in part), but could be closed because the issue did not affect the safety of the plant, or the licensee had identified the issue and had taken, or is taking, adequate corrective action. The remaining 25 technical allegations were not substantiated.

4.2 Maintenance

4.2.1 Control of Maintenance Work

4.2.1.1 Characterization of Allegation

It was alleged that maintenance work at South Texas was not controlled in 1991. In particular, maintenance work was performed without proper clearance and without regard to schedule. In addition, changes to work orders were made without proper review and approval.

A similar allegation was submitted to the NRC in early 1992, as discussed below.

4.2.1.2 Details

In early 1992, the NRC received an allegation that STP had identified a number of concerns pertaining to the control of work activities. Also in 1992, the NRC received a petition filed in accordance with 10 CFR 2.206. The petitioner expressed several concerns, including problems with the implementation of the maintenance program.

In response to these concerns, the NRC conducted an inspection in March 1992 (IR 92-07). The inspection team noted that some of these problems had been previously documented in the maintenance surveillance functional area of the SALP report (IR 91-99) dated July 31, 1991. The inspectors concluded that the licensee had a good maintenance work control process program. The NRC inspectors found instances in which some personnel did not fully comply with procedural requirements of minor safety significance. The examples identified by the inspectors involved proper use of the configuration control change log and adherence to work start approval. However, the majority of the procedural requirements were being met.

The team also found that some requirements of the internal procedures were not being satisfied by maintenance workers, and that the licensee's employees had not attained a philosophy of equipment ownership. The licensee was aware of these weaknesses, and issued revisions 4 and 5 to SP-OPGP03-ZA-0090, "Maintenance Work Practices and Requirements," to incorporate the lessons learned and to improve the practice of adherence to procedural requirement aspects. Revision 5 was issued in July 1992. Region IV administratively closed the allegation in September 1992 based on the conclusions of IR 92-07.

This concern was also raised to the licensee's employee concerns program, SPEAKOUT, in early 1992. The SPEAKOUT concern alleged that a contractor, Newport News Inc. (NNI) was violating work practices and procedures such as working on items not tagged out and working without work packages. It also alleged that NNI had worked on the wrong component, causing damage to the component, that HL&P personnel directed NNI to perform work not covered in work packages, and that HL&P and NNI supervision falsified valve packing data sheets. The licensee's investigation substantiated most of the allegations. The licensee issued its investigation report and recommended resolution on

April 30, 1994, stating, "NNI did work on components prior to obtaining work start approval, unauthorized changes were made to data entries and summaries of work performed, NNI took shortcuts and did not follow procedures, NNI machined components under the direction of HL&P personnel without detailed work instruction, and HL&P personnel responsible for NNI's work were interested in getting the work done to meet schedule and did not pay adequate attention to procedural requirements or quality."

The licensee's response to the Speakout recommendations is documented in an office memorandum dated May 26, 1992. The licensee performed a final review of NNI work documents to ensure that data recorded was complete and correct. In addition, the licensee committed to develop more effective training methods for the contract craft personnel and for HL&P contract personnel to understand their responsibilities.

The NRC Diagnostic Evaluation Team (DET) Report, dated June 10, 1993, stated that maintenance, in general, was still weak, indicating that the licensee's corrective actions were not effectively implemented. Specifically, the DET found that the work control process was inefficient and manpower intensive, resulting in a high maintenance backlog and poor material condition of the plant. Furthermore, the DET found weaknesses in maintenance training and insufficient management support to maintenance. This reduced the effectiveness of the maintenance process and the quality of the maintenance effort. As a corrective action, the licensee committed to several actions in its Operational Readiness Plan, including an evaluation of the effectiveness of contract labor and their supervisors; significant changes to the maintenance training program; relabeling equipment to reduce errors; assigning two supervisors to each maintenance crew; and revising OPGP03-ZA-0090 from 160 pages to a more workable 40 pages.

The NRC Operational Readiness Assessment Team (ORAT) inspection report (93-202), dated March 7, 1994, did not indicate any maintenance weakness. The more recent NRC Integrated Assessment Team Inspection (IATI) reported that maintenance, in general, was good. The report (IR 94-25, dated September 29, 1994) indicated that management of the maintenance program had improved. The team observed good supervisory involvement in maintenance work and found that maintenance managers demonstrated good safety focus. In addition, the team found that problem identification and documentation by maintenance were good. The quality of maintenance work observed was also good. These observations indicated that the licensee's corrective action program in maintenance had been effectively implemented, with encouraging results. However, the IATI team recommended increased NRC inspection and inspection focus. Increased inspection included the effectiveness of the "pen and ink" change process for maintenance work packages, the effectiveness of the repeat maintenance indicator, and the use of the maintenance feedback form. Inspection focus included monitoring the licensee's effort to reduce the maintenance backlog to within the licensee's goal.

4.2.1.3 Conclusion

This allegation was substantiated. However, the ART found that corrective actions taken by the licensee in issuing the new revisions to Station Procedure OPGP03-ZA-0090 and in the response to the SPEAKOUT concern were adequate. The licensee's corrective actions appear to be effectively implemented, as evidenced by the recent ORAT and IATI reports. This item is closed.

4.2.1.4 Recommended Action

None.

4.2.2 Changes to Fire Protection System Work Orders

4.2.2.1 Characterization of Allegation

It was alleged that in January 1994, STP contractors working on fire protection systems were altering design change documents and work orders and changing the scope. It was also alleged that the system engineer couldn't close several of the work packages because he had not authorized the changes and therefore did not know what had been done.

4.2.2.2 Details

The NRC identified a similar concern in its IATI report (IR 94-25, dated September 29, 1994). The team noted extensive use of the "pen and ink" method for making changes to work packages. According to licensee procedures, "pen and ink" changes could be approved by the field supervisor if the intent and scope of the work were not changed. Pen and ink changes were not reviewed before implementation. The IATI reviewed a Station Problem Report (SPR) that had been initiated by the licensee (SPR 941460, dated July 25, 1994) to document a case in which a "pen and ink" change had broadened and changed the scope of a work package. Station Procedure OPGP03-ZA-0090, Revision 8, dated January 25, 1994, was in effect at the time of this incident. Step 3.5.2 of Revision 8 states, "A Work Package Revision is required when the additional instructions or clarifications change the Scope or Intent of the work activity, then the revisions are required to be routed as the original Work Package." Therefore, the incident described in SPR 941460 was a violation of the licensee's procedures. The licensee, after identifying the violation, implemented corrective action promptly by issuing a "Lessons Learned Transmittal." In it, the licensee stressed that a full understanding of equipment condition and history is necessary before "pen and ink" changes can be made. This transmittal was distributed throughout the site as training material.

The ART reviewed the current revision of procedure OGP03-ZA-0090, "Work Process Program," Revision 10, dated October 17, 1994. Step 4.4.5.4 of this procedure states, "...additional work instructions that do not alter the scope or intent....may be added as pen and ink changes." Step 4.4.5.5 of this procedure indicates that a work package revision is required when additional instruction or clarifications change the scope or intent of the work activity, the revisions are required to be routed in the same manner as the original work package, including work start authority. This routing includes engineering, as required by engineering program procedures. Therefore, if the original work package required the approval of the systems engineer, a change in scope would also require review and approval of the systems engineer.

The alleger did not provide detailed information for the team to investigate the specific allegation. However, because this allegation was one example of a weakness that had been previously identified and addressed, the team believed that no further action was necessary.

4.2.2.3 Conclusion

This allegation was not substantiated. Although the specific incident described by the alleger could not be substantiated, the ART is aware of at least one case in which the scope of work orders was changed without authorization. The licensee's procedures give clear guidance on the use of "pen and ink" changes; the licensee ensured that its staff was informed of this guidance by distributing the "Lessons Learned Transmittal" discussed above. This item is closed.

4.2.2.4 Recommended Action

The licensee's violation of its procedures appears to be a violation of NRC regulations. The NRC staff will determine whether a violation occurred. In view of the licensee's action in identifying and correcting this problem, a non-cited violation, in accordance with the provisions of the Enforcement Policy, may be appropriate in this case.

4.2.3 Backdating of Documentation

4.2.3.1 Characterization of Allegation

It was alleged that the paperwork for the repair of certain valves was completed after the work was finished. The incidents described by the alleger, which were performed by contractors, occurred in 1991.

The NRC received a similar allegation in March 1992. The alleger stated that the licensee had "paper clean-up" days during which documentation would be completed and work packages backdated.

4.2.3.2 Details

In response to the allegation received in 1992, the NRC performed an inspection to investigate this and other problems at STP. The results were documented in Inspection Report 92-07, issued June 1, 1993. Section 2.2.1.3 of IR 92-07 identified some examples of signatures and corresponding dates on completed work packages that appeared to be inconsistent with the times when the packages should have actually been signed and dated. The inspectors noted this most often in the "Personnel Performing Work" block. However, during the inspection, no wrong-doing was identified; rather, the inspectors found that an inconsistent approach to backdating was being practiced by supervisors. During interviews of instrumentation and control technicians, foremen, supervisors, and management at that time, it became clear to the inspectors that the licensee had not established a policy for late signing of a completed package. Some personnel stated that they would sign and date the document for the date the activity was performed; others indicated that they would sign and date the document with the date they actually signed the document; and some personnel indicated that they would sign and date for when the activity was performed, but then annotate in the remarks section that the signature was provided at a later date than documented. The licensee subsequently issued a station procedure revision (OPGP03-ZA-0090, Revision 4) to clarify management's expectation for backdating documents. The NRC closed this portion of allegation RIV-92-A-0012 when the revised procedure was issued.

The ART reviewed Section 4.1.2.7 of Revision 4 of OPGP03-ZA-0090 which stated, "Date is the date of signature not the date of performance." Revision 4 also requires that the person making a late entry note the date that the step was actually performed. The ART concluded that these statements provided adequate guidance to personnel performing work.

The ART reviewed Section 4.5.3.10 of the current revision, Revision 10, of Procedure OPGP03-ZA-0090, which was issued on October 17, 1994. This revision states that backdating of any work document is prohibited. If late entries must be made, the entry must be marked as a "late entry" and the date the activity actually occurred must be noted. The entry must then be initialed and dated by the person making the late entry, using the date the late entry is made.

4.2.3.3 Conclusion

This allegation was substantiated. The licensee took adequate corrective action to remedy this situation by issuing Revisions 4 and 10 to Station Procedure OPGP03-ZA-0090. The review did not substantiate that the licensee had "paper clean-up" days to complete work documentation. This item is closed.

4.2.3.4 Recommended Action

None.

4.2.4 Work Was Performed Without Documentation

4.2.4.1 Characterization of Allegation

It was alleged that, during construction, maintenance work was performed without paperwork in a trailer set up as a "fab" shop. The alleger provided an example in which a part was rewelded in the "fab" shop and no record was generated to document that the work was done.

4.2.4.2 Details

The alleger stated that this is not a concern today because the licensee had taken out the fab shop. The alleger did not provide specifics regarding which equipment had been worked on in this way or who was responsible for operating the "fab" shop (contractor or HL&P). As discussed in Section 4.2.1, problems have been identified in the past regarding uncontrolled maintenance work. Without knowing the type of work performed, or whether it was performed on safety-related equipment, the ART cannot determine the potential safety significance of this allegation.

Regarding welding performed in the fab shop, the NRC was aware of problems with weld traceability during construction. The Safety Significance Assessment Team (SSAT) inspection performed in 1988, which is documented in NUREG-1306, Section 5.5.2, investigated an allegation that welds could not be traced to determine who had performed a weld and when it was performed. It was alleged that welds were not stamped with the welder identification number at the time the welds were completed, but were stamped later by welders who had not performed the welding. The SSAT found eight SAFETEAM investigations of alleged loss of weld/welder identification traceability. SAFETEAM attributed this to problems the licensee had found with Quality Control (QC) procedures for inspection of structural steel in 1984, as a result of an insufficient number of QC inspectors. The SSAT partially substantiated this concern based on IR 86-38, which established the possibility that some structural welds may have been marked with the wrong welders' stamps. The SSAT reviewed the licensee's procedures for controlling the welding program and found that the procedures provided adequate controls. The SSAT inspectors also performed a walkdown of the heating, ventilation, and air conditioning (HVAC) system (the original allegation identified this as the system of concern) and found no deficiencies in the paperwork associated with welds.

The alleger provided no additional information that would change the NRC's conclusion.

4.2.4.3 Conclusion

This allegation was not substantiated. This item is closed.

4.2.4.4 Recommended Action

None.

4.2.5 Motor Pedestal Sandblasting

4.2.5.1 Characterization of Allegation

It was alleged that a motor pedestal was not sandblasted before painting contrary to the documentation.

4.2.5.2 Details

It was alleged that a piece of equipment supporting a motor was supposed to be sandblasted and then painted. Because the compressor was not working, the motor pedestal could not be sandblasted. However, the painter painted it and documented it as being sandblasted. The alleger also stated that a contract worker, after reviewing the documentation, advised the licensee that the pedestal could not have been sandblasted because the compressor was not working. The pedestal was then sandblasted and painted over a second time. No paperwork was generated to indicate that the second painting was ever done. The alleger could not provide clarifying information to identify where the motor pedestal would be installed.

4.2.5.3 Conclusion

This allegation was not substantiated. However, even if it were substantiated, this allegation would not raise a safety concern. This item is closed.

4.2.5.4 Recommended Action

None.

4.3 Station Problem Reports

4.3.1 Characterization of Allegation

It was alleged that the licensee misclassified some SPRs by assigning them to a lower priority. The alleger was concerned that this had been a continuing problem and was still occurring at the time of the ART's interview.

4.3.2 Details

Station Problem Reports were the forms used by the STP employees to report deficiencies identified in the plant. The licensee prioritized SPRs into six categories based on the significance of the deficiency or initiating event with category 1 being the most significant and category 6 being the least significant. SPRs in categories 4, 5, and 6 did not require a root cause determination. Both the licensee's quality assurance (QA) organization and the NRC ORAT inspection identified the SPR priority assignments as a concern.

Since the NRC had identified that a problem existed with the SPR process, it required the licensee to brief the NRC on its efforts to improve the SPR process. The licensee was also required to present to the NRC the results of its review of existing reports, before restarting either unit from the extended outage. This requirement was documented in a supplement to the Confirmatory Action Letter dated May 7, 1993.

The licensee's quality assurance organization also evaluated the SPR process; its results were published in Quality Assurance Surveillance Report 94-002 on January 17, 1994. The licensee evaluated 255 SPRs in categories 1 through 5 that had been closed before October 31, 1993. The QA report confirmed that certain category 5 SPRs should have been assigned a higher category. The report also found that the quality of investigation tended to be category-driven rather than issue-driven; therefore, some SPRs didn't get a complete investigation.

During its inspection in January 1994 (IR 93-202, issued March 7, 1994), the NRC ORAT found that many safety-significant deficiencies had been classified in category 4, 5, or 6 SPRs, which did not require a root-cause determination. The team also identified that adverse trend SPRs often did not address inadequate corrective actions or deal with performance problems. The team noted that these weaknesses did not indicate an immediate safety significant concern and did not impact restart of Unit 1. In response to the team's concerns, the licensee revised its procedure to give the Plant Review Group the latitude to categorize SPRs based on actual safety significance. The team observed this process and noted improvement. The licensee also made several commitments to improve the SPR process including training and monitoring program effectiveness.

IR 94-20, issued June 10, 1994, documented the NRC's inspection of the licensee's corrective actions to resolve Unit 2 restart issues. Restart Issue No. 2 was the SPR process. The inspectors found that as a result of the ORAT concern, the licensee established a problem report review group (PRG) to

review each SPR for correctness of category level and assignment of responsibility. All adverse trend SPRs were provided to the PRG for closure review. The inspectors reviewed a narrow band of SPRs written for Unit 2 since January 1, 1994, all SPRs closed for Unit 2 since February 1, 1994, and SPRs with operability reviews conducted since January 15, 1994. The inspection report concluded that the licensee's evaluation of existing SPRs for issues affecting operability and safe plant operation was appropriate; that the threshold and categorization of SPRs issued since the restart of Unit 1 had been adequate; and that the problem evaluation and adequacy of corrective actions for a sample of SPRs was thorough. The inspector also independently reviewed some category 5 and 6 SPRs and found no safety-significant deficiency. However, the inspector indicated that several of the SPRs would have benefitted from more detail supporting the assignment of the lower category. The inspection showed positive improvement compared with the prior inspection findings.

On October 17, 1994, the licensee issued Revision 6 to OPGP03-ZX-0002 "Condition Reporting Procedure". Revision 6 replaced the corrective action program (OPGP03-ZX-0002, Revision 5) and the SPR program. The new procedure uses the following levels to categorize issues: condition not adverse to quality, condition adverse to quality (station or department level), and significant condition adverse to quality. Conditions not adverse to quality and conditions adverse to quality (department level) do not require a root cause evaluation. Condition reports categorized at these lower levels must not affect plant safety, reliability, or public safety, according to the guidance in the new procedure. A condition review group was created to provide oversight of the station corrective action program. OPGP03-ZX-0002, Revision 6 requires that condition reports be categorized according to guidance provided in Addendum 2 to the procedure. Addendum 2 contains a clear description of each condition level and specific examples of problems for each level. The ART reviewed the new procedure and determined that it provides adequate guidance for problem identification and resolution.

4.3.3 Conclusion

This allegation was substantiated. Many SPRs were miscategorized, as identified by the licensee's QA Surveillance Report 94-002 and the NRC ORAT Inspection Report 93-202. However, the conclusion of IR 94-20 indicated that the licensee's corrective action was effective. Furthermore, the licensee eliminated the SPR process in October 1994 and now uses a condition reporting procedure to handle future station problems. This item is closed.

4.3.4 Recommended Actions

The effectiveness of the newly issued "Condition Reporting Procedure" has not been established. NRC should conduct a future inspection to evaluate the implementation of the new procedure and to assess the effectiveness of the corrective action program.

4.4 Modifications

4.4.1 Characterization of Allegation

It was alleged that the licensee performed large modifications in sections through the plant change form process. In this way it did not have to get the funding authorized; it also avoided safety reviews required of large modifications. The alleger was concerned that this method would not have the safety review and configuration control required for a larger modification. It was alleged that this practice was still occurring at the time of the interview with the alleger.

A similar concern was submitted to the NRC in early 1992. Although it was mentioned in a list of alleger concerns, it somehow was not included in the allegation close-out package.

4.4.2 Details

According to the alleger, the plant change form process is designed for small, limited-scope modifications. The alleger stated that, rather than doing a large modification, the work would be done piecemeal through the plant change form process and service requests. In some cases, a 10 CFR 50.59 evaluation was not performed on these service requests and an SPR would be written up later.

The ART reviewed plant procedure OPGP04-ZE-0310 "Plant Modification," Revision 2, dated October 17, 1994. This procedure describes the requirements for major versus minor modifications. Priority 1, 2, and 3 requests (major modifications) require that an economic evaluation be performed. Any modification with an estimated cost of less than $40,000 is considered a minor modification and a final economic screening may be bypassed. Both major and minor modifications are performed under the Design Change Implementation Procedure (OPGP04-ZE-0309) and the Work Process Program Procedure (OGP03-2A-0090). Therefore, the safety-related reviews which ensure configuration control are required regardless of whether a modification is classified as major or minor. The only added requirement for a major modification is the economic evaluation. The team was aware of no instances in which a modification was performed through several separate plant change forms. However, even if substantiated, this would not relieve the licensee from the requirement to perform a safety evaluation, and the avoidance of a funding authorization would not be a safety concern.

The NRC reviewed the modification process during the IATI in August 1994. The IATI reviewed the plant change form process, open plant change forms and 10 CFR 50.59 evaluations, and design change packages prepared in accordance with the plant modification procedure. The IATI inspectors found a weakness with the plant change form (PCF) process and issued a violation (9425-03). The IATI found three cases in which the licensee performed minor design changes designated as rework under the plant change form in which a screening

was not performed to determine if an unreviewed safety question evaluation was required. The inspectors noted that the licensee's previous corrective actions to address weaknesses in the PCF process did not identify this issue.

On October 27, 1994, the licensee responded to the Notice of Violation (NOV), stating that it had improperly dispositioned PCFs as rework, which does not require a 10 CFR 50.59 evaluation. As a corrective action, the licensee reviewed the PCF database (consisting of approximately 1037 PCFs) and identified 46 PCFs that resulted in physical changes and were misclassified as rework. The licensee subsequently performed a 10 CFR 50.59 evaluation for each PCF and found that no unreviewed safety question evaluations were necessary. In addition, the licensee distributed a bulletin to engineering personnel and committed to provide training on the requirements for 10 CFR 50.59 evaluations by December 15, 1994. By letter dated November 18, 1994, the NRC stated that it found the licensee's response to the violation responsive to the concerns, and that it would review implementation of the corrective actions during a future inspection.

4.4.3 Conclusion

This allegation was not substantiated. Although the allegation that modifications were performed piecemeal was not substantiated, previous NRC inspections had found weaknesses with the modification process. The NRC's review in August 1994 found that the licensee did not have a good understanding of the purpose of the safety evaluation and did not always perform evaluations when required. However, based on the licensee's corrective actions, the ART concluded that a safety concern does not exist. This item is closed.

4.4.4 Recommended Action

The NRC should perform an inspection of the licensee's 10 CFR 50.59 program during the current SALP cycle.

4.5 Steam Generators

4.5.1 Inadequate Welding Procedure on Steam Generator Plug Repair

4.5.1.1 Characterization of Allegation

It was alleged that in early 1994 the licensee performed a steam generator plug weld using an inadequate welding procedure.

4.5.1.2 Details

In February 1994, a mechanical plug was found to be leaking in steam generator 1C. On the evening of March 9, 1994, during the preparations to weld a tube sheet plug, it was identified that the B&W Nuclear Service Company (B&W, the contractor) welding procedure 51-1205396-01, which was to be used to perform the weld, referenced a superseded document. SPR 940636 was initiated to address this problem. Houston Lighting & Power Company management made a decision to proceed with the welding and address what they considered an administrative problem on the next morning. On March 9, 1994, B&W issued a design change notice, DCN 1229246-00, to supersede B&W procedure WPN-7 with B&W procedure SPP-2, which is B&W's General Procedure for Arc Welding.

The final HL&P corrective actions were to revise the B&W procedure to reference the correct document (SPP-2) and to revise the South Texas Electric Generating Station Welding Program (OPGP04-ZA-0310, Revision 1 dated August 17, 1994) to clarify the requirements for reviewing and approving contractors' documents. Section 4.3.1.2 of the STP welding program clearly states that the contractor's welding procedure specifications and supporting procedure qualification records shall be submitted for review and comparison to Codes and Standards prior to the performance of any welding.

The ART reviewed B&W's DCN 1229246-00, dated March 9, 1994, which stated, "WPN-7 had been revised and is now SPP-2." The ART also reviewed both procedures and found that the new procedure (SPP-2) appears to contain most information of the old procedure (WPN-7), as well as new clarifying details, and is technically equivalent to WNP-7. The ART concluded that the use of WPN-7 would not impact the quality of the welding performed.

4.5.1.3 Conclusion

This allegation was not substantiated. The licensee used a procedure which referenced a superseded document. However, the reference to the superseded document did not affect the adequacy of the procedure or the quality of work performed under that procedure. This item is closed.

4.5.1.4 Recommended Action

None.

4.5.2 Steam Generator Tubes Were Not All Inspected as Planned

4.5.2.1 Characterization of Allegation

It was alleged that the STP steam generator tubes were not 100 percent examined, as planned during the 1993 outages, and that the licensee provided false information when it told the NRC that the tubes were 100 percent examined.

4.5.2.2 Details

The licensee examined the steam generator tubes during the Unit 1 outage between September and October 1993. The Unit 2 steam generators were examined between February and December 1993. The licensee, on two occasions, verbally informed the NRC that 100 percent of the inservice tubes were bobbin-examined. The first occasion was on December 13, 1993, to the Office of Nuclear Reactor Regulation licensing staff; the second occasion was on April 19, 1994, to the Director of NRR during his visit to STP. The licensee later submitted the written results of the examinations to the NRC to fulfill technical specification (TS) requirements. These were submitted with HL&P letters ST-HL-AE-4894 (dated October 4, 1994) and ST-HL-AE-4872 (dated August 29, 1994) for Units 1 and 2, respectively. The reports are required per Sections 4.4.5.5 (b) and 6.9.2 of the STP TS.

The licensee stated in the reports that each generator contains a total of 4864 tubes. The inservice inspection examines the tubes that are in service at the time of the examination. The number of inservice tubes examined for each steam generator are listed as follows:

Unit	Steam Generator	Number of Tubes Examined
1	A	4861
	B	4860
	C	4861
	D	4844
2	A	4848
	B	4851
	C	4842
	D	4848

On page 2-5 of the Unit 1 Report, entitled "Report of the Summer 1993 and March 1994 Testing of the Steam Generator Tubes of the South Texas Project Electric Generating Station - Unit 1", the licensee stated, "All in-service tubes in each of Steam Generators A, B, and C were examined by the bobbin coil method. Nearly all in-service tubes in Steam Generator D were also examined full length by the bobbin coil method, except for fifteen tubes. Steam Generator D tube 40-17 was examined from the upper most tube support plate...". Thus, fourteen tubes in Steam Generator D were left unexamined.

An SPR was initiated on March 9, 1994 to report the findings of a B&W nonconformance report. B&W Nonconformance Report (NCR) #94-00187 stated that, due to error of recording, 14 tubes in steam generator D of Unit 1 were not examined as indicated in the report. Table 4.4-1 of the STP TS requires that 3*N percent of the tubes be inspected during IST, where N is the number of steam generators. A 100 percent examination is not required by the TS. The total number of inservice tubes in Steam Generator 1D is listed as 4844. Fourteen tubes out of 4844 is an insignificant percentage and will not invalidate the operability of the steam generator.

4.5.2.3 Conclusion

This allegation was substantiated based on the fact that the licensee verbally communicated to the NRC that 100 percent of the tubes were examined. However, the licensee stated, in its written report dated October 4, 1994, that fourteen inservice tubes in Steam Generator 1D were not examined. The licensee submitted these written reports within the 12 months required by Section 4.4.5.5 of the STP TS; therefore, no regulation was violated. The staff concluded there are no operability or safety concerns. This item is closed.

4.5.2.4 Recommended Action

None.

4.6 Polar Crane

4.6.1 Neglected Polar Crane Maintenance

4.6.1.1 Characterization of Allegation

It was alleged that, in early 1992, maintenance was neglected on the polar crane in order to get the outage back on schedule.

4.6.1.2 Details

An SPR was generated on September 1, 1992, describing a concern that certain preventive maintenance (PM) activities had not been performed on the polar crane in accordance with procedure during the previous refueling outages for Units 1 and 2. Sections 6.1.4 of Plant Procedure OPMP02-ZG-0003, "Inspection and Maintenance for Cranes, Hoists, Monorail Systems and Lifting Devices," Revision 6 required that the yearly inspections and lubrication be performed in accordance with the preventive maintenance program. During the 1992 refueling outage, planned outage activities were in conflict with the procedurally required preventive maintenance. Therefore, the licensee revised the procedure to resolve the schedule conflicts. Revision 8 to OPMP02-ZG-0003 still requires that standby cranes be inspected prior to being placed into service. However, the procedure allows reactor containment building standby crane preventive maintenance to be performed prior to plant heat-up at the completion of the outage.

In response to Generic Letter 81-07, "Control of Heavy Loads," HL&P stated that all preventive and corrective maintenance on overhead cranes handling heavy loads will be performed using procedures that invoke ANSI B30-2-1976, Chapter 2-2. This standard specifies that inspections shall be conducted prior to use of the crane. The revised procedure is in accordance with the ANSI standard because inspections are still performed prior to use but preventive maintenance is deferred. The ANSI standard does not specify time constraints for PMs. In addition, the PMs required by OPMP02-ZG-0003 are not required by technical specifications. Therefore, deferral of preventive maintenance is not a regulatory concern.

The ART reviewed all SPRs relating to the polar crane from the years 1991 to the present and found no reports of problems with the polar crane that could be attributed to neglected or ineffective maintenance.

4.6.1.3 Conclusion

This allegation was substantiated. However, the licensee determined that the deferral of preventive maintenance did not affect the operability of the crane, and revised its procedures to schedule the PMs at a more convenient time in the outage. While this was a violation of the licensee's procedures at the time, it is not a safety issue. This item is closed.

4.6.1.4 Recommended Action

The licensee's failure to follow its procedures in this case appears to be a violation of NRC regulations. The NRC staff will determine whether a violation occurred. In view of the fact that the licensee identified the potential violation and took corrective action, this matter could potentially be closed out with a non-cited violation in accordance with the Enforcement Policy.

4.6.2 Draft Report of Polar Crane Problems

4.6.2.1 Characterization of Allegation

It was alleged that the licensee would not publish a report on polar crane problems which was drafted in June 1994.

The ART interviewed two allegers who provided additional information as indicated below.

4.6.2.2 Details

The ART reviewed the draft report dated June 10, 1994. The report discusses two separate problems which occurred on the unit 2 polar crane: (1) recurring polar crane rail gap problems caused by lateral movement between adjacent rail sections, and (2) a recent event in which the orbital service bridge truck struck its own power supply and an event in which the truck wheels nearly left the polar crane rail.

The first problem is attributed to the inherent design of the crane that allows for movement during a design basis accident. The report states that the licensee's corrective action was to make a design change that increased the allowable gap from 1/8" to 5/8". The report recommended that rail clamps be installed at the midpoint of each rail to preclude lateral movement. The ART determined that this is not a safety concern and that the licensee's corrective actions were appropriate.

The second problem was discovered during an event on February 2, 1994, when the orbital service bridge truck struck one of its power supply masts feeding its busses. On February 5, 1994, the bridge truck wheels had nearly left the polar crane rail. The report states that, had the truck wheels left the polar crane rail, loss of power to the polar crane could have resulted. If this had occurred while the crane was transporting a load, this could have led to a dropped load accident. The report attributes these problems to the design of the bridge truck.

An SPR was initiated to address both events. The licensee determined that the cause of the events was that the polar crane brakes were not adjusted properly and sudden stops and starts of the crane would jar the polar crane and orbital bridge. The crane vendor stated that the braking problems could affect orbital bridge tracking.

On March 21, 1994, the licensee inspected and adjusted the orbital bridge brakes and polar crane brakes. After completion of these actions, the licensee determined that the orbital bridge brakes and polar crane brakes were operating properly and that there was no rubbing of the supports in the areas of concern. As a further corrective action, the licensee committed to revise OPMP04-JC-0002, "Polar Crane Inspection," to include steps to properly adjust the polar crane brakes. In addition, a plant change form was initiated. This PCF is an approved design change to modify the supports in the future if rubbing of the supports reoccurs, since the clearance between the supports is

still small and future perturbation could cause support rubbing. The report summary stated that the reliability of the orbital service bridge design was enhanced and its reliability increased by the corrective actions.

The report states that the recommendations were made to enhance the maintainability of the crane rail and enhance the tractability of the orbital device bridge truck. The report states that the problems discussed had been addressed by the licensee and the design and reliability had been enhanced. The ART reviewed the licensee's corrective actions and found that the actions are adequate to address the potential safety issues.

The allegers stated that the subject report had been in draft for approximately one year due to revisions indicating to the alleger that the licensee was attempting to suppress the report. The ART found no evidence that the licensee was attempting to suppress the report. One of the allegers stated that some programmatic and engineering recommendations in the report had been addressed and the others would be addressed shortly. Apparently, as a result of a 10 CFR Part 21 report from Whiting Corporation (the crane vendor) dated March 2, 1994, HL&P has focused attention on maintenance of the crane, including establishing a crane coordinator.

The allegers also questioned whether the crane vendor, Whiting Corporation, had done an inspection of the crane. The ART reviewed the results of the most recent inspection of the cranes. An inspection of the Unit 1 crane was performed in June 1993, the Unit 2 inspection was performed in March 1993. Vendor representatives were present at both inspections.

4.6.2.3 Conclusion

This allegation was not substantiated. The licensee's corrective actions, as documented in the SPRs, are adequate to resolve any safety concerns. This item is closed.

4.6.2.4 Recommended Action

None.

4.7 Diesel Generators

4.7.1 Diesel Generator Piston Tin Transfer

4.7.1.1 Characterization of Allegation

It was alleged that the following problems existed with the diesel generators at STP following the March 1994 diesel generator (DG) 22 piston failure:

- The licensee's corrective actions relative to a standby diesel generator piston failure had not been effective.
- The licensee had ignored recommendations for corrective actions proposed in a draft HL&P report entitled, "Assessment of Standby Diesel Generator Corrective Actions for Piston Tin Transfer."

4.7.1.2 Details

This allegation was based on a draft report which was provided to the ART by the alleger. The NRC staff has conducted a detailed review of the report and, based on this review, concluded that the allegation could not be substantiated. The following is the staff's evaluation of the draft report.

4.7.1.2.1 Piston Failure Corrective Actions

During the scheduled 18-month surveillance of diesel generator 22 in March 1994, the piston in cylinder number 4R was found to be broken in the lower skirt area. The author of the draft report disagreed with the licensee's corrective actions because he believed that the root cause of the failure was flawed and, therefore, the corrective actions could not address the real problem. The staff reviewed the licensee's corrective actions and concluded that the actions were, and continue to be, effective. The corrective actions taken included a thorough root cause analysis, replacement of the affected piston and cylinder liner, inspection of other engine components to verify the absence of collateral damage, and verifying that the engine block out-of-round condition was not adversely impacting operation of the 4R piston and cylinder. Post-maintenance testing and subsequent surveillance testing provided assurance that the standby diesel generator functions properly.

This portion of the allegation might have been influenced by an apparent misconception regarding the root cause of the piston failure. In a vendor report to the licensee dated March 28, 1994, regarding the 4R piston failure, Cooper Energy Services identified the root cause of the failure, in paragraph 6.7, as foreign material "...trapped above the oil ring during the assembly process." In Section 4.0 of the draft report, the author postulates that foreign matter large enough to have caused the piston failure could not have been introduced into the No. 4R cylinder via the SDG lube oil system and, therefore, the root cause analysis was flawed. Although the staff agreed with the alleger on this point, it had never been postulated by the vendor or the NRC that the foreign material entered the cylinder in this manner. The draft report also stated that any foreign matter would have to be similar to silicon

or tungsten carbide in order to cause the damage that occurred; because such material was not found, the foreign matter theory was further flawed. The staff disagreed with this concept. Sufficient operating experience was available to the NRC and the vendor which demonstrated that almost any foreign matter, if large enough to disrupt an oil film, could cause catastrophic component or engine failure.

The NRC reviewed HL&P's corrective actions to resolve the piston failure and was satisfied with the planned corrective actions. Inspection report 94-16 concluded that the videoscopic inspection and dimensional inspections of the cylinders should advise of any degradation to the engine. The NRC closed this issue based on the licensee's commitments to perform these inspections.

In summary, the staff concluded that the root cause of the 4R piston failure in SDG 22 was foreign matter as discussed above, that the corrective actions taken by the licensee were appropriate for the circumstances, and that these corrective actions had been effective. Therefore, this portion of the allegation is not substantiated.

4.7.1.2.2 Recommendations

The second portion of this allegation involves the alleger's concern that the licensee has ignored corrective actions recommended in Section 10 of the draft report. In a limited sense, this part of the allegation is substantiated because the licensee has not implemented the recommendations in the report. The following discussion addresses each recommendation and the staff's evaluation.

4.7.1.2.2.1 Upper Cylinder Lubrication

The report recommends that the licensee (1) augment upper cylinder lubrication by drilling a passage between the piston pin cavity and the No. 7 oil control ring land (groove), (2) provide oil spray nozzles and headers to augment cylinder liner lubrication, (3) delete the No. 5 oil control ring, and (4) reconfigure the KSV piston to have a piston-to-cylinder liner clearance of 0.010 inches at normal operating temperatures.

Recommendation (1) is based on a misconception that the KSV engines have an upper cylinder lubrication problem. A lack of sufficient upper cylinder lubrication has not been identified as a problem in either the piston failure problem or the generic tin transfer problems. The design of the KSV lubrication system is not an issue with respect to the No. 4R piston failure. With respect to the tin transfer issue, the root cause has been determined to involve excessive compression pressures during SDG start and initial phases of fast loading. The problem of excessive pressures is magnified by the draindown of lubricating oil from cylinder walls over the 30 day period between surveillance testing. The recommendation did not address this problem because the No. 7 oil ring land is at the lower end of the piston and would not provide lubrication in the area of concern at the time of concern; i.e., the initial piston movement when the SDG is started. In addition, the piston pin is approximately one inch above the No. 7 oil ring land, and removal of

the piston end caps will allow lube oil to flow into the cylinder and down into the No. 7 oil ring land. It is doubtful that this recommendation, if implemented, would provide any measurable benefit. This conclusion is based on the fact that the dynamics of an operating engine would preclude oil drainage down through the drilled passages. Finally, the recommendation is incomplete because it does not address the impact that the holes would have on piston structural integrity.

Part (2) of this recommendation is apparently based on a statement in another section of the report which states, "Large engines seldom rely on lubricant spray from the connecting rod journals to provide all the cylinder lubrication as is the case with the C-B KSV engines." The staff is not aware of any four stroke diesel engines in nuclear service that utilize any other method for cylinder lubrication. In addition, the recommended spray nozzles and header would only function with the SDG running, and would not be effective when needed most during engine startup. It should be noted that the adequacy of the KSV lubrication system to lubricate the cylinder walls during normal operation of the engine has not been questioned. As stated above, the primary lubrication concern is associated with oil draindown over the 30 days between surveillance contributing to a problem when the engines are initially started.

Part (3) of this recommendation does not contain a technical justification pertaining to potential benefits that would accrue from deleting the No. 5 oil control ring. The absence of drain holes behind this oil control ring has been part of the KSV piston design since 1957, and is a common design feature of other C-B engines. The staff is of the opinion that this oil control ring is designed to provide adequate lubrication for the compression rings above it without having excessive oil consumption. Removal of this oil control ring would lead to excessive oil consumption as a minimum, and possible inadequate lubrication for the compression. Based on the absence of technical justification and considering that the vendor has found this design to be acceptable for over 30 years, the staff considers the recommendation to delete the No. 5 oil control ring to be without merit.

Part (4) recommends reconfiguring the KSV pistons so that the entire piston would have a 0.010 inch cylinder wall clearance at operating temperatures. This is a reference to the fact that the KSV pistons have a slightly concave (hourglass) configuration at standby conditions, which expands to a slightly convex (barrel) configuration when the piston is at operating temperature. The recommendation envisions an ideal condition in which the piston is perfectly cylindrical at operating temperatures. Even if this could be achieved, it would be of no benefit in dealing with the tin transfer problem. The piston would still take on the convex configuration, which results in a converging attitude relative to the cylinder walls during engine startup. This is because the mass of metal in the piston varies as a function of location in the piston which, in turn, results in different expansion and contraction values over the entire piston. This difference in metal mass is necessary for the piston to function. The recommendation does not address this issue, which the staff considers to be an inherent design limitation. Therefore, the staff considers the recommendation to be without merit.

4.7.1.2.2.2 Compliance with Cooper-Bessemer Bulletin #752

The report recommends that the licensee determine how many of the SDG cylinders at STP have been modified to remove the No. 7 oil control ring and piston pin end caps, and compare the findings with the status of all cylinders as detailed in MPR Associates, Inc. Report MPR-1475, "South Texas Project Emergency Diesel Generator Number 22 Piston Failure Trip Report," dated May 1994. The recommendation does not include a discussion of the purpose this activity will serve. However, the staff has assurance that the current physical condition and modification status is known for all SDG cylinders at STP.

4.7.1.2.2.3 Lubrication Oil Data Analysis

The report recommends that the licensee establish alarm parameters for wear particles in the lube oil identified through lube oil analysis. The report recommends these parameters reflect the C-B Owners Group recommendations. However, the report, including all attachments, does not include any information regarding C-B Owners Group recommendations relative to wear particle concentration. Without specific references, the staff cannot determine whether or not this recommendation has merit. The staff is aware that the licensee has implemented procedures to perform additional SDG inspections if wear particle concentration reaches a level greater than 7 ppm. This is more conservative than the licensee's previous criteria of 50 ppm and should provide for timely corrective action if the particle concentration increases.

4.7.1.2.2.4 Adequacy of Piston Temperature Control

The report recommends that the licensee saw the piston head off some KSV pistons that have been removed from service at the No. 5 oil ring and inspect the underside of the piston head for deposits that may confirm or deny the adequacy of the coolant in this area. The staff is not aware of any concerns being raised regarding the adequacy of KSV piston cooling for any reason, including the 4R piston failure and the generic tin transfer issue. None of the attachments to the report mention this issue. In addition, the body of the report does not provide any details on why KSV piston cooling is thought to be a problem. In light of this, the staff considers this recommendation to be without merit.

4.7.1.2.3 Generic Questions

The report raises four questions regarding symptoms of tin transfer, scratches, scuffing, piston ring wear, and poor service life. The first three questions deal with metal transfer, ring wear, and oil quality. These questions were raised subsequent to several crankcase overpressure events at the Susquehanna Steam Electric Station, prior to any detailed investigation of the events. These three questions have all been adequately answered in one or more reports regarding the tin transfer problem, produced by Cooper-Bessemer, MPR Associates, and/or Ricardo Consulting Engineers, Ltd.

The fourth question addresses "...indications of high temperature such as vaporized oil, carbon deposits, discoloration, vaporized tin, etc." Taken in order, vaporized oil is mentioned briefly on page 34 of the Ricardo Consulting Engineers, Ltd., Report No. DP91/1245, dated September 1991. This brief mention is in the context of crankcase vapors being ignited. The presence of oil vapors in the crankcase of an internal combustion engine is the result of lubricating oil being heated during operation, and is a completely normal condition. Carbon deposits were also mentioned briefly on pages 2 through 10 of MPR Associates, Inc. Report MPR-1309, dated September 1992. Carbon deposits are mentioned as a cause of frozen or stuck compression rings which were considered and then dismissed as a potential cause of tin transfer. The causes of carbon deposits behind compression rings are thoroughly understood by the NRC and the industry. The presence or absence of carbon deposits is completely unrelated to the No. 4R piston failure or the generic tin transfer problem. Discoloration of various SDG parts is addressed a number of times in attachments to the report. Some examples of parts which were discolored are piston pins, piston pin bushings, cylinder liners, and pistons. This discoloration is a direct result of the high heat created during the piston failure or crankcase overpressurization event. Under these conditions, the presence of discoloration is thoroughly understood and is to be expected. Discoloration is an effect that may be associated with events such as No. 4R piston failure or the generic tin transfer problem, but is not the cause of either; further investigation of discoloration is thus not warranted. With respect to "vaporized tin," the staff does not know the origin of this item. None of the report attachments mention "vaporized tin," and the staff has not heard the term used in connection with either the No. 4R piston failure or the generic tin transfer problem. In light of this, the staff concludes that this issue does not warrant further investigation.

4.7.1.3 Conclusion

This allegation was not substantiated. The staff has concluded that the licensee's corrective actions relative to a SDG piston failure have been effective. With regard to the recommendations in the draft report, the staff has concluded that the recommendations would not provide a significant safety benefit. This item is closed.

4.7.1.4 Recommended Action

None.

4.7.2 Diesel Generator Fuel Pump Hold Down Studs

4.7.2.1 Characterization of Allegation

It was alleged that the hollow hold down studs for the diesel generator 22 fuel injection pump may not have been tested to determine breaking strength after they failed in April 1994. Allegedly, the studs were kept in an impound area in the office and were not removed for testing.

4.7.2.2 Details

On April 14, 1994, diesel generator 22 was declared inoperable because four hold down studs on the fuel injector pump were sheared off at the base plate. The NRC had been aware of previous hold down stud failures. Section 2.2.1 of the DET Report, issued June 10, 1993, noted that SDG injection pump hold down studs had failed on nine separate occasions. The team found that "The root cause analysis was shallow and corrective actions were insufficient to preclude recurrence. The licensee did not perform a more detailed analysis of the stud failures until the team became involved." Based on the number of failures of these studs, the licensee decided to replace the hollow studs with solid studs after the April 1994 incident.

The ART did not substantiate the location in which the removed studs had been stored. However, the NRC had reviewed the licensee's analysis and calculations relating to the root cause of the April 1994 stud failure in the course of inspection as documented in IR 94-16. There is no evidence to indicate that the licensee did not perform a metallurgical examination as indicated. In addition, the alleger provided a copy of the licensee's metallurgical report. The ART does not consider this an issue because the licensee replaced all of the hollow studs with solid studs in 1994. The NRC reviewed the licensee's analysis of the hollow stud and solid stud designs in IR 94-16, and determined that the solid stud design offered a wider margin of safety.

4.7.2.3 Conclusion

This allegation was not substantiated. In addition, because the licensee replaced all of the hollow studs with solid studs, this is no longer a concern. This item is closed.

4.7.2.4 Recommended Action

None.

4.8 Valves

4.8.1 Valves Installed Backwards

4.8.1.1 Characterization of Allegation

It was alleged that a plant trip during startup from the 1991 outage was caused by valves that were installed backwards in secondary systems.

4.8.1.2 Details

No specific details were given by the alleger to indicate which valves in which system were installed backwards. The ART reviewed all licensee event reports (LERs) which discussed plant trips in 1991 and 1992 and found no instance in which the cause of a plant trip involved valves installed backwards in secondary systems.

During the review of documentation, the ART discovered one incident in which valves were installed backwards. An SPR was initiated on January 7, 1993, to document several drain valves (non-safety related) that appeared to be installed backwards. On May 3, 1993, the licensee removed valve N2MTFV7977 from Unit 2 and found that it was installed with the flow arrows in direct conflict to the installed configuration. This was documented in PCF 146934-A (superseded by PCF 146934-B on March 16, 1994). The valve was installed with the flow going under the valve seat; the vendor drawing indicated that the flow should go over the seat. The valve in question is in the condensate system. It functions to permit condensate drainage to the main condenser and does not serve a safety function. The installed configuration required flow to open the valve. These valves were designed "flow to close." In the installed configuration, the pneumatic operators did not exert enough force to prevent leakage and contributed to main steam leakage during startup.

The SPR indicated that a total of 27 identical valves in the plant were installed with flow under the seat. These valves included all Unit 1 and 2 moisture separator reheater tube bundle drain valves, all Unit 1 and 2 extraction steam to high pressure feedwater heater drain valves, and Unit 1 above seat main steam isolation valve drains. Service requests were generated in June 1993 to cut out and rotate the valves to the design configuration. All service requests were completed by June 24, 1994.

The reason for the delay of approximately a year from the time the situation was identified until the change was made was because the licensee originally believed that the installed configuration was more suitable for plant conditions. The valves had been installed with flow under the seat, per Bechtel request during construction. Bechtel believed that orienting the valve with flow over the seat would subject the valve packing to high pressure, which would damage the seat.

This condition has existed since construction, and it is possible that these valves may have leaked during startups since construction. However, it is unlikely that it could have contributed to a plant trip.

NUREG-1306 also addressed an allegation that 20 percent of the valves were installed backwards. The SSAT inspected 70 valve installations in various systems and, based on this sample, did not substantiate the allegation. NUREG-1306, Section 5.2.1.3, stated, "...the SSAT found no evidence that valves were installed backwards at STP, Unit 1."

A manual trip of Unit 1 occurred on February 28, 1994, due to a leaking feedwater regulating valve. The ART reviewed LER 94-009 and found that this leaking valve was not installed backwards.

4.8.1.3 Conclusion

This allegation was not substantiated. The ART found one instance in which valves were installed backwards, but the installation would not cause a plant trip. The licensee had reinstalled the valves in the correct configuration. This item is closed.

4.8.1.4 Recommended Action

None.

4.8.2 Valves Were Repeatedly Reworked

4.8.2.1 Characterization of Allegation

It was alleged that during 1991 some valves were repeatedly repaired after they were supposedly fixed the first time. The alleger was concerned that there were deficiencies with the maintenance practices, installation process, or design that required repeat maintenance. In addition, the interview with the alleger indicated that inadequate verification and documentation of repairs contributed to the problem.

4.8.2.2 Details

No specific details were provided by the alleger. The ART found that recurring valve deficiencies has been a continuing problem, as evidenced by the findings of several NRC inspection reports.

IR 92-26, issued October 16, 1992, documented a leaking motor-operated valve (MOV) that had been repeatedly repaired. The valve was originally identified as leaking on September 6, 1991. Repair work was not performed until April 1992. Repeated repairs were done in June 1992 and September 1992.

In December 1992, the NRC reviewed an SPR related to MOVs as noted in IR 92-35, issued February 24, 1993. The inspectors reviewed MOV maintenance activities that had been performed during the second refueling outage for Unit 2 and the third refueling outage for Unit 1. They found that for two safety-related MOVs, repetitive problems were not resolved for two or more years. The inspectors declared this an unresolved item. This was one of several examples which indicated that the corrective action program was not effectively implemented, resulting in repetitive problems. Four examples of failure to take adequate corrective action were cited as a Severity Level IV violation.

In early 1993, the NRC inspected a February 9, 1993, event in which valve SI-31A (A2SIMOV0031A) failed to open on demand from the control room. The results of this inspection are documented in IR 93-08. The same valve had failed before under what may have been identical circumstances in April 1989 and had other failures in July and August, 1988 (LER 93-006-00). The NRC issued a Notice of Violation (9308-02) on April 19, 1993 for failure to acceptably investigate the April 1989 failure of this valve. During the enforcement conference held on March 25, 1993, the licensee committed to "...trend equipment history to identify repetitive component degradation and failures and to take corrective action to prevent recurrence." The licensee committed to have the plan developed by June 17, 1993, and to complete implementation by March 31, 1994.

Inspection Report 93-13, dated April 23, 1993, addressed the results of an NRC inspection of the licensee's maintenance activities on MOVs. In particular, Section 1.2 of the report discussed repetitive MOV maintenance activities. The report stated that maintenance work histories of 30 MOVs within the scope of Generic Letter 89-10, for the time period from 1989 to 1993, were selected

for review. Of those 30 MOVs, 11 required maintenance to be performed at least one additional time. The inspector noted that, although the symptoms were always addressed, the cause of the problem was not always found.

The DET identified a similar concern with inadequate corrective actions for all maintenance activities. The DET report, issued June 10, 1993, identified that poor root cause analysis, poor prioritization of work, and poor craft performance resulted in ineffective or untimely resolution of equipment problems. For example, in Section 2.3.1, the report indicated that widespread, longstanding problems with the application and performance of Target Rock solenoid-operated valves were not resolved. Multiple LERs involving wear, aging, debris, contamination, and valve misapplication had occurred since 1990. Previous corrective actions did not prevent additional failures. The DET also concluded that large engineering backlogs and ineffective use of site operational experience led to repetitive equipment failures. Inaccurate information databases and a limited number of computers for system-level trending made it difficult for the licensee to identify negative trends. In a supplement to the confirmatory action letter dated May 7, 1993, the NRC required the licensee to address "...management effectiveness in identifying, pursuing, and correcting plant problems..." prior to restarting either unit.

IR 94-31 (issued October 20, 1994) documented the NRC inspection of the equipment history program as a follow-up to a concern identified during the DET inspection. The DET had identified that the equipment maintenance history database was not accurate or current. The licensee revised the program and completed implementation of a revised equipment history program in August 1993. During the NRC inspection in September 1994, the inspectors found that the plant engineering staff had been increased to perform data entry, review, analysis, and trending. The inspector reviewed selected data bases and found that all required equipment history was stored in the plant computer system. The inspector concluded that the licensee's actions were adequate to close out this concern.

The ART reviewed the licensee's "MOV Tracking and Trending Program" (OPEP07-ZE-0007 Rev. 2) dated June 1, 1994. This procedure describes the methods by which MOVs requiring frequent and repeated maintenance are identified so that actions can be taken to remedy all detectable generic problems. The program involves use of a tracking and trending database which includes the MOV database, the MOV maintenance history database, and the diagnostic database. The procedure requires that a trend investigation be performed whenever an adverse maintenance or test result trend is identified. The ART discussed this program with licensee personnel. The licensee stated that this program is actually a compilation of several programs that were in existence previously, such as the equipment history program, to specifically address MOVs.

The NRC conducted an inspection of the licensee's MOV testing and surveillance program in October 1994 (documented in IR 94-32). As part of this inspection, the inspectors reviewed the MOV trending program and observed a demonstration of the licensee's trending software. The inspectors found that the licensee's

trending program had not yet matured to provide meaningful information for the purpose of maintaining design basis capability. Also, the licensee did not trend anomalies in valve behavior. In response to the inspector's concerns, the licensee revised its trending procedure to establish bounds for expected variations in valve performance and to include anomalies as trended parameters. The licensee stated that enhancements would be made to its trending program as more industry guidance develops in this area and as additional data is obtained during periodic testing. The inspectors found the trending program, as revised, to be acceptable for closure of the staff's review of the GL 89-10 program.

4.8.2.3 Conclusions

This allegation was substantiated. However, the licensee has implemented an acceptable program to trend equipment history and identify repetitive failure and degradation. Therefore, this item is closed.

4.8.2.4 Recommended Action

None.

4.8.3 Valve Packing Procedures Were Not Followed

4.8.3.1 Characterization of Allegation

It was alleged that, during the 1991 outage, a maintenance contractor (NNI) did not use the correct valve packing procedure to perform the maintenance work.

The allegation was previously submitted to the NRC in early 1992, as discussed below.

4.8.3.2 Details

Station Procedure OPMP02-ZG-0011, "Alternate Valve Packing and Live-Load Valve Packing," was the procedure that should have been used to perform this maintenance work. During the 1991 outage, NNI was using Procedure OPMP04-ZG-0003, "Valve Packing" and Specification SL749T51018, "Alternate Valve Packing and Live-Load Valve Packing," to perform valve maintenance work. The Individual Valve Survey Sheet (IVSS) contained in the specification was used instead of the Valve Packing Data Sheet (VPDS) Addendum 1 of OPMP-ZG-0011. Request for Action (RFA) 91-1495, dated October 4, 1991, requested approval to use the IVSS in lieu of the VPDS. RFA 91-1852 was written on November 9, 1991, to readdress the use of VPDS and IVSS.

In early 1992, the NRC received an allegation that "Procedure OZG003 for valves cannot be used for Live Load Procedure OZG0011." Region IV closed this allegation in November 1992 and concluded that this allegation was partially substantiated because there was a problem with contract maintenance during the 1991 refueling. However, the licensee had identified the issue and corrected the hardware problems. The NRC determined that the SPRs that were generated were an appropriate method of addressing problems encountered with generic station procedures. The allegation closure recommended further inspection to determine the disposition of valves identified as being unable to be packed with OZG003.

IR 92-27, issued on September 15, 1992, identified that the contract maintenance group had repacked 34 non-safety-related valves using an incorrect procedure. When the problem was discovered, the licensee inspected the affected valves for hardware problems and corrected any noted problems. The licensee found that only two of the valves required rework. The work packages were required to be upgraded to incorporate the appropriate valve packing data forms. The licensee also revised the controlling repacking procedures to eliminate confusion. The NRC inspector verified that the licensee took the appropriate corrective actions.

The ART reviewed both the VPDS and IVSS for a 1" globe valve (3Q152XSD002A) attached to RFA 91-1495 and found that the two forms reference each other. The IVSS referenced Procedure OPMP02-ZG-0011, on the IPDS, the words "see attached survey sheet" were written. Both sheets contain roughly identical information.

The ART interviewed the licensee staff from the mechanical maintenance department and was told that the IVSS was a vendor-generated form. When STP received the vendor documentation, it transferred all information to the VPDS, which was an STP form. The ART reviewed the IVSS and IPDS of several valves and found that they appeared to contain the same information. The licensee also told the ART that a new form was created to resolve this deficiency. The new form, created by the computer, is called "Journeyman Worksheet" and will be the official record for repacking valves.

4.8.3.3 Conclusion

This allegation was substantiated. However, the licensee took appropriate corrective action and created a new form to be the official record for repacking valves. This item is closed.

4.8.3.4 Recommended Action

None.

4.8.4 Valve Lineup Was Not Verified

4.8.4.1 Characterization of Allegation

It was alleged that, during openings of the auxiliary feedwater storage tank #C valve pit in March 1994, a valve lineup was not performed as required by STP procedures.

4.8.4.2 Details

On March 22, 1994, the licensee's maintenance personnel entered the auxiliary feedwater storage tank (AFWST) # C valve pit to repair a light fixture. Upon completion of the work, the AFWST valve pit hatch was re-closed and sealed without performing a valve lineup. Upon discovery of this omission, the licensee reviewed the records for Unit 1 AFWST train A-D valve pits and found that they had been opened several times for work activities from December 3, 1993 through March 24, 1994, without the procedurally required valve lineup verifications being performed.

STP Station Procedure OPOP02-AF-0001, step 4.17, and Plant Operations Department Procedure OPGP01-ZA-0001, step 2.4, both require, in part, that if the AFWST valve security barrier is breached, then valves in the AFWST valve pit shall be verified according to the applicable lineup, just prior to the final closure of the security barrier.

An SPR was initiated in March 1994 to document this event. The SPR documented the root causes of this event as: unnecessary procedural requirements, lack of configuration control, ineffective utilization of existing security barrier breach process, and lack of definition and requirements for unlocking barriers.

The licensee proposed corrective actions that included revising station procedures to clarify the requirements for identifying, tracking, scheduling, and performing valve lineups, and providing training regarding procedural compliance. Upon review of the auxiliary feedwater procedure, the licensee determined that the current requirements for performing an AFWST valve lineup were appropriate and no revision was necessary. The ART reviewed OPOP01-ZA-0001, "Plant Operation Department Administrative Guidelines, Step 4.18," Revision 7, dated May 24, 1994, and OPOP02-AF-0001, "Auxiliary Feedwater, Step 2.4," Revision 2 dated March 8, 1994, and found that the requirements for a valve lineup were clearly stated.

In addition, the licensee attached information labels to barriers that require control room notification when opened so that a valve lineup can be performed. HL&P procedure OSOP02-ZS-0039, "Access Control," was also revised to incorporate requirements to notify the shift supervisor prior to opening or closing of these barriers.

4.8.4.3 Conclusion

This allegation was substantiated. However, the corrective actions taken by the licensee were adequate. This item is closed.

4.8.4.4 Recommended Action

The licensee's failure to follow its procedures in this case appears to be a violation of NRC regulations. The NRC staff will determine whether a violation occurred. In view of the fact that the licensee identified the potential violation and took corrective action, this matter could potentially be closed out with a non-cited violation in accordance with the Enforcement Policy.

4.8.5 Thermal Binding of Gate Valves

4.8.5.1 Characterization of Allegation

It was alleged that HL&P told the NRC that gate valve failure had been resolved during an NRC inspection in April 1994, but they knew that the actions taken to resolve the problem did not really solve it.

4.8.5.2 Details

On February 9, 1993, motor-operated valve SI-31A in Unit 2 failed to open on demand. SI-31A is the cold leg injection isolation valve for the Train A RHR pump. The licensee initiated an SPR to document this issue on February 11, 1993. At that time the licensee determined that the root cause was hydraulic locking of the spring pack. The NRC investigated this event in February 1993, and documented its results in IR 93-08. The NRC issued a Notice of Violation (9308-02) on April 19, 1993 for failure to acceptably investigate an April 1989 failure of this valve. At the time of the inspection, the licensee believed the cause to be either: (1) hydraulic lock of the actuator spring pack; (2) thermal binding; or, (3) wedging of the valve stem bearing block on the valve disc. The licensee responded to violation 9308-02 on May 19, 1993. In this letter, the licensee attributed the valve failure to grease hardening in the spring pack. According to the licensee, grease hardening in the spring pack caused the MOV torque switch to delay motor tripping at the appropriate torque level; the MOV was then shut with excessive force. The licensee committed to electronically disable the torque switch from the circuit in the next refueling outage.

The licensee discussed this event in LER 93-006-00, dated March 19, 1993. The LER stated that MOV-0031A in Unit 2 had been modified from torqued closed to limit closed. The licensee stated that this would prevent hard seating of the valve and reduce the possibility for thermal binding and wedging of the valve stem bearing block. Additionally, this change eliminated the control function of the spring pack. The licensee stated in Revision 1 to LER 93-006 that the same modification was made on MOV-0031B and MOV-0031C. The Unit 1 valves had been modified to be limit closed in the previous refueling outage.

On August 9, 1993, SI-31B failed in a similar manner as SI-31A. An SPR was initiated. As part of the corrective actions for the SPR, the licensee re-established the thermal conditions during cooldown in order to determine if binding had occurred. The initial cause determination was questioned when testing was performed to determine if thermal binding of the valve was the cause of motor failure. The empirical tests demonstrated that the valve body cooled faster than the valve gate, which led to binding of the gate when commanded to open before the gate had reached an equilibrium temperature. Three actions were taken to resolve the generic problem of thermal binding/pressure locking:

(1) Operations Procedure OPGP02-RH-0001 was revised to provide enhanced direction to prevent future thermal binding/pressure locking of the SI-031 valves.

(2) A checklist was included in the design basis reviews which were part of the GL 89-10 effort.

(3) All MOVs with actuators that rely on a torque switch to turn off the motor, that had not previously been diagnostically tested, were tested.

When the SPR was closed out on December 27, 1993, the licensee had determined that thermal binding was the root cause. "Pressure Locking and Thermal Binding Report" was issued on July 21, 1994. The report states that an engineering evaluation and corrective actions were performed for the RHR pump cold leg injection isolation valves (6 MOVs total) with subsequent testing validating the effectiveness of the operational procedure changes.

During the week of April 25-29, 1994, the NRC conducted an inspection to close out several open items from MOV inspections in 1993 (IR 94-14). The alleger is concerned that the NRC closed out this issue based on the licensee's determination that the actions taken to correct the problem were successful. The alleger believes that the actions (disabling torque switches) did not fix the problem because the actual root cause was thermal binding. The ART obtained information suggesting that several days before the inspection, the licensee had determined that disabling of the torque switches did not fix the MOV gate valve problems in Unit 1, and therefore, the licensee did not intend to complete the action for Unit 2. However, this issue was not discussed in Inspection Report 94-14. IR 94-14 does not close out violation 9308-02. Because the inspection report does not discuss this issue, it cannot be determined from IR 94-14 whether the inspectors were given this information. The NRC addressed the generic issue of pressure locking and thermal binding during the April 1994 inspection, stating that this item would remain open pending resolution of the generic concerns related to pressure locking and thermal binding.

On September 22, 1994, the licensee provided a revised response to the Notice of Violation. In this letter, the licensee stated that it did not believe that grease hardening was the primary factor in the original valve motor failure but that motor failure was due to thermal binding/pressure locking of the valve base in the valve body as a result of rapid cooling of the valve body when the valve was closed. The letter stated that this information had been provided to members of the Regional NRC staff during the Unit 1 and 2 restart inspections.

In October 1994, as part of an inspection of MOV issues (IR 94-32), the inspectors reviewed the July 21, 1994, internal report summarizing the status of pressure locking and thermal binding reviews. Sixty-six MOVs had been determined to be potentially susceptible to pressure locking and thermal binding. The inspectors found that the licensee had completed detailed evaluations of 36 of the 66 valves and no operability concerns were identified. The licensee committed to evaluate the remaining 30 valves before the end of 1994. The inspectors found some deficiencies with the calculation

assumptions but concluded that the licensee had satisfactorily addressed this area for closure of the staff's review of the GL 89-10 program. The inspectors noted that the area of pressure locking and thermal binding will be reevaluated in the future under the guidance of a new generic letter.

4.8.5.3 Conclusion

This allegation is not substantiated. Although the licensee determined that the initial root cause of the valve failure was incorrect, it could not be substantiated that the licensee withheld this information from the NRC during its inspection. The licensee has taken adequate corrective actions to resolve the issue of thermal binding of MOVs. This item is closed.

4.8.5.4 Recommended Action

The NRC should review the licensee's resolution of pressure locking and thermal binding of motor-operated valves following issuance of a future supplement to Generic Letter 89-10, which will address this issue.

4.8.6 Work Was Done on Valve Without Instruction

4.8.6.1 Characterization of Allegation

It was alleged that during 1991, STP contractor personnel performed maintenance work on a valve without proper instructions.

4.8.6.2 Details

The alleger did not provide any specific details on this allegation. However, the NRC investigated a similar concern during its inspection of the MOV program in December 1992 (IR 92-35, dated March 10, 1993). The inspectors selected to review and investigate problems associated with an SPR which was initiated on February 4, 1992. The SPR originator was concerned that some mechanical maintenance was being performed on safety-related and non-safety-related MOVs without approved maintenance procedures. The SPR noted that MOV corrective maintenance was being performed using work instructions instead of procedures. The SPR also noted that the quality level of job-specific work instructions was not consistent and could potentially affect the adequacy of the MOV maintenance. The licensee voided the SPR on February 21, 1992, prior to an announced NRC inspection of the licensee's MOV program. The SPR was voided on the basis that adequate work instructions were developed for each MOV service request, that work instructions provided needed flexibility during the conduct of MOV maintenance, and that there was no evidence of MOV degradation because of a lack of properly performed maintenance. The NRC inspectors expressed concern that this SPR was not properly addressed prior to its voidance. The NRC inspection team performed an independent assessment of 25 MOV work packages and concluded that some of the problems found may have been caused by deficient MOV work instructions or procedures. An unresolved item (9235-04) was issued to document the inspectors' concern.

NRC Inspection Report 93-13, issued April 23, 1993, documented the resolution of the unresolved item. The report indicated that the NRC inspectors found there were no standardized guidelines for the preparation of work instructions for MOV maintenance. The individual maintenance planners had their own set of generic work instructions, which varied from planner to planner. The NRC inspectors determined that the lack of standardized guidelines led to the inconsistencies in the work packages. The licensee committed, during the inspection, that a contractor would be hired within the next two months to work on the maintenance procedures and that the procedures would be ready by the summer of 1993.

The ART verified that the licensee had hired ITI MOVATS as the contractor. ITI MOVATS' existing MOV maintenance procedures, including packing, lubrication, testing, inspection, installation, assembly and disassembly, and overhaul, were approved by the licensee for use at STP and were adopted as STP's MOV maintenance procedures with STP's procedure numbers. STP is in the process of converting all the ITI MOVATS maintenance procedures into STP maintenance procedures. The licensee now has its own procedures to instruct crafts to perform valve maintenance.

4.8.6.3 Conclusion

This allegation was substantiated. However, the licensee has approved contractor-supplied maintenance procedures for use and is in the process of developing its own procedures. This item is closed.

4.8.6.4 Recommended Action

The NRC should perform a future inspection of the licensee's commitment to develop standardized guidelines for the preparation of motor-operated valve maintenance work instructions.

4.8.7 Valves Were Not Well-Protected in the Warehouse

4.8.7.1 Characterization of Allegation

It was alleged that, during construction, valves were not where they were supposed to be. Also, once removed from the warehouse, valves were not well-protected from dirt.

4.8.7.2 Details

The alleger stated that he had been tasked with finding valves for the purpose of repairing coatings. He discovered that many of the valves were found in piles and covered with dust. The alleger could not recall any specific valves or systems that were affected.

The NRC reviewed a similar concern regarding valves that did not receive proper maintenance before installation. The results of this review are documented in NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2," dated March 1988. Section 5.2.2 of this report addresses an allegation that valves did not receive proper maintenance before installation, and, when valves were removed from a system for reworking, they were mislocated when reinstalled. The inspectors conducted a generic review of valve installations. They found that detailed procedures and guidelines were in place to eliminate all potential areas of concern. They also reviewed the licensee's QC inspection reports for a list of valves and found that corrective actions had been taken for all nonconforming conditions. The SSAT inspectors also performed a walkdown of 70 valve installations and did not find any discrepancy in the as-built valve configurations or locations. In conclusion, the SSAT did not substantiate the allegation of inadequate valve installations. The current allegation did not provide any new or additional information that would change this conclusion.

4.8.7.3 Conclusion

This allegation was not substantiated. Although it would not be unusual for components to be exposed to dirt at a construction site, the team could not substantiate that valves received inadequate protection. However, the NRC does not consider this a significant safety concern because the valves are tested after installation to ensure operability. In addition, valve installations were reviewed by the SSAT following construction and were found to be satisfactory. This item is closed.

4.8.7.4 Recommended Action

None.

4.9 Motor-Operated Valve Program

4.9.1 MOV Inspection

4.9.1.1 Characterization of Allegation

It was alleged that in preparation for the NRC MOV inspection in March 1993, the licensee had planned not to show certain information to the inspectors unless they requested it. Because of the way the databases were set up, it would be difficult for the inspectors to find certain information on valves.

4.9.1.2 Details

The alleger is referring to an inspection conducted March 22-26, 1993, that is documented in IR 93-13. The inspectors reviewed maintenance on MOVs as a follow-up to a concern identified in IR 93-08 that a number of work activities appeared to be repetitive. The inspectors requested a computer printout of the work histories for all MOVs within the scope of GL 89-10 for a 4-year period from 1989 to 1993. The inspectors were provided with a list that the licensee indicated contained all the corrective work requests that had been completed or voided during the requested time period. The inspectors selected and reviewed the work histories of approximately 30 of the MOVs in the GL 89-10 program. While the inspectors did not verify that the list was complete, they did not express any concern that it was not.

From the information supplied by the licensee, the inspectors found several MOVs that required maintenance to be performed at least one additional time. The inspectors also found that repeat maintenance was often required because the cause of the problem was not determined. For some valves, the inspectors found that maintenance was untimely or ineffective. The inspectors' conclusions were primarily negative. Therefore, even if deficiencies in the program were not presented to the inspectors, the inspectors did see enough examples of ineffective maintenance to come to the conclusion that deficiencies existed.

Another inspection was conducted in June 1993 (IR 93-06) to examine the implementation of the licensee's GL 89-10 program. The focus of this inspection was to select and review in-depth several MOVs from the GL 89-10 program, based on an information matrix provided by the licensee. The selection was biased toward MOVs that appeared to have less than average margin; otherwise, an attempt was made to select various valve and actuator sizes and tests conducted under various differential pressure conditions. The inspectors reviewed the design basis calculations of design flow, temperature, and the maximum expected differential pressure, the sizing and switch setting calculation, the diagnostic test data package, and the diagnostic traces. The inspectors concluded that the licensee's MOV program generally fulfilled its GL 89-10 commitments. but found numerous examples of inadequate calculations and analyses.

Additional inspections of the MOV program were conducted in February 1993 (IR 93-08), April 1994 (IR 94-14), and October 1994 (IR 94-32).

4.9.1.3 Conclusion

The allegation was not substantiated. This evaluation reviewed only the potential safety impact of the alleged withholding of information from inspectors. Based on the conclusions of the inspectors, sufficient deficiencies were identified to show the true condition of the licensee's MOV program and to alert the NRC and the licensee that improvement was necessary. In addition, the significant amount of inspection of the MOV program since March 1993 would likely have revealed any problems that were not identified at the time. This item is closed.

4.9.1.4 Recommended Action

None.

4.9.2 MOV Program Self-Assessment

4.9.2.1 Characterization of Allegation

It was alleged that the licensee's self-assessment of its MOV program in January 1994 did not address all problems with the program and that the June 1994 GL 89-10 closure letter from the licensee may have falsely stated that the program was complete. The alleger referred to a station problem report that was written in 1994, the concerns of which were not adequately addressed.

This allegation was previously submitted to the NRC in March 1994, as discussed below.

4.9.2.2 Details

The licensee conducted a self-assessment of its MOV program in January 1994. On January 28, 1994, an SPR was initiated that documented concerns that had been identified during the assessment. In particular, it identified that MOVATS/HL&P MOV work packages were not effectively controlled, revised, and implemented with the appropriate approvals. In addition, it states that duplicate work documents were generated to perform maintenance, maintenance activities were not effectively monitored to ensure they met the provisions of GL 89-10, there was a lack of QA/QC oversight regarding vendor activities, and some repairs were done by ITI MOVATS without licensee oversight and approval. Many of these problems were identified by previous SPRs. This SPR was the last of 10 SPRs documenting MOV problems which had been initiated during the assessment.

The licensee closed out the SPR on April 15, 1994. The close-out memorandum acknowledged that deficiencies existed and recorded the findings as part of a process improvement initiative. The following corrective actions were taken to address the non-conformance issues:

- HL&P supervision was included in the MOV functional organization.
- An HL&P scheduler reviews all MOV activities.
- HL&P QC became involved in the work package planning and work activities.
- Training was performed on the conformance to SPR and PCF processes.

In addition, the licensee stated that several issues were being addressed for long term process improvement.

The final report of the licensee's MOV self-assessment was issued on March 30, 1994. The final report contained several recommendations that addressed the deficiencies noted in this problem report and in other SPRs. The alleger stated that the report concluded that everything was fine with the program, and that conclusion was not true. The ART reviewed the HL&P self-assessment

report. The report did not conclude that everything was satisfactory with the GL 89-10 program. The report identified several strengths but also noted several key areas for improvement. The report states, "Completion of the scope of work required to comply with the June 26, 1994, NRC Generic Letter 89-10 commitments will require extensive planning and management attention."

An allegation of these concerns with the MOV program was previously received in March 1994 by OIG and was referred to Region IV for resolution. Region IV found that the allegation was substantiated in that numerous problems existed with the MOV program at STP. The closure letter for this allegation states that IR 94-14 documents the closure of this allegation. RIV conducted the inspection, documented in IR 94-14, during the week of April 25-29, 1994, using NRC Temporary Instruction 2515/109, "Inspection Requirements for Generic Letter 89-10, Safety-Related Motor-Operated Valve Testing and Surveillance." The inspectors reviewed the licensee's self-assessment as part of the inspection. The inspectors also noted that the SPR discussed above had been initiated to document the concerns of this allegation. The inspectors noted that the management team support of the assessment team members and the overall cooperation shown by all individuals in supporting the assessment was an improvement over previous activities undertaken for the MOV program. The inspectors also noted that the licensee had identified several key areas for improvement and had provided recommendations for achieving ownership, program management, quality, work processes, and long-term program maintenance. One area that the licensee identified as a key area for improvement was licensee ownership and program oversight. The inspectors concluded that the licensee had taken a thorough, objective look at its performance in the MOV area and the issues were being adequately addressed.

The licensee submitted a letter on June 28, 1994, "Response to Generic Letter 89-10." The letter states, "The South Texas Project.... has confidence that the requirements of the Generic Letter have been appropriately addressed and implemented." The alleger expressed concern that the provisions of the generic letter had not been appropriately addressed at this time because the licensee would not have had enough time to complete all calculations. The NRC staff was not aware of the exact state of the licensee's program at the time of the letter, but it would not be uncommon if the program still had some minor deficiencies that required additional effort.

In October 1994, the NRC conducted a closeout inspection of the MOV program. This inspection identified some areas which needed to be addressed but, in general, verified that the licensee had adequately addressed its commitments to GL 89-10. The results of this inspection are documented in IR 94-32, dated November 10, 1994. The inspectors reviewed calculations, including Calculation MC-6442, "Phase II GL 89-10 Justifications." The inspectors found it to be comprehensive in providing explanations of the assumptions, methodologies, and philosophies used in the evaluation process. The inspectors concluded that the licensee had satisfactorily established the design basis capability of the Phase II MOVs in the GL 89-10 program. The inspectors also reviewed the licensee's evaluations of pressure locking and thermal binding of MOVs and found that the licensee had completed evaluations for only 36 of the 66 valves determined to be potentially susceptible to

pressure locking and thermal binding. The inspectors recognized the circumstances requiring deferral of the evaluations, and the licensee committed to complete the calculations by the end of 1994.

The inspectors reviewed efforts taken by quality assurance and self-assessment groups to monitor the status of the MOV program during the past year, including the January 1994 self-assessment, and found them to be comprehensive. The inspectors reviewed an HL&P in-office memorandum dated June 8, 1994, which stated that actions identified in the self-assessment had been completed. The licensee's quality assurance staff also performed an assessment of the MOV program before and after submittal of the June 28, 1994, closure letter. This assessment concluded that all GL 89-10 commitments had been addressed by June 28, 1994. The inspectors concluded, based on a review of these reports, that the stated objectives were met and that the licensee had effectively utilized quality assurance and self-assessment resources as part of a concerted effort to optimize the MOV program.

IR 94-32 verified completion of the licensee's commitments to GL 89-10, contingent on the licensee submitting, within 60 days, a letter documenting additional commitments related to periodic verification and post-maintenance testing of MOVs. The licensee submitted this letter on January 9, 1995. The NRC has concluded that all significant issues related to the MOV program have been resolved, and closed its review of the STP GL 89-10 program as noted in a letter dated March 2, 1995.

4.9.2.3 Conclusion

This allegation was not substantiated. The NRC reviewed the licensee's self-assessment and found it to be complete. The NRC also performed several inspections of the MOV program and determined that all significant issues related to the MOV program have been resolved and all commitments to GL 89-10 have been completed.

4.9.2.4 Recommended Action

None.

4.10 Inservice Testing (IST)

4.10.1 Characterization of Allegation

It was alleged that the IST program used on site is different from that submitted to the NRC. It was also alleged that HL&P took exemptions that were never authorized by the NRC and got verbal approval before Unit 1 startup in early 1994.

This allegation had been previously submitted to the NRC in March 1994, as discussed below.

4.10.2 Details

Few details were provided by the alleger, but this allegation is similar to an allegation received by the OIG and forwarded to Region IV in March 1994. The NRC closed this allegation in August 1994 and determined that this portion of the allegation was partially substantiated, but that the licensee had taken appropriate corrective actions.

The alleger was concerned that certain surveillances of valves were not being performed in accordance with plant requirements. In particular, the alleger stated that it was unclear which revision of the IST plan was in effect. This concern was documented in an SPR dated February 4, 1994. The SPR was generated during a self-assessment of the GL 89-10 MOV program. The NRC addressed this allegation in the course of an inspection of HL&P's IST program in May 1994 (IR 94-19).

The inspectors reviewed the SPR, which noted that four valves were not included in Revision 5 of the IST plan. The licensee was aware that these valves were not in the current revision of the plan; however, the valves were included in the surveillance database and appropriately tested. These valves were subsequently included in the revision of the IST plan that was submitted to the NRC. The SPR was initially screened by the Plant Review Group on February 4, 1994 and categorized as a possible mode restraint. The resulting operability review determined that two of the valves (component cooling water (CCW) check valves) were being tested in accordance with an alternate test method allowed by GL 89-04. This alternate test method was submitted as Relief Request 51 in Revision 6 to the IST plan. The licensee determined that the remaining two valves (flow control valves) were also tested using alternate testing methods described in GL 89-04 (Relief Request 52). Based on this review, the licensee determined that the SPR was not a mode restraint. The inspectors agreed that the licensee had taken appropriate steps to demonstrate that the valves were operable.

The inspectors noted that, upon identification of the discrepancies, the licensee began using Revision 6 (Unit 1) and Revision 4 (Unit 2) of the IST plan, although Revision 5 was the approved version. This resulted in confusion as to which revision of the IST plan was in effect.

IR 94-19 documents another instance in which the approved IST plan was not the plan used at STP. The inspectors found that the revised inservice test plan was approved in June 1993, but had not been implemented at the time of the inspection in May 1994. This resulted in the reactor makeup water pumps being listed in the NRC-approved plan, but not being tested. The licensee had initially identified that certain components, including the reactor makeup water pumps, were not listed in the IST in May 1990. These components were subsequently added to Revision 6 (Unit 1) and Revision 4 (Unit 2) of the IST plans; procedures were developed to test the components. However, the reactor makeup water pumps, although added to the IST plan, were not tested. The inspectors noted that, although this had been identified by the licensee in May 1990, as of June 1994, the pumps had not been tested. The NRC issued a Severity Level IV violation for not promptly correcting a condition adverse to quality. The inspectors reviewed HL&P's method of ensuring that components added to the IST plan were tested. The inspectors also verified that the method was working and that no other cases of failure to test were identified.

HL&P responded to the Notice of Violation on August 18, 1994. As a corrective action, HL&P approved and issued the test procedure for the reactor makeup water pumps and tested the pumps; revised the program procedures for identifying potentially safety-related components and adding them to the IST program; and, committed to develop a bases document for the IST program that will provide a technical justification for the inclusion or exclusion of every Class 1, 2, or 3 pump or valve in the program. This document is scheduled to be completed by March, 1995.

It was also alleged that the licensee was never given approval for relief requests prior to using them. Allegedly, the licensee called the NRC and got relief just before starting up Unit 1 in February 1994. The ART reviewed a note by the licensee which documented the telephone call. The relief requests in question, RR-51, RR-52, and RR-9, involve the CCW and residual heat removal systems. During the telephone call, the licensee did not request relief but verified with the NRC staff that formal relief was not required because the provisions of GL 89-06 were applicable to the first two relief requests, and the third request is consistent with OM-6. The licensee committed to submit a supplement to the IST plan to clarify these positions. This letter was submitted on June 14, 1994. By letter dated August 16, 1994, the NRC documented its evaluation of the information and noted that the revisions to the IST program do not require NRC approval.

4.10.3 Conclusion

This allegation was partially substantiated. The licensee did use a version other than the approved version of the IST program. However, a violation was issued and appropriate corrective actions were taken. The allegation that HL&P took exemptions that were not authorized was not substantiated. This item is closed.

4.10.4 Recommended Action

The NRC staff should ensure that the licensee's commitment to develop a bases document for the IST program has been fulfilled.

4.11 Training and Qualification

4.11.1 Worker Qualification

4.11.1.1 Characterization of Allegation

It was alleged that during construction, workers without a technical degree were given titles such as coating engineer or electrical engineer. The contractor (Ebasco) would "create" workers' backgrounds.

4.11.1.2 Details

The alleger explained that a background would be created by placing an employee in various work groups. The employee would get experience in each area; this would be reflected in his resume. Apparently, Ebasco gave the workers titles according to the position they held rather than their technical degree. At the time of this allegation, this action did not violate NRC requirements. The alleger did not provide indication of inadequate quality of the work performed, nor sufficient details to allow further NRC review.

4.11.1.3 Conclusion

This allegation was not substantiated. However, even if substantiated, it was not a violation of NRC requirements. This item is closed.

4.11.1.4 Recommended Action

None.

4.11.2 Training

4.11.2.1 Characterization of Allegation

It was alleged that many electricians on the work crews do not attend the required classes to learn the procedures. The example provided by the alleger occurred in March 1994.

4.11.2.2 Details

The alleger did not express any concerns regarding the quality of work that was performed.

HL&P's Procedure OPGP03-ZA-0113, "Work Direction," allows for non-certified persons to perform work as long as work direction is provided in which a certified person directs the work and directly observes activities. The alleger did not provide adequate details as to the particular personnel and work involved to determine whether work was performed contrary to HL&P's procedures.

However, a training weakness in the timeliness of certification for electricians has recently been brought to the attention of licensee management by self-assessments, third party training audits, and an NRC training inspection conducted May 23-27, 1994, as documented in IR 94-22. During this inspection, the NRC advised the licensee that the timeliness of certification was considered a training weakness. In some cases the interval between formal training and pending certification was as long as two years. The NRC found no evidence that work had been performed contrary to HL&P procedures. In addition, the inspectors concluded that maintenance training had been significantly strengthened by standardization of formal training procedures.

4.11.2.3 Conclusion

This allegation was not substantiated. This item is closed.

4.11.2.4 Recommended Action

None.

4.12 Security

4.12.1 Visitor Access

4.12.1.1 Characterization of Allegation

On June 4, 1988, a visitor access form was approved by an individual who was not authorized to do so. Upon discovery of the incident, on June 15, 1988, a licensee manager signed the visitor access form but did not date his signature. It was alleged that the event was not reported to the NRC.

This allegation was previously submitted to the NRC, as discussed below.

4.12.1.2 Details

The NRC evaluated this concern during an inspection of the safeguards program in August 1991 (IR 91-21). The inspectors reviewed the licensee's investigation report, which found no evidence of willfully misleading the NRC. The inspection report states, "This event is considered to be of minor safeguards significance, identified by the licensee and investigated by the Safe Team. In 1988, the NRC reportability criteria (10 CFR 73.71) was being revised and redefined and, thus, the subject of numerous and varied interpretations. Based upon the above, it could not be determined whether this was a reportable issue."

The ART found that 10 CFR 73.71 was published as revised on June 9, 1987, to be effective October 8, 1987, and Revision 1 to Regulatory Guide (RG) 5.62, "Reporting of Safeguards Events," was published in November 1987 to provide guidance for proper implementation of the revised reporting rule. Also, the NRC held a workshop in Bethesda, Maryland on September 14, 1987 to answer affected licensees' questions on the revised rule. Subsequently, NUREG-1304, "Reporting of Safeguards Events," was published in February 1988 to document questions discussed at the workshop.

The ART agrees that there could have been interpretation problems, as indicated by the need for a workshop. However, according to NRR staff, licensees were encouraged in the early stages of the revised rule to contact the NRC if they were uncertain as to the reportability of a safeguards event. The inspection report does not address whether the licensee did or did not make a reportability determination. The report appears to indicate that the team of inspectors could not determine whether this was a reportable issue.

Without reviewing the licensee's security plan that was in effect for June 1988, it is not possible for the ART to determine reportability with certainty. Nevertheless, it appears that the event may have been reportable as a loggable event in accordance with paragraph II.(b) of Appendix G to 10 CFR Part 73. The paragraph states, "Any other threatened, attempted, or committed act not previously defined in Appendix G with the potential for reducing the effectiveness of the safeguards system below that committed to in a licensed physical security or contingency plan or the actual condition of

such reduction in effectiveness." The event would have met this reporting requirement if it was a decrease in security plan commitments, even if it was of minor safeguards significance.

According to the alleger, there was no problem with authorizing access for this particular visitor, and he was escorted the entire time he was onsite. The alleger provided no new information to the ART that was not known during the inspection documented in IR 91-21.

4.12.1.3 Conclusion

This allegation was substantiated. The allegation does not involve a significant safety or safeguards issue, but the failure to record the improper authorization in the safeguards event log forwarded to the NRC for that time frame may be a violation of NRC regulations. This item is closed.

4.12.1.4 Recommended Action

The licensee's failure to submit this incident in a safeguards event log to the NRC may be a violation of NRC regulations. The NRC will determine the need for enforcement. However, based on the low safety significance and improved licensee performance in the safeguards area, this violation may be non-cited.

4.12.2 Unit 2 Lockdown

4.12.2.1 Characterization of Allegation

Following construction of Unit 2, the licensee performed a search and reported to the NRC that a complete lockdown of the Unit 2 facility had been completed at 1730 on October 30, 1988. It was alleged that, at that time, only about half of the vital area doors had been recorded to security and no security officers were posted for the unrecorded doors. According to the alleger, operability testing of the alarm points on the doors did not begin until two hours after the lockdown. It was alleged that the licensee falsified information to the NRC when it stated that the lockdown was performed properly.

4.12.2.2 Details

A security lockdown consists of searching the protected and vital areas for contraband, replacing construction locks with security locks (recording) and testing all intrusion detection devices. According to the alleger, the recording and testing of the system must be completed prior to completion of a search, or the system must be replaced by a posted security officer to preclude reintroduction of contraband. The alleger also stated that testing of the protected area intrusion detection devices was started two hours after completion of the search and testing of the vital area intrusion detection devices was started four hours after the search. According to the alleger, no security officers were posted.

Because the main purpose of performing the lockdown is to ensure that contraband is not introduced into the protected or vital areas, this is not a safety or safeguards concern because any contraband in these areas would have been discovered before startup.

The NRC does not regulate how a lockdown of a facility is performed. NUREG-0800, "Standard Review Plan," Section 13.6, states "...implementation of the physical security program should be accomplished 1 to 2 months before fuel loading." The SRP does not specify how the lockdown should be accomplished. The NRC's review of a licensee's physical security program prior to licensing consists of review of the plan prior to implementation and inspection. Following the licensee's lockdown declaration, the NRC will inspect the facility to verify that the protected and vital area physical security program is functioning in the acceptable manner, as committed to in the Physical Security Plan. The 1 to 2 month period following the implementation of the program is designed to allow the licensee to prove operability of systems and correct problems, and for the NRC to verify that the systems are acceptable. Although the NRC expects that all construction locks would have been replaced with security locks at the time the licensee declared the lockdown complete, the NRC will not declare the system operable until an inspection is completed.

The team attempted to locate documentation relating to this incident. None was found. However, the team determined that there was no regulatory or safety significance and closed this allegation without further investigation.

4.12.2.3 Conclusion

This allegation was not substantiated. This allegation does not raise a safeguards or regulatory issue and is closed.

4.12.2.4 Recommended Action

None.

4.12.3 Control of Safeguards Information

4.12.3.1 Safeguards Documents Not Properly Decontrolled

4.12.3.1.1 Characterization of Allegation

It was alleged that safeguards information was not properly controlled. Additionally, it was sent with trial information and should not have been made public because it was marked as safeguards.

This allegation was previously provided to the NRC in 1993, as discussed below.

4.12.3.1.2 Details

The alleger is referring to an event which occurred in August 1993. During litigation with former employees, HL&P attorneys utilized documents pertaining to plant security. One of these pages had been redacted to contain no safeguards material; however, it was still marked "SAFEGUARDS INFORMATION." The page was not handled as safeguards information. This page came from a document which had earlier been found offsite in violation of safeguards procedures. The attorneys left the "SAFEGUARDS INFORMATION" stamp on it because they wanted to use it in the form in which it was discovered for the deposition hearing.

Region IV responded to the previous allegation on October 25, 1993, and determined that the failure to control this page as safeguards information was not a violation of 10 CFR 73.21, based on the fact that the page did not contain safeguards information and that the reason for not removing the safeguards label was satisfactory. The allegers were not satisfied with Region IV's response.

The ART consulted with the Safeguards Branch of NRR. The Safeguards Branch staff agreed that this page did not contain any safeguards information. Also, in this case, the document was not mismarked because leaving the Safeguards Information stamp on the document was necessary for use in the deposition hearing. There did not appear to be any attempt to willfully mislead. In addition, the staff recognizes that there are cases in which documents containing protected information such as "Nuclear Safeguards Information" need to be provided to a court with certain controls, and the NRC has typically found this to be acceptable.

4.12.3.1.3 Conclusion

This allegation was not substantiated. The document did not contain safeguards information and the document was not mismarked, since leaving the marked "SAFEGUARDS INFORMATION" stamp on the document was necessary for use in the deposition hearing. This item is closed.

4.12.3.1.4 Recommended Action

None.

4.12.3.2 Safeguards Information Left Unguarded

4.12.3.2.1 Characterization of Allegation

It was alleged that safeguards information was left in an unoccupied office in the STP administrative building for 22 minutes on June 27, 1991. The licensee discussed the incident with the NRC Resident Inspector but stated that the office in question was protected by a secretary who would have seen if anyone had gone in. The alleger stated that the licensee showed the inspector the wrong office in the wrong building. The office where the information was left was in the Administration Building, and it was not protected.

This concern was originally provided to the NRC and investigated in 1991. Additional information was provided during an interview with an alleger in May 1992.

4.12.3.2.2 Details

The NRC reviewed the allegation during an inspection in August 1991 (IR 91-21). The inspector determined that the event was reported in the licensee's safeguards event log and that this event warranted no further effort, based on the fact that the office was protected by a secretary and that the building was the security building, which is inside the protected area. Apparently, the inspectors misunderstood the facts or were given the wrong facts. As part of an investigation of activities at STP by the NRC Office of Inspector General, present and former employees raised concerns regarding inaccurate statements in IR 91-21. As a result of these concerns, the licensee reviewed the inspection report and submitted a letter on February 2, 1993, stating that certain statements in IR 91-21 were incorrect. The letter stated that a secretary did not sit in front of the Nuclear Security Department offices in which the safeguards information was left unattended. It also stated that the office was in the Administration Building and not the Security Building. However, the Administration Building is within the protected area. The NRC determined that the clarifying information did not affect previous conclusions, as documented in a letter to the licensee dated March 10, 1993.

It was not substantiated that there was an attempt to remove the safeguards material. However, the NRR staff position is that, because the material was left unprotected for a period of time, the material was compromised because it could have been copied. The event would have been reportable to the NRC within one hour of discovery if the compromised information would significantly assist a person in an act of radiological sabotage (paragraph 2.2.17 of RG 5.62 and paragraph 2.2.Q.17.b of NUREG-1304). The licensee would have been required to record the event in its safeguards event log (paragraph 2.2.Q.17.b of NUREG-1304) if it could not significantly assist in an act of radiological sabotage, but had the potential to reduce the effectiveness of a physical security system below that committed to in a licensed physical security plan or contingency plan. The safeguards significance of the material could not be determined by the ART because details regarding its content were not available for review.

IR 91-21 states that the licensee's safeguards events log documented this event but it is not documented in the quarterly log that was submitted to the NRC for this time frame. The NRC noted in IR 91-21 that the licensee's quality assurance audit found various occasions in which the licensee failed to transcribe all of the entries from the handwritten Safeguards Event Log, kept by the shift supervisors, to the formal log furnished to the NRC. The failure to properly report the June 27, 1991, incident appears to be a violation of NRC requirements.

4.12.3.2.3 Conclusion

This allegation was substantiated. Based on a review of the licensee's clarification of the information, the NRC determined that previous enforcement actions were not affected by the noted clarifications. While, the ART noted that no reporting violations were cited for this event, the ART could not determine the safeguards significance from the documents available for review. However, the team determined that the event may have been reportable to the NRC either as a one hour report or as a safeguards log entry. This item is closed.

4.12.3.2.4 Recommended Action

The licensee's failure to report this event within one hour of discovery may be a violation of 10 CFR 73.71. The NRC will determine the need for enforcement; however, because of the length of time since the violation occurred, the low safety significance and improved licensee performance in the safeguards area, this may be a non-cited violation.

4.12.4 Non-compliance with the Physical Security Plan

4.12.4.1 Security Lighting

4.12.4.1.1 Characterization of Allegation

It was alleged that, in 1988, a security supervisor was responsible for a change to Procedure OSDP01-SE09994, directing that compensation for general lighting failures was to be limited to the perimeter of the protected area. According to the alleger, the procedure change lessened the effectiveness of the Physical Security Plan. It was also alleged that this supervisor directed, on November 30, 1990, that lighting readings were not to be checked under vehicles or inside dumpsters.

4.12.4.1.2 Details

Section 73.55(c)(5) of Title 10 of the Code of Federal Regulations requires that isolation zones and all exterior areas within the protected area shall be provided with illumination sufficient to meet monitoring and observation requirements but not less than 0.2 foot-candle measured horizontally at ground level. Section 8.5(b) of Title 10 of the Code of Federal Regulations clarifies that all exterior areas within the protected area are included, not just the protected area boundary and the isolation zone. Section 73.55(g)(1) of Title 10 of the Code of Federal Regulations discusses maintenance of security-related equipment and requires that "...licensees shall develop and employ compensatory measures...to assure that the effectiveness of the security system is not reduced by failure or other contingencies affecting the operation of the...equipment."

This allegation was submitted to the NRC in 1989. An inspection in August of 1991 addressed another concern regarding lighting within the protected area. The inspectors evaluated a concern that illumination under vehicles was in violation of the Physical Security Plan (PSP). The inspectors found that lighting was marginal in areas but noted that temporary lights were utilized and that officers on patrol had flashlights. The inspectors recommended that illumination be verified during a future NRC inspection. The ART found no documentation verifying that the specific allegations discussed in Section 4.12.4.1.1 above had been evaluated.

Another inspection was performed in July 1992 (IR 92-20) in which lighting was inspected. The inspectors reviewed the security program for compliance with 10 CFR 73.55 and the PSP. They physically inspected the protected area and isolation zone during dark hours with a calibrated light meter. Three trailers were found not to have lights underneath but were compensated for by posts adjacent to each area. The licensee took immediate corrective actions and initiated a work order to install lighting. The inspectors concluded that the lighting was very good.

Regarding the allegation that the procedure was changed, the licensee reviewed this allegation in response to a SAFETEAM concern in February 1989. The licensee reviewed the applicable procedure and found no evidence that it

directed that compensation for general lighting failures be limited to the perimeter. An NRC inspection in 1992 (IR 92-34) reviewed several security procedures and concluded that procedures were in accordance with the PSP. Another inspection in 1993 (IR 93-16) reviewed changes to security procedures and determined that the changes did not decrease the effectiveness of the PSP. The inspectors reviewed several security implementing procedures, and found that they were adequate and appropriate to meet the general performance requirement in accordance with the PSP. Neither inspection specifically addressed review of procedures associated with protected area lighting.

4.12.4.1.3 Conclusion

The allegation was not substantiated. The ART could not find specific documentation to verify that the allegations were evaluated, but the general documentation supports that protected area lighting and security procedures were inspected subsequent to the allegations, and found to be in compliance with the licensee's security plan commitment. This item is closed.

4.12.4.1.4 Recommended Action

None.

4.12.4.2 Lock and Key Procedure

4.12.4.2.1 Characterization of Allegation

It was alleged that a security supervisor directed a procedure be changed to allow management to unlock vital areas without a security officer present to control access or document the entry. The NRC issued a violation but it was alleged that the procedure that was previously changed was not corrected. In addition, it was alleged that the managers did not have authorized access to these areas.

This allegation was originally provided to the NRC and investigated in 1991, as discussed below.

4.12.4.2.2 Details

The NRC inspected this issue in IR 91-21 and issued a Notice of Violation because the revision to the procedure decreased the effectiveness of the PSP. The licensee responded to the NOV on December 13, 1991. The licensee disagreed with the violation but stated that it had suspended use of the key until the matter was resolved. On July 7, 1992, HL&P revised its response to the NOV to state that, while they still did not believe that the revision decreased the effectiveness of the PSP, they accepted the NRC decision and would not issue vital area keys. HL&P committed to revise the procedure (OPGP03-ZS-0005) by July 31, 1992. The NRC reviewed the lock and key program (including the revised procedure) during an inspection in April 1993 (IR 93-16) and found that it was consistent with the PSP and that the licensee did adequately revise its procedure. The inspectors closed out this issue based on their determination that the licensee had implemented adequate corrective action to prevent recurrence. The inspectors found that the licensee was controlling and accounting for security keys according to the PSP and procedures.

The alleger also claimed that the managers who were given access to the keys did not have authorized access to all the areas that the keys opened. In its response to the NOV, the licensee stated that the managers already had access to the areas. Because keys were never issued and the procedure was changed, this does not constitute a safety issue.

4.12.4.2.3 Conclusion

This allegation was partially substantiated. The licensee did revise its procedure to allow management access to vital areas without a security officer present. However, the NRC issued a violation and the corrective actions taken by the licensee were verified and found to be satisfactory. The allegation that the licensee did not correct the procedure is unsubstantiated. The

licensee had revised the procedure to eliminate use of the management key, and the NRC verified that the program was consistent with the PSP. The allegation that the managers who were to receive keys did not have authorized access to all areas could not be substantiated. This item is closed.

4.12.4.2.4 Recommended Action

None.

4.12.5 Reporting of Security Incidents

4.12.5.1 Discovery of a Weapon in the Protected Area

4.12.5.1.1 Characterization of Allegation

It was alleged that on June 17, 1988, a security officer's firearm was left unattended for 15 minutes in the protected area and it was not reported to the NRC. The alleger believes that a one-hour report should have been made.

4.12.5.1.2 Details

The ART reviewed the quarterly Safeguards Event Log for the second quarter of 1988 that was submitted to the NRC and found that the first event was logged on June 17, 1988. The log states that an employee found a security weapon on the ground in the protected area. A security incident report was written. Reportability of this incident would depend on the safeguards significance. However, in most cases, discovery of a weapon lost in the protected area would be subject to a one-hour report (paragraph 2.2.24 of RG 5.62, "Reporting of Safeguards Events"). No details on the location of the weapon were provided to the ART.

In 1991, the NRC received an allegation similar to this one concerning the licensee's failure to report security events. IR 91-21, which addressed the failure to furnish complete security logs to the NRC, states that the region will continue to monitor the reportability issue. Subsequent inspection reports state that "...the licensee was correctly reporting security events based on the location of the unattended weapon..." and the licensee was "...knowledgeable of reporting requirements..." (IR 92-34).

4.12.5.1.3 Conclusion

This allegation was partially substantiated. The event occurred as alleged; however, the allegation that the event was not reported to the NRC was not substantiated since it was submitted in the quarterly event log. The allegation that this should have been a one-hour report may be substantiated. The discovery of a weapon in the protected area is usually reportable to the NRC within one hour, and a reporting violation may have occurred. This item is closed.

4.12.5.1.4 Recommended Action

The licensee's failure to make a one-hour report upon discovery of a weapon in the protected area may be a violation of NRC requirements. The NRC will determine the need for enforcement. However, based on the low safety significance and improved licensee performance in the safeguards area, this violation may be non-cited.

4.12.5.2 Attempted Entry through Security Door

4.12.5.2.1 Characterization of Allegation

It was alleged that an event on March 3, 1991, in which the security computer room door appeared to have been kicked in, should have been reported to the NRC within one hour.

4.12.5.2.2 Details

This event involved what initially appeared to be an apparent attempt to gain entry into the security computer room by damaging a doorknob. This event was previously evaluated in IR 91-21. The inspectors determined that there was no damage to the security equipment and no unauthorized entries or alarms occurred. According to the alleger, this event was logged by the licensee and the log was submitted to the NRC in the next quarterly report.

The alleger is concerned that this should have been a one-hour report. A one-hour report is required under 10 CFR 73.71 if a licensee has "reason to believe" that a person committed, caused, or attempted to commit or cause, or has made a "credible" threat to commit or cause certain events described in paragraph I(a) of Appendix G to Part 73, or if events described in paragraph I(b) or (c) of Appendix G to Part 73 occur. The licensee's security manager stated that it could not be substantiated that the damage to the door was caused by an attempted intrusion. The NRC determined that the licensee took adequate actions to investigate the event and made a reasonable assessment. The NRC accepts the licensee's determination that the attempted intrusion could not be substantiated; therefore, no report to the NRC is required.

4.12.5.2.3 Conclusion

This allegation was not substantiated. This item is closed.

4.12.5.2.4 Recommended Action

None.

4.12.6 Security System Cables

4.12.6.1 Characterization of Allegation

It was alleged that, in early 1994, maintenance workers did not follow procedures which required that ducts be cleaned before pulling fiberoptic cable through the ducts for the security system. The alleger was concerned that, due to the sensitivity of fiberoptic cable, dirt in the ducts could cause the system to operate improperly.

4.12.6.2 Details

The alleger was concerned because the maintenance training class taught that the proper method of pulling wire is to first clean out the ducts. The alleger stated that HL&P does not currently have a fiberoptics class, but this guidance was given in a wire-pulling class. Cleaning out the ducts is a preparation step that may not be specifically required by the procedure used for this particular maintenance. According to the alleger, prior to pulling the fiberoptic cable through, an interduct was pulled through and the fiberoptic cable was placed inside the interduct. The interduct serves as the protection for the cable from dirt and debris. In order for fiberoptic cable to function properly, both ends must be free from debris that could block light. Dirt on the length of the cable would not affect this function. If dirt were to collect on the tip of the cable as it was being pulled through, the system would not function and this problem could be identified immediately. The ART determined that the safety or safeguards significance of this allegation is low. Therefore, no further review or investigation was determined to be necessary.

4.12.6.3 Conclusion

This allegation was not substantiated. However, even if substantiated, this allegation would not raise a safety or safeguards concern because the interduct helps to protect the fiberoptic cable and any dirt which may collect along the length of the cable would not affect its operability. This item is closed.

4.12.6.4 Recommended Action

None.

4.13 Independent Safety Engineering Group

4.13.1 Characterization of Allegation

It was alleged that the licensee's Independent Safety Engineering Group (ISEG) had lost the independence required by technical specifications because of a reorganization in 1994 that combined it with the engineering assurance group. The alleger was also concerned that the ISEG process, which requires that potential reviews be approved by two supervisors, could cause the group to lose some independence.

4.13.2 Details

The regulatory requirements for ISEG are discussed in Technical Specification 6.2.3. It states, "ISEG shall be responsible for maintaining surveillance of unit activities to provide independent verification that these activities are performed correctly and that human errors are reduced as much as practical." It clarifies that "independent" means that ISEG members are not responsible for signoff functions. The ISEG procedures satisfy this requirement. Section 6.2.2.6 of ISEG-01, "Organization and Responsibilities" dated July 8, 1993, states, "ISEG maintains the independence and objectivity necessary to effectively focus on where improvements to plant safety and reliability should be made. ISEG personnel shall have no production or audit signoff responsibility." The technical specifications do not specify that ISEG must be separate from engineering assurance. Therefore, ISEG need only be independent from the activities which it is reviewing and this requirement is fulfilled by STP procedures.

In reference to the second concern, ISEG procedures do require that the Director, ISEG decides whether to perform a task based on the potential relevance to safe and reliable operation of the plant, and significance with respect to other ISEG commitments. Final reports are also approved by the Director, ISEG. The task lead is required to prepare an assessment plan or investigation plan that includes the scope of the assessment or investigation, individuals to be interviewed, documents to be reviewed, and activities to be observed. The Director, ISEG must also approve this plan. The requirements for Director approval of the task and its plan were implemented by Revision 1 of ISEG-06, "Assessments and Investigations," dated April 30, 1990. This procedure has not been revised as a result of recent changes in ISEG.

4.13.3 Conclusion

This allegation was not substantiated. The current changes in ISEG discussed by the alleger do not violate technical specification requirements. The current ISEG procedures ensure adequate independence. This item is closed.

4.13.4 Recommended Action

None.

4.14 Plant Trip

4.14.1 Characterization of Allegation

It was alleged that in June 1994, a plant trip in Unit 2 caused valve braces in the turbine building to be torn out, and the plant was restarted before the braces were repaired and uprights were replaced.

4.14.2 Details

The alleger is referring to a plant trip of Unit 2 on June 25, 1994. The NRC evaluated the licensee's response to the trip, and documented its findings in Inspection Report 94-24 (August 30, 1994). This event was also documented in a Plant Station Report (94-1308). The trip resulted from a main transformer lockout that caused a direct turbine generator trip and a reactor trip. As a result of the main transformer lockout, all 13.8 kV normal power was lost to the balance of plant electrical busses. Approximately 13 minutes after the plant trip, instrument air system pressure had decreased to 69 psig, which resulted in the opening of condensate minimum flow recirculation valve 2-FV-7022. When the valve opened, water in the condensate system was vented to the main condenser and began flashing to steam. The flashing and collapsing of water in the condensate piping caused pressure waves that resulted in movement of the piping within the region of valve 2-FV-7022. The instrument air system pressure was restored above 95 psig approximately 11 minutes later, and valve 2-FV-7022 was closed.

PSR 94-1308 evaluated this hydraulic transient and found that it was well within system design boundaries. There was some pipe support damage, and flange and tubing connection leaks. Licensee engineers found that the pipe stresses were within code-allowable values, and no pipe degradation or pressure boundary failures were experienced. The ART contacted the NRC senior resident inspector at STP who had reviewed the transient and the licensee's response. The senior resident inspector stated that the system involved was not a safety-related system, and that the supports which were damaged did not affect the ability of the system to operate. The senior resident inspector determined that resuming operation without the pipe support repaired would not be a safety concern.

4.14.3 Conclusion

This allegation was substantiated. Unit 2 did experience a plant trip that resulted in damage to valve supports which may not have been repaired prior to restart. However, the NRC had evaluated the event and determined that the damage did not compromise the safety of the plant during or after restart. This item is closed.

4.14.4 Recommended Action

None.

4.15 Falsification

4.15.1 Falsification of Work Packages

4.15.1.1 Characterization of Allegation

It was alleged that in early 1994, the alleger was asked to sign as the performer or verifier on work packages that he didn't perform or verify.

4.15.1.2 Details

The alleger stated that he was asked to sign as the performer for work because the actual performer was not certified to do the job. The work included terminations of electrical cables in the control cabinets for modifications to equipment on the demineralization units. This work was not safety-related. The alleger was asked to sign a ZM21 form (a document verifying that when a wire is lifted, it is put back in the correct place) when he did not see the work performed. When the alleger questioned his supervisor, he was told that it had always been done that way and it was standard procedure.

Plant procedure OPGP03-ZM-0021, "Control of Configuration Changes," Revision 5, dated February 14, 1994, requires that activities which involve lifting and landing of electrical leads shall be verified. This verification consists of positively identifying the test point prior to installation or removal, as well as the proper placement of the test lead.

During an interview with the NRC, another individual stated that this type of falsification was common practice, from the time the job began in November 1993 until this particular concern was brought up. He believed that this was approved and directed by supervision and was used as a time-saving method. He stated that he did not believe that the work was ever verified but, because of the ability of the craftsmen involved, he believed that the work was done correctly. According to him, the foreman, who asked the alleger to sign-off, quit when this issue came to management in order to protect his reputation. The individual believed that since this incident, procedures have been followed properly.

HL&P procedure OPGP03-ZA-0113, "Work Direction," Revision 0, dated February 27, 1993, states that supervisors should assign job tasks based on having at least one certified individual within the crew performing the task. If this is not possible, then uncertified individuals may be used under work direction of a certified individual designated as the work director. The work director must be in a position to identify and correct errors in performance and perform a final job review. The work director signs as the verifier on work documents, and the uncertified person signs as the performer if he performed the work.

In the allegation described above, the alleger would be in violation of procedures to sign as the performer when he did not perform the work, and he would be in violation of procedures to sign as the verifier if he did not supervise the uncertified worker.

The ART investigated this allegation and found that the alleger was present while the work was being performed and signed as the verifier. The team concluded that this incident was not a falsification.

4.15.1.3 Conclusion

This allegation was not substantiated. In addition, since the work was not safety-related, it does not raise a safety concern. This item is closed.

4.15.1.4 Recommended Action

None.

4.15.2 Foreman Signed Off Package Without Verifying Work

4.15.2.1 Characterization of Allegation

It was alleged that, after a job was completed, the foreman was required to verify that the work was done, and a particular foreman signed off the work packages without ever going into the field to inspect the work.

4.15.2.2 Details

The alleged incident took place in early 1994. The alleger stated that a foreman was required to verify that work was being done on non-safety-related demineralization units in accordance with procedure OPGP03-ZM-0021, "Control of Configuration Changes," Revision 4, dated March 15, 1992. Rather than inspecting the work in the field, this foreman signed the work packages at his desk. The ART reviewed OPGP03-ZM-0021 and found that it contains no requirement that the supervisor physically verify completed work to close out the work package.

OPGP03-ZM-0021 requires that all activities requiring configuration changes on permanent plant equipment shall be controlled in accordance with OPGP03-ZA-0090. Procedure OPGP03-ZA-0090, "Work Process Program," Revision 8, dated January 25, 1994, describes the process for evaluating, planning, scheduling, and implementing work activities. The procedure states that, upon completion of work, the work group personnel: (1) reviews the work package to verify signatures, signoffs, and summary documentation are complete and correct; (2) ensures work areas are restored to original cleanliness; (3) ensures that SR tags are removed and discarded; (4) all work documentation is complete, including M&TE, permits, and job summary; (5) unused parts are returned; and, (6) Engineering Notification Record Tag is completed. Revision 10 to this procedure specifies that the supervisor should ensure these actions are performed.

These requirements, with the exception of (2) and (3), may be performed at the supervisor's desk. Requirements (2) and (3) only verify that the work area is restored to its original state, and do not verify that work was performed correctly. The supervisor must rely on the documentation and dual verification of the craft personnel performing the work. The procedure specifically states that proper documentation of work performed is the responsibility of the craft performing the work, and details the documentation that is required. Based on the documentation provided, the work supervisor should be able to determine whether work was appropriately performed without physically witnessing the work in progress. The licensee relies on independent verification and dual verification to ensure that work is performed correctly.

Without any further details regarding the specific requirement for the foreman to verify work, it appears from review of the applicable procedures that a foreman would not be in violation of procedures by signing off work packages at his desk.

4.15.2.3 Conclusion

This allegation was not substantiated. However, even if substantiated it does not appear to be a violation of procedures or a safety issue. This item is closed.

4.15.2.4 Recommended Action

None.

4.15.3 Supervisor Signed Off Paper Without Actually Verifying

4.15.3.1 Characterization of Allegation

It was alleged that, in 1992, during a calibration, a supervisor signed that a switch was in the correct position without actually verifying that it was.

4.15.3.2 Details

According to the alleger, this incident took place while the plant was in an outage. The alleger stated that the switch in question was always in the position required for the calibration while the plant was in an outage so the supervisor did not feel it was necessary to physically verify it. The alleger expressed no concern that the switch may have been in the incorrect position. Without further information regarding the procedure number, the equipment being calibrated, or switch in question, the ART could not investigate further or determine the safety significance.

The alleger also stated that this event was reported to management and the supervisor was suspended. If so, the licensee became aware of the allegation, and apparently took the necessary disciplinary action to ensure that others would comply with plant procedures.

4.15.3.3 Conclusion

This allegation was not substantiated. However, based on the information given by the alleger and if it was substantiated, this appears to be an isolated event, and the licensee apparently took appropriate corrective action to prevent recurrence. This item is closed.

4.15.3.4 Recommended Action

None.

4.15.4 An Unqualified Person Worked on Seismic Monitors

4.15.4.1 Characterization of Allegation

It was alleged that the person who installed and calibrated seismic monitors was not certified to work on seismic monitors, and someone else signed off.

4.15.4.2 Details

According to the alleger, the uncertified person had the assistance of a representative of the seismic monitor vendor when he installed the monitor, and he was working with a certified individual when he performed the preventive maintenance calibrations. The alleger believes that the person who was not certified may have done the work, but the certified person signed off as the performer. The alleger stated that the uncertified person was qualified to do the work because he had been trained, and he was knowledgeable of the system. Based on the information given by the alleger, there is no concern regarding the quality of work performed on the seismic monitor.

In addition, the seismic monitors do not perform a direct safety function. Seismic instrumentation ensures that sufficient capability is available to promptly determine the magnitude of a seismic event, and evaluate the response of those features important to safety. This capability is required to permit comparison of the measured response to that used in the design basis for the facility to determine if plant shutdown is required.

The alleger expressed a concern with the method for signing off on maintenance work when an uncertified individual is involved in the work. However, HL&P Procedure OPGP03-ZA-0113, "Work Direction," Revision 0, dated February 27, 1993, allows an uncertified person to perform maintenance work under supervision of a certified Work Director. The Work Director observes the work activities, performs a final job review, and signs as the verifier on work documentation. The person who performs the maintenance signs as the performer on work documentation, even if that person is not certified.

Due to a lack of details regarding the procedure number or time frame, the ART could not substantiate whether the certified person had actually signed as the performer when he did not perform the work. The licensee adhered to its procedure by assigning a certified person to every job that involved work on the seismic monitors. Because this person was present during the work, and because the person performing the work was qualified, this does not raise a safety concern.

4.15.4.3 Conclusion

This allegation was not substantiated. However, if substantiated, it would not have a direct safety impact on the plant. This item is closed.

4.15.4.4 Recommended Action

None.

5 REVIEW OF SOUTH TEXAS PROJECT ELECTRIC GENERATING STATION RECORDS FALSIFICATION ISSUES

5.1 Introduction

This section documents a review of records falsification issues pertaining to the South Texas Project (STP) Electric Generating Station. This historical review was performed in response to U.S. House of Representative staff members' concerns about past and continuing instances of records falsification at STP.

In the spring of 1994, Congressional staff members on the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce in the U.S. House of Representatives initiated an inquiry into the NRC's regulatory oversight of STP, as well as the safety performance and licensee management oversight of the facility. One concern of the Congressional staff members was in the area of falsification of STP records.

In May 1994, the Deputy Director for Nuclear Reactor Regulation, Regional Operations and Research (DEDO), directed a special assistant to the DEDO, to perform a review of the NRC follow-up of records falsification-related allegations pertaining to STP.

5.2 Objectives and Scope of Historical Review

The primary objectives of this review were to determine: (1) whether instances of substantiated records falsification were indicative of an adverse trend or pattern that was not previously recognized by the NRC; (2) the significance of any identified adverse trend or pattern; and, (3) whether the regulatory action taken in response to each issue was consistent with the NRC policy and guidance that existed at the time the issues were identified. To the extent practicable, the review was also intended to assess the adequacy of licensee actions in response to substantiated records falsification.

The review was conducted from May 16, 1994, through September 26, 1994. The initial review scope included an analysis of NRC allegations pertaining to STP to determine what allegations, if any, involved apparent records falsification. Prior to the implementation of NRC Inspection Manual Temporary Instruction 2515/115, "Verification of Plant Records," beginning in May 1992, there were no NRC inspection requirements for identifying potentially falsified records. As a result, for the purposes of this review, allegation data were selected for the review sample because these data were the most likely source of documented NRC follow-up of records falsification concerns. The review scope sample was subsequently expanded to include NRC OI investigation reports, NRC inspection reports issued during the period January 1, 1982, through July 31, 1994, and NUREG-1306, "NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2."

Although this review involved discussions with some NRC staff members who had involvement with STP, it mainly consisted of a review of documentation because many of those staff members who were involved in the regulatory oversight of STP are no longer employees of NRC. The review did not include discussions or interviews with licensee and licensee contractor personnel, nor did it include a review of licensee records. The South Texas Project Allegations Review Team and Inspection Program Effectiveness Task Force, the two STP special teams initiated by the DEDO (refer to Section 1.2 of this report), were briefed on the results of this review in NRC headquarters on September 26, 1994.

A screening review of the Allegation Management System (AMS) data sheets was conducted to identify allegations that involved or potentially involved records falsification. In addition, allegation data sheets that preceded the AMS were also reviewed for completeness. Records of STP allegations that preceded 1982 were not identified. For the issues identified by this screening, the corresponding allegation file was subsequently reviewed.

NRC inspection reports for the period January 1982 through July 1994 were reviewed because inspection reports are the primary document that discusses the details of NRC allegation follow-up. Inspection reports preceding 1982 were not included in the review sample because there were no allegation data that preceded 1982, and 1982 is the year in which safety-related work activities were resumed at STP. In addition, the reports were also reviewed to determine whether there was documentation of reviews of licensee investigations pertaining to records falsification. NUREG-1306 was reviewed because it documents the NRC review of alleged construction deficiencies at STP which were provided by the Government Accountability Project (GAP). The allegations provided by GAP encompassed a wide range of concerns about hardware and quality assurance and control, as well as issues of management, harassment/intimidation, and wrong-doing. Investigation reports pertaining to STP were reviewed because these reports document investigations of alleged or suspected wrong-doing.

5.3 Evaluation of Records Falsification Concerns

Forty-six concerns, including related concerns such as false oral statements, willful procedure violations, and inaccurate records, were identified. Forty of the 46 concerns have been closed. Of the remaining six concerns, the technical issues have been closed for two. These two concerns remain open because they are the subject of on-going U.S Department of Labor reviews. The remaining four concerns were under NRC review as of September 26, 1994.[6] The 46 concerns were evaluated relative to the selected attributes to identify trends and patterns.

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[6]Since this review culminated in September 1994, all information reflects this historical perspective. Any updates are provided in footnotes. At the time of issuance of this report, three of the four pending concerns noted in Section 5.3.3 were still active, with two of those three concerns near closure. The technical issues have been addressed for all concerns.

5.3.1 Substantiated Concerns

The concerns were evaluated to determine how many could be classified as partially or fully substantiated. The information detailed in the review documents was the sole source of information used in making these determinations. The following is a brief description of the 16 concerns that were partially or fully substantiated.

(1) Welder Certification Records

An allegation pertaining to welder certification records was entered into the AMS in 1984. The licensee substantiated that welder certification records were falsified by a contractor foreman (refer to Section 5.5.1.1).

(2) Welder Certification Records

An allegation pertaining to welder certification records was entered into the AMS in 1985. The licensee substantiated that a contractor foreman attempted to falsify welder certification records (refer to Section 5.5.1.2).

(3) Weld Filler Material Issue Records

Two allegations pertaining, in part, to weld filler material issue records were entered into the AMS in 1985. The licensee substantiated 18 instances of forgery by contractor foremen of weld filler material issue records (refer to Section 5.5.1.3).

(4) Construction Procedures

An allegation pertaining to construction procedures was entered into the AMS in 1985. The NRC substantiated that unauthorized rework had occurred during construction of the facility (refer to Section 5.5.1.4).

(5) Quality Control Hold Point

An allegation pertaining to a quality control (QC) hold point associated with a construction procedure was entered into the AMS in 1985. The licensee substantiated that a contractor supervisor directed a contractor worker to skip a QC hold point step in an installation procedure (refer to Section 5.5.1.5).

(6) Fire Watch Log

An NRC inspector identified instances of apparent falsification of fire watch logs during an inspection conducted in 1988. A subsequent NRC investigation substantiated that contractor fire watch personnel had falsified fire watch logs.

(7) Torque Wrench Calibration Records

An allegation pertaining to torque wrench calibration records was entered into the AMS in 1988. The licensee substantiated that an HL&P employee willfully miscalibrated four torque wrenches/adapters (refer to Section 5.5.1.6).

(8) Fire Watch Logs

The licensee identified several falsified fire watch logs in 1989.

(9) Radiation Work Permit

The licensee investigated the apparent willful violation of a radiation work permit in 1990. The licensee substantiated that a reactor plant operator intentionally violated the requirements of a radiation work permit.

(10) Security Patrol Log

An NRC inspector identified the apparent falsification of a security patrol log during an inspection conducted in 1990. The licensee subsequently substantiated that a security patrol log was falsified by a contractor security officer.

(11) Quality Assurance Surveillance Report

The licensee identified that a quality assurance surveillance report pertaining to vendor document control was falsified by an HL&P employee in 1990.

(12) Maintenance Work Package

An allegation pertaining to the falsification of a mechanical maintenance work package was entered into the AMS in 1991. The licensee substantiated that a contractor foreman pressured a contractor mechanic to falsify a safety-related maintenance work package that involved safety injection system valve packing maintenance, which occurred in the latter part of 1990.

(13) Control Room Operator Logs

As a result of licensee actions in response to employee integrity issues, a reactor operator admitted to HL&P management in 1991 that he falsified his control room logs on one occasion.

(14) Maintenance Technician Certifications

In 1991, the licensee investigated a concern pertaining to instrument and control technician training qualification records. The licensee concluded that maintenance technician certification records were

falsified by a HL&P foreman but this occurred because the foreman did not understand the certification requirements.

(15) Visitor Access Record

An allegation pertaining to security event reports and Speakout (licensee employee concerns program) reports was entered into the AMS in 1991. The licensee substantiated that the security manager falsified the access record of a visitor, but concluded that it was not a willful act.

(16) Chemical Operator Logs

In 1992, the licensee identified falsified chemical operator logs as the result of performing a quality assurance surveillance in response to NRC Information Notice 92-30, "Falsification of Plant Records."

5.3.2 Unsubstantiated Concerns

The following concerns were determined to be unsubstantiated.

- QC and Coatings Records

  Two allegations pertaining to QC reports and coatings records were entered into the AMS in 1984. Alleged falsification of QC and coatings records was not substantiated by the licensee and NRC.

- Piping Heat Numbers

  An allegation pertaining to piping heat numbers was entered into the AMS in 1984. Alleged falsification of piping heat numbers was not substantiated by the licensee and NRC.

- Electrical Termination Records

  An allegation pertaining to electrical termination records was entered into the AMS in 1985. Alleged falsification of Unit 1 control room electrical termination records was not substantiated by NRC (refer to Section 5.5.1.7).

- Measuring and Test Equipment (M&TE) Calibration Records

  An allegation pertaining to M&TE calibration records was entered into the AMS in 1985. Alleged falsification of M&TE calibration records was not substantiated by the licensee and NRC.

- Structural Steel Beams

  An allegation pertaining to the identification numbers associated with structural steel beams was entered into the AMS in 1985. Alleged

falsification of steel beam numbering was not substantiated by the licensee and NRC.

- Contractor Time Sheets

  An allegation pertaining to contractor time and attendance sheets was entered into the AMS in 1985. Alleged falsification of contractor time and attendance sheets was not substantiated by the licensee and NRC.

- QC Inspector Qualification Records

  An allegation pertaining to QC inspector qualification records was entered into the AMS in 1985. Alleged falsification of QC inspector qualification records was not substantiated by NRC.

- Component Cooling Water (CCW) System Weld Records

  An allegation pertaining to CCW system weld records was entered into the AMS in 1986. Alleged falsification of CCW system weld records was not substantiated by the licensee's contractor. The NRC substantiated a deficiency with the work performed but not records falsification.

- Heating, Ventilating, and Air Conditioning (HVAC) System Weld Records

  An allegation pertaining to HVAC weld records and other HVAC-related concerns was entered into the AMS in 1987. Alleged falsification of HVAC system weld records was not substantiated by the licensee's contractor. The licensee's contractor and NRC identified that the welding performed deviated from a field change request without a deficiency notice being initiated. The welding was found to be technically acceptable (refer to Section 5.5.1.8).

- Valve Seismic Inspection Procedure

  An allegation pertaining to the valve seismic inspection procedure was entered into the AMS in 1987. Alleged falsification of the engineering sign-off steps for the valve seismic inspection procedure was not substantiated by the licensee and NRC (refer to Section 5.5.1.9).

- N-5 Code Data Sheets

  An allegation pertaining to N-5 Forms was entered into the AMS in 1987. Alleged inaccurate N-5 Code Data Sheets was not substantiated by NRC.

- Pre-Operational Test Procedures

  During an inspection conducted in 1987, the NRC identified inconsistencies associated with the completion of "witness" sign-off steps, as well as the date in which specific "witness" sign-off steps were completed relative to pre-operational test procedures. The

licensee attributed these inconsistencies to administrative error and NRC concurred.

- Security Training Records

  In 1987, the Region IV OI Field Office received a concern pertaining to security training records. Alleged falsification of security training records was not substantiated by NRC.

- Security/Fitness For Duty (FFD) Records

  An allegation pertaining to numerous concerns, including records falsification, involving the functional areas of security and FFD was entered into the AMS in 1987. Alleged falsification of non-specific records in the functional areas of security and FFD was not substantiated by the licensee and NRC.

- Reinforcing Steel (Rebar) Records

  An allegation pertaining to construction rebar reports was entered into the AMS in 1988. Alleged falsification of rebar reports was not substantiated by NRC.

- Maintenance Work Request QC Hold Points

  An allegation pertaining to maintenance work request QC inspection hold points was entered into the AMS in 1988. Alleged falsification of maintenance work request QC hold points was not substantiated by NRC.

- Maintenance Verification Points

  In 1991, the licensee's Speakout organization investigated a concern pertaining to maintenance verification points. Alleged falsification of maintenance verification points was not substantiated by the licensee and NRC, but inconsistencies, which were attributed to a lack of guidance, were identified.

- Engineering Contractor Training Records

  In 1991, the licensee initiated a third-party review of a concern pertaining to engineering contractor training records. Alleged falsification of engineering contractor training records was not substantiated by a licensee third-party investigation and NRC.

- Health Physics Technician Resumes

  An allegation pertaining to contractor health physics technician resumes was entered into the AMS in 1991. Alleged falsification of contractor health physics technician resumes was not substantiated by NRC.

- Maintenance Work Packages

  An allegation pertaining to several concerns involving plant maintenance activities, including the falsification of maintenance work packages and equipment clearance orders, was entered into the AMS in 1992. Alleged falsification of information contained in maintenance work packages and other documents was not substantiated by the licensee and NRC. Inconsistencies associated with the dates of signature sign-off steps were identified and attributed to a lack of procedural guidance.

- Handgun Inspection Record

  An allegation pertaining to handgun inspection records was entered into the AMS in 1992. Alleged falsification of handgun inspection records was not substantiated by the licensee and NRC.

- Oral Statements

  An allegation pertaining to the accuracy of oral statements made by HL&P management representatives during a management meeting conducted in May 1992 between NRC and HL&P to discuss a plant event was entered into the AMS in 1992. Alleged false oral statements were not substantiated by NRC.

- Radiation Monitor Source Check Record

  An allegation pertaining to the falsification of certain plant and chemical operations-related records was entered into the AMS in 1992. Alleged falsification of a radiation monitor source check record was not substantiated by the licensee and NRC.

- Control Access Monitor Log

  An allegation pertaining to a control access monitor log was entered into the AMS in 1993. Alleged falsification of a control access monitor log was not substantiated by the licensee and NRC.

- Pre-Operational Hydrostatic Test Procedure

  An allegation pertaining to a pre-operational hydrostatic test procedure was entered into the AMS in 1993. Alleged falsification of pre-operational hydrostatic test records was not substantiated by NRC.

- Licensee Event Report

  In 1993, during the in-office review of a licensee event report (LER) that pertained to HVAC dampers, NRC identified potentially inaccurate information contained in the LER. A subsequent OI investigation determined that the information was not willfully falsified.

5.3.3 Pending Concerns

As of September 26, 1994, the following four concerns were still open pending further NRC review.

(1) Equipment Clearance Order

In 1993, while conducting an investigation relative to the concerns discussed under Radiation Monitor Source Check Log, a Region IV OI Field Office investigator was provided a concern pertaining to an equipment clearance order. The NRC determined that the safety significance was minimal. The identification of a potentially falsified equipment clearance order was under NRC review as of September 26, 1994.[7]

(2) HVAC Construction and Installation Records

An allegation pertaining to numerous concerns, including falsified records, involving the HVAC systems (dating to the time that the systems were installed in the facility) was entered into the AMS in 1993. The NRC determined there were no technical concerns associated with this allegation. This allegation was under NRC review as of September 26, 1994.

(3) Records Falsification

In 1994, concerns received from the House Subcommittee on Oversight and Investigations staff were entered into the AMS. These concerns, which include records falsification, are being reviewed by the South Texas Project Allegations Review Team.[8]

(4) Local Leak Rate Test (LLRT) Records

In 1994, during the conduct of an NRC inspection, the inspectors identified a concern pertaining to the documentation involving the LLRT of a motor-operated valve. The identification of potentially falsified LLRT records was under NRC review as of September 26, 1994.[9]

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[7]The Office of Enforcement expects to issue a close-out letter in March 1995.

[8]This NUREG documents the results of the ART's efforts. This allegation may be closed upon issuance of this report.

[9]This issue pertained to a local leak rate test (LLRT) record and was subsequently closed on October 31, 1994. This concern was partially substantiated in that the procedure sign-off step that authorized the LLRT, which was supposed to have been signed by the LLRT coordinator, was signed by a contractor who was not authorized to sign. The LLRT coordinator was on vacation. The safety significance of this concern was minimal because the LLRT test was required and was satisfactorily performed. The contractor had

The following tables reflect statistical information by source, year, functional area, and contractors.

Table 1

Number of Concerns by Source

Source of Concern	Number of Concerns
Anonymous	5
Contractors	7
Former Contractors	11
Former HL&P Employees	4
HL&P Employees	3
Licensee (Programs/Initiatives, etc.)	8
NRC Inspection	5
NRC Investigation	1
Other	2

Table 2

Number of Concerns Identified per Calendar Year

Year	Number of Concerns
1984	3
1985	9
1986	1
1987	6
1988	4
1989	1
1990	3
1991	7
1992	5
1993	4
1994 (9/26/94)	3

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already left the site before this was identified, and the licensee did not interview him during its investigation. In terms of NRC action, OI declined to investigate based on a lack of apparent willfulness. The Region IV office issued a Level IV violation as documented in IR 94-36 dated February 6, 1995.

Table 3

Number of Concerns per Licensee Program/Organizational Functional Area

Functional Area	Number of Concerns
Administration	1
Chemical Operations	2
Construction (fabrication and installation)	11
Fire Protection	2
Maintenance	5
Measuring & Test Equipment	2
Other	2
Plant Operations	4
Pre-Operational Testing	2
Quality Assurance	1
Quality Control	3
Security/Fitness For Duty	5
Training/Qualification	6

Table 4

Number of Concerns per Licensee Contractor

Contractor	Number of Concerns
Applied Radiological Controls	1
Bechtel	1
Ebasco	19
ITI MOVATS	1
Other (indeterminate)	2
Wackenhut	4

The NRC's Office of Investigations was involved in investigating (inquiries, investigations, and assists) 24 of the 46 concerns. Either the licensee or its contractors were involved in investigating at least 35 of the 46 concerns. Eleven of the 46 concerns were also the subject of a related DOL complaint. Twenty-four concerns were identified prior to the full power licensing of Unit 1, or pertained to the period prior to the full power licensing of Unit 1, which occurred on March 22, 1988. Twenty-one concerns pertained to the period following the full power licensing of Unit 1. One concern pertained to both periods.

5.4 Insights into STP Records Falsification

Insights gained from review of the data are presented below. The major topic areas in which significant insights were gained were in the areas of source of concerns, construction/plant operations, organizations and programs,

contractor involvement, level of personnel, wrong-doing, safety significance, causes, licensee actions, and NRC actions. In the context of this review, safety significance is defined as involving the consideration of the actual safety consequence. It does not include considerations of the regulatory significance and potential safety consequences of a given issue. Regulatory significance is addressed in Section 5.5.2.1.

Many sources were involved in the identification of the concerns; however, former and current contractor personnel comprised the single largest source. A minimum of 25 of the 46 concerns (approximately 54 percent) were identified by then current and former HL&P and contractor personnel. Former and current contractor personnel identified at least 18 of the 46 concerns (approximately 39 percent). Relatively few concerns were identified by the NRC, 6 of 46, which can be attributed, in part, to a lack of inspection guidance until 1992. Licensee management personnel were responsible for the identification of at least 8 of the 46 concerns, which can be attributed, in part, to the efforts undertaken by the licensee to address several employee integrity issues that were identified in 1990 and 1991, as well as to actions taken by the licensee in response to NRC Information Notice 92-30, "Falsification of Plant Records."

No distinct trend or pattern was identified as a result of the concerns being evaluated relative to whether they pertained to the construction phase or the operational phase of the facility. Approximately half of the concerns (24 of 46) pertained to the period prior to the full power licensing of Unit 1. Twenty-one concerns pertained to the period subsequent to the full power licensing of Unit 1, while one concern pertained to both periods. However, for any consecutive three-year period, 1985-1987 and 1990-1992 were the periods in which the most concerns were identified (16 for each period). Approximately 70 percent of the 46 concerns were identified during these two periods. Relatively few concerns pertained to calendar years 1988 and 1989, which are the years in which full power licenses were issued for both units.

Also, there was no distinct trend or pattern identified as the result of evaluating the 16 partially or fully substantiated concerns relative to the construction and operational phases of the facility. Seven of the substantiated concerns occurred prior to March 22, 1988, while nine occurred after March 22, 1988.

The identified concerns pertained to many functional areas; however, a majority of the concerns were concentrated in only five areas. Thirty of the 46 concerns, or approximately 65 percent, involved the functional areas of construction (installation and fabrication), quality control, maintenance, training/qualification, and security. Ten of the 16 substantiated concerns pertained to these five areas as well.

A majority of the concerns involved contractor rather than HL&P personnel. Twenty-eight, or 61 percent, of the 46 concerns pertained to contractors who performed work at the facility. Nineteen of these 28 concerns involved Ebasco (approximately 68 percent of the contractor-related concerns), the constructor of the facility. Ten of the 16 substantiated concerns involved contractor personnel. Six of these 10 involved Ebasco personnel.

All levels of contractor and HL&P personnel were the subject of the 46 concerns, including workers (professional and craft), first line supervisors, middle managers, and senior managers. A majority of the 46 concerns pertained to plant workers and first-line supervisors. Eight of the 16 substantiated concerns involved contractor and licensee foremen. Seven of the 16 substantiated concerns involved contractor and HL&P workers. The remaining substantiated concern involved a licensee manager; however, this substantiated concern did not appear to involve willfulness on the part of the involved manager.

Thirteen of the 16 substantiated concerns appear to involve willful misconduct on the part of the involved individuals.

The substantiated concerns were evaluated to determine the actual safety consequences associated with the falsified records. Fifteen of the 16 partially and fully substantiated concerns were assessed as having minimal safety significance. This determination was made on the basis of the following:

- The concern did not pertain to a safety-related activity or a safety-related structure, system, or component (SSC).
- The activity that was performed was technically acceptable despite the falsified records.
- The inadequate activity was detected and corrected before an SSC was required to be operable.
- No personnel received a radiation overexposure.
- There were no events or conditions adverse to quality, which the activity was intended to detect (e.g., fire watch, control room operator rounds, QA surveillance, security patrol, etc.), that occurred or existed at the time that the records associated with the activity were falsified.

The safety significance of the remaining concern was indeterminate (refer to Section 5.5.1.7).

Of the seven substantiated concerns that occurred prior to the full power licensing of Unit 1, three appear to have been caused or influenced by duress from a direct supervisor. Construction schedular pressure was a factor in all three cases. The remaining four substantiated concerns involved individuals who apparently acted on their own volition (without being directed or unduly pressured) to willfully falsify documents.

Of the nine substantiated concerns that occurred after the full power licensing of Unit 1, three appear to have been caused by a lack of guidance or a lack of awareness of existing guidance. One was caused by a lack of appropriate guidance from a supervisor. One was caused by duress from a

contract supervisor.[10] The remaining four substantiated concerns involved individuals who apparently acted on their own volition to willfully violate procedures or falsify records.

The majority of the unsubstantiated concerns can be attributed to administrative error, a lack of awareness or understanding of procedural and programmatic requirements, a lack of procedural guidance, a lack of sufficient information to substantiate a concern, or inaccurate but not falsified records.

It appears that licensee corrective actions relative to specific concerns were appropriate to the circumstances. The licensee and its contractors were involved in the investigation of at least 35 of the 46 concerns. The licensee, and in some cases its contractors, investigated 15 of the 16 substantiated concerns. For those cases in which the licensee determined that procedures were willfully violated or records were intentionally falsified, the corrective action usually included the termination of the involved individuals' employment. In addition, the licensee usually implemented broader corrective actions for those concerns that it investigated subsequent to the investigations conducted by its contractors, however, the licensee did not consider the generic implications in all cases. For example, the licensee's SAFETEAM organization concluded that contractor foremen were forging the signatures of superintendents, who had the responsibility to authorize the issuance of weld filler material, in order to expedite the work of their crews. It does not appear that the broader implications of willfully violating procedures to enhance production were considered by the licensee.

For two concerns, the conclusions reached by the licensee did not appear to be supported by the facts. However, the corrective actions for these two concerns were appropriate. In a few instances, the scope of the licensee's employee concerns program investigations were not sufficiently broad.

As the result of the identification of a number of employee integrity concerns that were identified by the licensee or provided to the licensee's Speakout organization in the second half of 1990 and the first half of 1991, the licensee undertook several positive actions to address this negative trend. These actions included, in part,

- Discussions with HL&P and contractor personnel regarding management's expectations
- Enhanced guidance and expectations
- Actions that resulted in the identification of additional records falsification issues

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[10]Although maintenance production pressure was a factor in this concern, the ART views this as an isolated case that does not affect the ART's conclusions regarding the work environment at STP.

The concerns were evaluated to determine whether the level of NRC inspection follow-up and, as appropriate, investigation follow-up was adequate. Also, the concerns were evaluated to determine whether the regulatory action taken was consistent with NRC policy and guidance that existed at the time that the concerns were dispositioned.

With one exception, the inspection follow-up of the technical and safety implications of the closed concerns was adequate. However, as noted in Section 5.5.1, the documentation of this follow-up was not complete in every instance.

With one exception, the level of OI involvement was appropriate. Twenty-four of the 46 concerns resulted in OI inquiries, investigations, or assists. Six of these occurred during the period 1984 through 1988, while 18 occurred (or were ongoing) during the period 1989 through September 26, 1994. Of the 5 concerns that OI did not investigate subsequent to 1988, four of the five involved issues in which the regional staff had sufficient information to make the appropriate regulatory decision, while the NRC's Office of the Inspector General investigated the remaining concern which comprised one issue of a broader allegation. There was documented evidence that 16 of the 17 concerns that OI did not investigate prior to 1989 were dispositioned in accordance with the guidance found in NRC Manual Chapter 0517, Appendix 0517, Part III, or OI involvement was determined to be unnecessary on the basis of the results of the initial inspection follow-up of the concerns by the regional technical staff. There was insufficient documentation to determine the reason(s) why OI did not investigate the remaining concern.

The guidance noted above provided for the prioritization of investigation resources on the basis of the significance of the concern and provided for the administrative termination of wrong-doing investigations on a case-by-case basis. For low and normal priority cases, OI could close a case if its projection of resource allocations indicated that the investigation could not be initiated within a reasonable period of time, which was normally six months. Since the beginning of 1989, enforcement action determinations have been made consistently in accordance with NRC policy. An analysis of the concerns revealed that enforcement action was not taken for those substantiated concerns that were identified prior to 1989 in most instances. Because of a lack of documentation relating to these older concerns, it is not clear whether or not enforcement action was considered by the appropriate level of NRC management.

Three considerations potentially account for a lack of enforcement regarding these older concerns. First, 10 CFR 50.9, which requires, in part, that licensees provide information that is complete and accurate in all material respects, did not become effective until February 1, 1988. Although there was guidance in the NRC's Enforcement Policy (10 CFR Part 2, Appendix C), which provided enforcement sanctions for willful violations of requirements, there was additional guidance in the 1987 revision of NRC Manual Chapter 0517, NRC Appendix 0517, Part III, which provided a basis for taking no further regulatory action for those cases in which a licensee discovers that a low level employee deliberately violated a requirement or falsified a document,

disciplines the employee, and takes appropriate corrective action, which the NRC staff has reviewed. An additional consideration that may have accounted for a lack of enforcement action was that six of the seven substantiated concerns that were identified prior to 1989 were determined to be of minimal safety significance or pertained to nonsafety-related activities. Enforcement action was taken for the remaining substantiated concern.

Subsequent to 1988, enforcement action was consistently taken, or considered and enforcement discretion granted in those cases for which a violation occurred and the criteria specified in the Enforcement Policy were satisfied. This can be attributed, in part, to 10 CFR 50.9 becoming effective in 1988, and to enhanced Enforcement Policy guidance relative to willful violations and enforcement discretion. For example, one concern resulted in the issuance of a Severity Level III Notice of Violation of 10 CFR 50.9 and a $50,000 civil penalty. A second example involved the identification of a noncited violation because the criteria specified in the Enforcement Policy were satisfied.

5.5 Conclusions and Recommendations

5.5.1 Results of Review

For nine of the 46 concerns (seven substantiated and two unsubstantiated concerns), the review results indicated that (1) the level of NRC follow-up did not provide an adequate basis for closure of the concern, (2) the basis for closure was not fully documented, or (3) the justification for not taking enforcement action was not sufficiently documented. The safety significance of eight of these nine concerns was minimal. The safety significance of the remaining issue was indeterminate on the basis of the available documentation.

5.5.1.1 Follow-up of an Allegation Pertaining to Welder Certification Records (1984)

A contractor foreman's employment was terminated for intentionally documenting the performance of a weld that he did not actually perform. The foreman falsified the records in an attempt to maintain his welder certification. The NRC closed this allegation on the basis of a letter to HL&P that acknowledged the licensee's action. A review of the licensee's investigation report by NRC confirmed that the weld, which was actually performed by another individual, pertained to a nonsafety-related system. The basis for not conducting an OI investigation of this issue is not documented, nor was the basis for not taking enforcement action. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.2 Follow-up of an Allegation Pertaining to Welder Certification Records (1985)

A licensee's SAFETEAM investigation substantiated that a contractor supervisor had attempted to falsify his welder's certification, but the licensee concluded that since the individual never became certified, he never actually committed the act of falsification. Since the individual was never certified,

the safety significance was minimal. The individual's employment was terminated. This allegation was closed, but there is no documentation in the corresponding inspection report that explicitly documented whether any records required to be maintained by NRC regulations were actually falsified in this instance, regardless of whether or not the individual in question was certified as a welder. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.3 Follow-up of an Allegation Pertaining to Weld Filler Material Issue Records (1985)

A licensee SAFETEAM investigation substantiated 18 instances in which contractor foremen were forging the signatures of the superintendents responsible for authorizing the issuance of weld rods and verifying that the weld rods and procedures were appropriate for the work to be performed and that the welders were certified. The 18 instances occurred in 1983, and the licensee concluded that the signatures were forged by the foremen to expedite work by their crews. The licensee concluded that all other data documented on the filler material issue records were accurate. The safety significance of this issue was minimal because there was no evidence that the wrong weld rods were issued, nor was welding conducted by uncertified welders. This issue was closed in an inspection report. There is no documentation as to whether the regulatory implications (e.g., numerous examples of falsification by first line supervisors because of schedular pressure) of this were considered. The Director of the Region IV OI Field Office was apprised of this concern, but the technical staff recommended that an OI investigation not be performed because of the low safety significance of the concern. No enforcement action was taken. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.4 Follow-up of an Allegation Pertaining to Violations of Construction Procedures (1985)

An NRC inspection substantiated that rework pertaining to the installation of cable tray clips had been conducted prior to the issuance of the field change requests (FCRs) that authorized the rework. The inspector concluded that this unauthorized rework occurred as the result of schedular pressure ("pushing production"). Although the safety significance of this issue was minimal because the unauthorized rework generally conformed to the FCRs that were subsequently issued and the licensee's contractor had implemented corrective actions, there is no documentation as to whether this unauthorized rework constituted a willful violation of construction procedures. Similarly, there is no documentation as to whether there were any falsified records associated with this unauthorized rework. This allegation was closed with no other NRC action taken. Given the age of the concern, the actions taken by the licensee and its contractor, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.5 Follow-up of an Allegation Pertaining to Violation of QC Hold Points (1985)

The licensee's SAFETEAM substantiated that a contractor foreman directed welders to perform welding in Unit 2 without complying with the QC hold point requirements. The foreman's employment at STP was terminated as the result of a SAFETEAM recommendation. The Region IV OI Field Office declined to investigate this case on the basis of a lack of safety significance of the issue. The safety significance of this concern was minimal because the welding was satisfactorily performed. No enforcement action was taken for this willful procedure violation, nor was there any documentation that provided the justification for not taking enforcement action. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.6 Follow-up of an Allegation Pertaining to Torque Wrench Calibration Records (1988)

A licensee SAFETEAM investigation substantiated that a Physical/Dimensional Laboratory technician had knowingly incorrectly calibrated four torque wrenches/adapters. The documented accuracy span was not in agreement with the calibration check results which were obtained as a result of the investigation within 24 hours of the torque wrench calibrations that were performed by the involved individual. The licensee's SAFETEAM did not conclude that the documented accuracy span data had been falsified. The inspection report documents that there was evidence that the technician falsified records that indicated the completion of required reading requirements, but no details of this issue were provided. The technician resigned. The safety significance of this issue was minimal because the miscalibrated torque wrenches were used in nonsafety-related applications and a sample of other calibrations performed by the technician revealed no other problems. It appears that the licensee had enough information to substantiate that records falsification occurred as alleged, but this is not identified in the inspection report documentation. The allegation was technically closed with no further NRC action. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.7 Follow-up of an Allegation Pertaining to Electrical Termination Records (1985)

The Region IV OI Field Office initiated an inquiry to determine whether a contractor electrician and his coworkers were being harassed and intimidated by a contractor foreman, thereby causing paperwork, specifically Unit 1 control room electrical termination records, to be falsified. This allegation was closed approximately 1-1/2 years after it was opened. The OI inquiry was closed administratively without an investigation on the basis of the low priority that it was assigned and the lack of OI resources. This justification conformed to the NRC guidance that existed at the time. The technical basis for closure of the allegation was that there was no evidence of records falsification identified during previous inspections of electrical work pertaining to the control room. No on-site inspection follow-up was

conducted specifically in response to this concern. As a result, it is recommended that the Region IV Allegation Review Panel (ARP) review this concern to determine whether additional follow-up action is warranted and document the basis for its decision.

5.5.1.8 Follow-up of an Allegation Pertaining to HVAC Weld Records (1987)

An NRC inspection substantiated that welding of an HVAC plenum did not conform to an FCR, and that this nonconformance was not documented in a Non-Conformance Report or a Deficiency Notice. The safety significance of this issue was minimal because the nonconforming condition was determined to be acceptable. However, there is no documentation in the inspection report regarding the cause of the nonconforming condition (e.g., a procedure violation). Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.1.9 Follow-up of an Allegation Pertaining to the Valve Seismic Inspection Procedure (1987)

The NRC performed inspection follow-up of a licensee SAFETEAM investigation of whether or not records pertaining to seismic inspection requirements for valves had been falsified. The licensee concluded that the seismic inspection requirements had not been falsified, but there were instances of failure to follow the procedural requirements, which occurred because of a lack of procedural guidance. No technical concerns affecting the valves were identified. The inspection report documentation states that the concern was substantiated but was of minor significance. There is no discussion that explains whether or not the NRC concluded that the procedure documentation was deliberately falsified or that the procedure had been violated. No other NRC action was taken. Given the age of the concern, the actions taken by the licensee, and the lack of safety significance, it is recommended that this concern remain closed.

5.5.2 Conclusions

5.5.2.1 Significance of Records Falsification

The actual safety significance of the substantiated instances of records falsification and related concerns was minimal; however, these concerns were potentially significant. Prior to the full power licensing of Unit 1, the available evidence indicated that during the construction of the facility, some licensee contractor personnel, particularly first level supervisors who were involved in the construction of the facility, willfully circumvented established procedures in order to facilitate construction and installation activities. This adverse trend pertaining to inappropriate schedular pressure was generally recognized by NRC as evidenced by the number of special reviews that were conducted by NRC Region IV and the Office of Nuclear Reactor Regulation prior to the full power licensing of Unit 1.

For those issues substantiated after full power licensing, there was no discernible trend or pattern. These issues were potentially significant primarily because there were several instances of willful violations committed by licensee employees and contractors that occurred over a period of a few months. However, this adverse trend was recognized by NRC and the licensee, and the licensee implemented corrective actions to address it.

5.5.2.2 Adequacy of NRC Actions

Before 1989, there were several instances in which the NRC follow-up of potential records falsification issues either were not conducted fully in accordance with existing NRC guidance or were not documented fully. However, in all but one instance, the safety significance of the issues were identified and assessed. As the result of enhanced NRC policy and guidance, such as a revised enforcement policy and 10 CFR Section 50.9, the NRC's sensitivity and handling of STP records falsification concerns has been consistent and appropriate for the past several years.

5.5.2.3 Adequacy of Licensee Actions

On the basis of a review of the available documentation, licensee corrective actions in response to substantiated instances of records falsification and related concerns were adequate relative to a specific concern. There was some evidence that suggested, particularly prior to the full power licensing of the two units, that the licensee did not always consider the generic implications of substantiated records falsification. In two instances, the licensee's investigative conclusions did not appear to be supported by the facts of the case; however, the corrective actions taken were appropriate. Beginning in 1991, the licensee began to implement comprehensive corrective actions to address a variety of employee integrity issues, including records falsification.

5.5.3 ART Recommendations

- It is recommended that the NRC Region IV ARP perform a review of Section 5.5.1.7 to determine whether additional NRC action is appropriate and to implement any identified follow-up actions. The results of this review should be provided to the NRR OAC.

- Given that the licensee's corrective actions have not addressed the generic implications of an issue in every instance, which has also been noted by other NRC reviews and assessments of licensee activities, it is recommended that NRC Region IV identify a sample of substantiated records falsification issues in order to reverify the overall, long-term effectiveness of the corrective actions taken. The results of this follow-up review should be provided to the NRR OAC.

6 SUMMARY AND CONCLUSION

The South Texas Project ART reviewed, referred, and dispositioned allegations related to discriminatory issues (harassment and intimidation), falsification of records and omission of information, and various technical issues. This report addresses the status of the OI review of the discrimination allegations (one potential discrimination case is still being reviewed and investigated by the Office of Investigations) and addresses resolution of the various technical issues.

The team was able to substantiate certain technical issues of minor safety significance or regulatory concern at the South Texas Project facility. The team noted that the licensee, as well as the NRC, was aware of the issues and had taken steps to correct any outstanding deficiencies. In most instances, the allegations were not substantiated. The team referred certain items to the NRC Region IV office for further follow-up action. The team did not uncover widespread discriminatory practices such as harassment and intimidation. While some examples of discriminatory behavior were identified, and some of the technical issues were substantiated, the team concluded that these substantiated allegations did not affect the safe operation of the plant.

The ART received nine allegations regarding potential discriminatory conduct by the licensee or its contractor. One allegation is under active investigation by OI, and one allegation was consolidated into this ongoing investigation due to the supporting nature of the allegation. Seven allegations have been closed. The status of these allegations is listed in Table 1.

Technical allegations, including allegations of falsification and omission of information, were reviewed and evaluated by the STP ART. The team took the view that a determination of the safety and regulatory significance of the issue in question was necessary. Subsequently, the team's objective was to ensure that the allegation, if substantiated, was being adequately addressed.

The ART reviewed 40 technical allegations. Of the 40 allegations, 15 were substantiated (at least in part), but could be closed because the issue was not safety-related or the licensee had identified the issue and had taken or is taking adequate corrective action. The remaining 25 technical allegations were not substantiated. Table 2 lists the status of these allegations.

The ART's final report also includes the results of a special historical review of record falsification allegations (the third DEDO initiative noted in Section 1.2 of this report). Forty-six concerns were reviewed, including false oral statements, willful procedure violations, and inaccurate records.

Forty-three of the 46 concerns have been closed. Although the technical aspects of the three remaining concerns have been addressed, these concerns are still open pending the results of an OI investigation or potential enforcement. Table 3 lists the status of the record falsification allegations.

TABLE 1

STATUS OF DISCRIMINATION ALLEGATIONS

SECTION	DESCRIPTION OF ALLEGATION
3.2	Discrimination Allegation #1 - OI investigated this allegation under case number 4-92-005, which was administratively closed on February 8, 1995. A complaint was filed with the DOL in February 1992, and the NRC is holding further action in abeyance pending the DOL decision.
3.3	Discrimination Allegation #2 - OI investigated this new allegation under case number 4-94-044. OI closed this case on January 17, 1995, and found that the evidence did not substantiate that discrimination occurred.
3.4	Discrimination Allegation #3 - The NRC Office of the Inspector General had previously opened case number 9249I for this allegation in 1992 and closed the case in February 1993. OI closed its case on February 6, 1995, based on the conclusions of the OIG report. A DOL complaint was filed and the NRC is holding further action in abeyance pending the DOL decision.
3.5	Discrimination Allegation #4 - This allegation is being pursued by OI with a new case number 4-94-037. A DOL complaint was filed in September 1994 and the NRC is monitoring DOL activities. Although the DOL Area Director found in favor of the licensee, OI has yet to dismiss that discrimination was a factor in some of the actions taken against the alleger.
3.6	Discrimination Allegation #5 - OI has not found evidence of adverse action taken against this individual to pursue an allegation of discrimination. Because this individual was supporting the alleger discussed in Section 3.5, OI consolidated this allegation under case number 4-94-037. This allegation remains open pending closure of 4-94-037.
3.7	Discrimination Allegation #6 - This individual was supporting the alleger discussed in Section 3.2. The alleger later contacted the Region IV office which opened case number 4-94-057. This case was closed on February 9, 1995, based on the withdrawal of the concerns by the alleger and no apparent violation of NRC regulations.
3.8	Discrimination Allegation #7 - This individual was supporting the alleger discussed in Section 3.2. When contacted by OI, the individual did not allege a discrimination concern. This allegation is closed.

TABLE 1 (continued)

SECTION	DESCRIPTION OF ALLEGATION
3.9	Discrimination Allegation #8 - OI investigated this allegation under case number 4-94-043. OI did not find evidence of action taken against this alleger to pursue an investigation of discrimination and closed this allegation on February 9, 1995.
3.10	Distributing Whistleblowers' Names - The ART determined that this allegation is substantiated. However, the reasons given by the licensee for maintaining such a database for litigation activities to assist its staff in responding to legal matters are reasonable. The ART finds the licensee's response to this concern acceptable.
3.11	Allegation of Potential Discriminatory Action - This potential alleger did not specifically allege a discrimination issue. Based on this review, OI concluded that if the individual were to have actually had this discrimination concern, there appeared to be no basis for a claim of discrimination (for no adverse action had been taken against the individual). Additionally, the ART concluded that no allegation had, in fact, been made, and no further action was warranted.
3.12	Conclusion Regarding the Work Environment at STP - The congressional subcommittee staff indicated that it suspected widespread discriminatory practices had occurred at STP. However, the relatively few number of DOL cases opened and allegations of discrimination received by the ART do not suggest this. The ART concluded that the allegation of widespread discriminatory practices is unsubstantiated.

TABLE 2

STATUS OF TECHNICAL ALLEGATIONS

STATUS	SECTION	DESCRIPTION OF ALLEGATION
S	4.2.1	Control of maintenance work
N,V*	4.2.2	Changes to fire protection system work order
S	4.2.3	Backdating of documentation
N	4.2.4	Work was performed without documentation
N	4.2.5	Motor pedestal sandblasting
S,F	4.3	Station problem reports
N,F*	4.4	Modifications
N	4.5.1	Inadequate welding procedure on steam generator plug repair
S	4.5.2	Steam generator tubes were not all inspected as planned
S,V	4.6.1	Neglected polar crane maintenance
N	4.6.2	Draft report of polar crane problems
N	4.7.1	Diesel generator piston tin transfer
N	4.7.2	Diesel generator fuel pump hold down studs
N	4.8.1	Valves installed backwards
S	4.8.2	Valves were repeatedly reworked
S	4.8.3	Valve packing procedures were not followed
S,V	4.8.4	Valve lineup was not verified
N,F*	4.8.5	Thermal binding of gate valves
S,F	4.8.6	Work was done on valve without instruction
N	4.8.7	Valves were not well-protected in the warehouse
N	4.9.1	MOV inspection
N	4.9.2	MOV program self-assessment
SP,F	4.10	Inservice testing
N	4.11.1	Worker qualification
N	4.11.2	Training
S,V	4.12.1	Visitor access
N	4.12.2	Unit 2 lockdown
N	4.12.3.1	Safeguards documents not properly decontrolled
S,V	4.12.3.2	Safeguards information left unguarded
N	4.12.4.1	Security lighting
SP	4.12.4.2	Lock and key procedure
SP,V	4.12.5.1	Discovery of a weapon in the protected area
N	4.12.5.2	Attempted entry through security door
N	4.12.6	Security system cables

TABLE 2 (continued)

STATUS	SECTION	DESCRIPTION OF ALLEGATION
N	4.13	Independent safety engineering group
S	4.14	Plant trip
N	4.15.1	Falsification of work packages
N	4.15.2	Foreman signed off package without verifying work
N	4.15.3	Supervisor signed off paper without actually verifying
N	4.15.4	An unqualified person worked on seismic monitors

Legend:

S Substantiated
N Not substantiated
F NRC follow-up recommended
V Possible enforcement action
SP Substantiated, in part
* Violation or inspection follow-up is due to information related, or similar to, allegation.

TABLE 3

RECORD FALSIFICATION ISSUES

I. Section 5.3.1, "Substantiated Concerns," Closed Allegations:

1. Welder Certification Records (1984)
2. Welder Certification Records (1985)
3. Weld Filler Material Issue Records (1985)
4. Construction Procedures (1985)
5. Quality Control Hold Point (1985)
6. Fire Watch Log (1988)
7. Torque Wrench Calibration Records (1988)
8. Fire Watch Logs (1989)
9. Radiation Work Permit (1990)
10. Security Patrol Log (1990)
11. Quality Assurance Surveillance Report (1990)
12. Maintenance Work Package (1991)
13. Control Room Operator Logs (1991)
14. Maintenance Technician Certifications (1991)
15. Visitor Access Record (1991)
16. Chemical Operator Logs (1992)

II. Section 5.3.2, "Unsubstantiated Concerns," Closed Allegations:

1. QC and Coating Records (1984)
2. Piping Heat Numbers (1985)
3. Electrical Termination Records (1985)
4. Measuring and Test Equipment (M&TE) Calibration Records (1985)
5. Structural Steel Beams (1985)
6. Contractor Time Sheets (1985)
7. QC Inspector Qualification Records (1985)
8. Component Cooling Water (CCW) System Weld Records (1986)
9. Heating, Ventilating, and Air Conditioning (HVAC) System Weld Records (1987)
10. Valve Seismic Inspection Procedure (1987)
11. N-5 Code Data Sheets (1987)
12. Pre-Operational Test Procedures (1987)
13. Security Training Records (1987)
14. Security/Fitness For Duty (FFD) Records (1987)
15. Reinforcing Steel (Rebar) Records (1988)
16. Maintenance Work Request QC Hold Points (1988)
17. Maintenance Verification Points (1991)
18. Engineering Contractor Training Records (1991)
19. Health Physics Technician Resumes (1991)
20. Maintenance Work Packages (1992)
21. Handgun Inspection Record (1992)
22. Oral Statements (1992)
23. Radiation Monitor Source Check Record (1992)
24. Control Access Monitor Log (1993)
25. Pre-Operational Hydrostatic Test Procedure (1993)
26. Licensee Event Report (1993)

TABLE 3 (continued)

III. Status of Section 5.3.3, "Pending Concerns," Allegations:

1. Equipment Clearance Order (1993) - Active; OE expects to issue a close-out letter in March 1995.

2. HVAC Construction and Installation Records (1993) - Active; this item is still in progress.

3. Records Falsification (1994) - Active; this allegation may be closed upon issuance of this NUREG report.

4. Local Leak Rate Test (LLRT) Records (1994) - Closed; this allegation was closed on October 31, 1994, and was considered partially substantiated.

7 LESSONS LEARNED

Although the ART interviewed only a limited number of allegers, several common themes were suggested by nearly every individual interviewed. The following themes were frequently mentioned: (1) individuals could not approach their supervisors without fear of retaliation; (2) if individuals approached NRC Region IV personnel with a concern, they believed their identity would be released to the licensee; (3) individuals had no confidence that the NRC Region IV Office would adequately address their concerns; and, (4) little or no response was ever received from the NRC Region IV Office regarding the disposition of their concerns.

As a result of these interviews, the team believes that the licensee should develop and maintain a climate that fosters the identification and correction of problems, issues, and concerns without fear of retaliation. The team believes a method should be established so that individuals can raise concerns beyond normal processes (which is usually through a supervisor), and employees should be informed of those methods. Also, each licensee's contractors should conform to the prohibition against discrimination and encourage problem identification.

The team recognizes that the NRC is aware of these types of concerns and issues, and has taken steps to address them. The goal of recent NRC staff efforts is to encourage licensees to create and maintain a "quality-conscious workplace," in which employees are encouraged to identify and report safety problems, and do not fear retaliation for doing so. To this end, the NRC issued NUREG-1499, "Reassessment of the NRC's Program for Protecting Allegers Against Retaliation." This report discussed, and made specific recommendations in regard to, licensee actions to foster a quality-conscious work climate, and NRC actions to improve allegations management, among other subjects. The review and implementation of the report's recommendations were discussed in SECY-94-089, dated March 29, 1994. The Commission agreed with the staff recommendations, with comment, as noted in the staff requirements memorandum of June 2, 1994.

As a result, a draft policy statement, "Freedom of Employees in the Nuclear Industry To Raise Safety and Compliance Concerns Without Fear of Retaliation" was published in SECY-94-303 on December 19, 1994. The Commission agreed with the staff recommendations, with comment, as noted in the staff requirements memorandum dated January 24, 1995. Subsequently, the NRC published the draft policy statement, "Freedom of Employees in the Nuclear Industry to Raise Safety Concerns Without Fear of Retaliation" for public comment in the Federal Register on February 8, 1995 (60 FR 7592). This NRC draft policy statement addresses the need to foster a quality-conscious work environment in which concerns can be raised without fear of retaliation; the team supports this statement.

Additionally, the NRC has revised its policy for protecting the identity of individuals bringing concerns to the attention of the NRC. This policy is in the process of being approved by the Commission and will be published as a revision to Management Directive 8.8, "Management of Allegations." To ensure that the NRC afforded as much protection as possible to those individuals raising concerns prior to formal approval, the NRC Executive Director for Operations required implementation of this new policy by issuing an interim policy statement on August 22, 1994, entitled "Informing Allegers of the Degree to Which the NRC Can Protect Their Identity." (For those allegers interviewed by the ART, this interim policy statement was included in the ART's initial response letter to each alleger.) This directive, upon approval, should improve the overall agency management of allegations.

The team also knows that the Office of Nuclear Reactor Regulation is developing guidance to review licensee efforts in regard to handling employee concerns. Although there is limited inspection guidance regarding the review of licensee handling of employee concerns in NRC Inspection Procedure 40500, "Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems," the new guidance should provide insight for improvements in the licensee programs as well as for the NRC review of those programs.

The team believes that the actions taken or planned by the NRC staff, as discussed above, should over time address the common themes suggested by the allegers who were interviewed by the ART. The team fully endorses these actions.

APPENDIX A

CHRONOLOGICAL LIST OF CORRESPONDENCE REGARDING ALLEGATION REVIEW TEAM ACTIVITIES

May 6, 1994	Memorandum, James Milhoan to Ben Hayes and William Russell, "Review of Allegations Regarding South Texas Project."
May 23, 1994	Memorandum, Ben Hayes to James Milhoan, "Allegations Team Charter for Review of Allegations Regarding the South Texas Project."
May 31, 1994	Memorandum, James Milhoan to Ben Hayes and William Russell, "Team Charter for Review of Allegations Regarding the South Texas Project."
August 26, 1994	Memorandum, James Milhoan to James Fitzpatrick (sic, Fitzgerald) and William Russell, "South Texas Project Review Activities."
September 9, 1995	Allegations Review Board Summary for Allegation No. NRR-94-A-0029, with attachment, "STP Allegation Review Team - Plan for Handling Allegations."
October 19, 1994	Memorandum, Lawrence Kokajko and Daniel Murphy to W. Russell, "Charter Revision."
February 3, 1995	Allegations Review Board Summary for Allegation No. NRR-94-A-0029.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

MEMORANDUM FOR: Ben B. Hayes, Director
Office of Investigations

William T. Russell, Director
Office of Nuclear Reactor Regulation

FROM: James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

SUBJECT: REVIEW OF ALLEGATIONS REGARDING THE SOUTH TEXAS PROJECT

NRC personnel recently met with staff of the Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce to discuss the NRC's handling of problems at the South Texas Project (STP). The Subcommittee's staff informed the NRC of their recent meetings with persons in Bay City, Texas who shared their safety concerns regarding STP. The Subcommittee's staff stated, however, that the individuals who voiced the concerns did not wish to share them with NRC personnel in Region IV. Although the Subcommittee's staff did not give the specific safety concerns to the NRC, the discussions indicated a need to obtain, review and evaluate any safety concerns held by these persons. The Subcommittee's staff also discussed the Quadrex Report, a critical review of the engineering work performed by the Brown and Root Company in early 1981, and suggested that the findings in the report were similar to those reported in the 1993 Diagnostic Evaluation Team (DET) inspection report of STP. To address this matter, you are to take the following actions (these actions should be performed independent of Region IV):

1. Form an Allegation Team led by OI to obtain transcribed interviews of any persons who may have safety concerns regarding STP, including STP employees (present and former).

   - prepare a team charter for my approval within one week of the date of this memorandum
   - this assignment has priority over all other assignments for the designated team members and should be conducted expeditiously
   - maintain a chronology of all persons contacted in addressing this matter
   - document the results of interviews to the extent necessary to capture all salient information
   - maintain records of the information that you collect
   - keep me apprised of the status of your activities on this matter on about a weekly basis

2. Present any allegations obtained by the Allegation Team to the NRR Allegation Review Board (ARB). The ARB should review and evaluate the allegations and, if necessary, recommend further action.

3. After completing items 1 and 2, the Allegation Team should submit a report to me on the results of their activities, including information on the allegations referred to the ARB.

4. NRR should review and evaluate the allegations and compare them to the information contained in the Quadrex Report, NUREG-1306, and the 1993 STP DET report to identify any common problems identified in the reports. Based on this review, identify any lessons learned from this effort that would improve similar staff actions in the future.

5. NRR should periodically provide the status of actions taken to address the allegations referred to the ARB by the Allegation Team.

6. Since there are continuing concerns about the STP employee concern program, NRR also should provide a schedule and plan for conducting a future inspection(s) of the program.

James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

May 23, 1994

MEMORANDUM FOR: James L. Milhoan, Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research

FROM: Ben B. Hayes, Director
Office of Investigations

SUBJECT: ALLEGATIONS TEAM CHARTER FOR REVIEW OF ALLEGATIONS REGARDING THE SOUTH TEXAS PROJECT

In response to your memorandum dated May 6, 1994, a team consisting of Daniel D. Murphy, of my staff, and Lawrence E. Kokajko, NRR, will take the following actions to address the concerns of Congressman John Dingell and his staff, regarding allegations raised by whistleblowers at the South Texas Project.

1. Obtain a list of all Department of Labor complaints filed by whistleblowers at STP. Determine the disposition of each of the cases and, if possible, the safety concerns they raised to place them in a "protected activity" status. (OI)

2. Contact Leo Norton, NRC Inspector General's Office, and obtain a list of all names and addresses of individuals they have interviewed regarding allegations at STP. (OI)

3. Contact members of Congressman Dingell's staff and obtain a list of all the names and addresses of individuals they interviewed regarding allegations at STP. This could involve contacting the attorneys who represent a segment of the whistleblowers. (OI)

4. With the information obtained from these three sources, compile a list of potential interviewees. (OI)

5. Once the list has been compiled, determine how many, if any, have submitted allegations to the NRC and how the allegations have been dispositioned. In addition, obtain copies of Transcripts, Reports of Interviews, Sworn Statements, or any other document outlining their concerns. (OI)

6. Review any inspection report or OI investigative report which resulted from these allegations. Attempt to determine if the allegations were substantiated. If substantiated, what action was taken by the NRC or licensee. (OI)

7. Attempt to determine, without disclosing the identity of the individual, if

they had submitted an allegation through STP's Speak Out/Employee Concern Program. In those instances where an allegation was submitted to STP, determine the disposition of the allegation. (OI)

8. Review the major NRC inspection efforts and Regional/NRR allegation records for the years since NUREG 1306, (the Calvo Report) was completed. Attempt to determine if allegations by any of the potential interviewees were addressed by the inspection or allegation review. Determine if the allegations were substantiated. (OI/NRR)

9. Once all of these activities have been completed, and a list of interviewees has been compiled, take action to set-up dates and location for the interviews. If the interviewee is represented by an attorney, notify the attorney of the tentative date and location of the interview. (OI)

   NOTE:
   It would clearly be more efficient and cost effective if all the interviews were conducted at the same location. This would probably be in the vicinity of STP. Any special logistic or administrative problems would have to be addressed as they surface. Based on past experience, the availability of the interviewee's attorney has constantly created delays in the process. Hopefully this can be overcome by addressing the issue early on with the respective attorneys. All arrangements for court reporters and space to conduct the interviews will be accomplished by OI.

10. Interview all of the whistleblowers and obtain sworn transcribed interviews. Allow each interviewee the opportunity to openly discuss their concerns. In addition, obtain any documents or other forms of evidence which might substantiate their allegations. (OI/NRR)

11. Brief the DEDO of status of investigative activities on or about a weekly basis. (OI/NRR)

12. From the information obtained during these interviews, attempt to establish which allegations are new and not previously addressed by the NRC. (OI/NRR)

13. Send a letter to each whistleblower expressing our appreciation for their taking the time to apprise us of their concerns and informing them, when possible, of the action taken or to be taken by the NRC. (OI)

14. Present all new allegations to the Allegations Review Board (ARB) for review and evaluation; the ARB will recommend appropriate action, if necessary; NOTE: Allegations may be provided to the ARB in "groups" as the interviews are completed and allegations screened. When possible, they will be grouped by technical discipline. (OI/NRR)

15. Prepare a summary report to DEDO documenting the activities of the team. A copy of the report and all the testimony and documentation should be sent to the NRR Allegations Coordinator. The report should outline all the concerns of the whistleblowers, both technical and wrongdoing, and the

disposition of these concerns. (OI/NRR)

16. Review and evaluate the allegations, and compare them to the information contained in the Special Inspection Report, NUREG 0948, the Calvo Report, NUREG 1306, and the 1993 STP DET Report to identify any common problems identified in the reports. For all new allegations, assess resource needs and conduct on-site inspection or transmit requests for information to licensee, as appropriate, to complete evaluation. (NRR)

17. Maintain a data base (separate from AMS) of allegations and provide status periodically to DEDO. (NRR)

18. Provide written results of technical evaluation back to alleger. (NRR)

19. Plan and schedule a future inspection(s) of the STP Employee Concern Program. (NRR)

MAY 31 1994

MEMORANDUM FOR: Ben B. Hayes, Director
Office of Investigations

William T. Russell, Director
Office of Nuclear Reactor Regulations

FROM: James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

SUBJECT: TEAM CHARTER FOR REVIEW OF ALLEGATIONS
REGARDING THE SOUTH TEXAS PROJECT

I approve the subject charter provided by B. Hayes memorandum dated May 23, 1994 subject to the following:

1. The team should maintain a chronology of its activities.

2. With respect to item 16, NRR should identify any lessons learned from this effort that would improve similar staff actions in the future.

ORIGINAL SIGNED BY:
JAMES L. MILHOAN

James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

cc: J. Taylor
F. Miraglia
J. Callan, RIV
V. McCree
OCA

AUG 26 1994

MEMORANDUM TO: James A. Fitzpatrick, Acting Director
Office of Investigations

William T. Russell, Director
Office of Nuclear Reactor Regulation

FROM: James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations and Research

ORIGINAL SIGNED BY:
JAMES L. MILHOAN

SUBJECT: SOUTH TEXAS PROJECT REVIEW ACTIVITIES

The Allegations Team Charter for Review of Allegations Regarding the South Texas Project (memo, B. Hayes to J. Milhoan dated May 23, 1994) subsequently approved on May 31, 1994 (memo, J. Milhoan to B. Hayes and W. Russell) indicated that I would be briefed periodically on the status of activities (Items 11 and 17). The Charter (Item 15) also indicates that a summary report should be provided to me documenting the activities of the team.

Separately, the Charter for the South Texas Project Inspection Program and Implementation Effectiveness Review Team (memo, W. Russell to J. Milhoan dated July 8, 1994) also indicated that I would be provided monthly briefings on team activities.

Since the teams have now been established and are now beginning their review activities, and due to my past involvement in NRC inspection activities related to the South Texas Project (as Regional Administrator and Division Director) I request W. Russell assume responsibilities for me on maintaining status of the Allegation Team and Inspection Program and Implementation Effectiveness Review Team activities and brief the EDO directly on significant developments. Team reports should also be provided directly to the EDO. The EDO has concurred in the above request.

cc: K. Cyr, OGC
J. Taylor, EDO
D. Murphy, OI
W. Bateman, NRR

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ALLEGATION REVIEW BOARD

SUMMARY

Allegation Number NRR-94-A-0029
TAC Nos. M89497 and M89498

1. The NRR Allegation Review Board met on September 9, 1994, at 8:00 am.

2. Present at the meeting were:

RLSpessard*	LKokajko
JRoe*	DMurphy
WBeckner	H-BWang
WBateman	DSkay
AGallow	JLee*

3. Facilities/organizations involved: South Texas

4. Allegation title: (A) Multiple Technical Issues; (B) H&I; (C) Potential Wrongdoing by Licensee; (D) Potential OIG Issues

5. This allegation has been previously assigned by the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research to a Special Review Team (of PDIV-2 and OI)

6. The ARB previously determined the allegation to be of potential safety significance.

7. The ARB previously assigned this allegation a Priority Level of 2 after consideration of its safety significance.

8. Attached is a copy of the resolution plan approved by the ARB.

9. Additional comments: The ARB reconvened to discuss the first compilation of allegations that have been received by the Special Review Team. The team reported that its efforts are ongoing to interview the

*ARB members

allegers and gather allegations. As additional allegations are received and screened, the team will inform the ARB of its progress.

11. Prepared by: Jean Lee — 9/20/94
Jean Lee, Office Allegations Coordinator — Date

12. Approved by: [signature] — 9/21/94
R. Lee Spessard, Chairman, ARB — Date

Distribution:
DD:NRR
ADT:NRR
ADPR:NRR
Director, OI
CERossi
WBeckner
DMurphy
LKokajko
AGautam
NRR OAC

STP ALLEGATION REVIEW TEAM - PLAN FOR HANDLING ALLEGATIONS

The team will interview potential allegers in accordance with the team charter dated May 23, 1994, and in accordance with standard NRC policy on allegations management. After interviewing allegers and receiving a transcript, affidavit, or other documents, the team will process the allegations in the following manner:

1. OI will contact allegers by letter thanking them for the interview, confirming the specifics of the allegations, stating that their concerns are being evaluated, and that the NRC will inform them by letter of the actions taken. Additionally, this letter will inform the allegers of the limitations on the protection of their identity as outlined in the J. Taylor (EDO) memorandum dated August 22, 1994.

2. The team will review all transcripts, documents, and affidavits to extract allegations, and will attempt to collect required additional information from the allegers. The team will maintain a database of allegations and documents received, which will be maintained for transmittal to the Allegations Management System upon completion of the team's activities.

- The allegations will be compared to previous allegations, NUREG 1306, the Quadrex Report, and major NRC inspections (DET, ORAT, etc.) to determine if the issue had already been addressed. If so, the team will determine if additional review is warranted.

- The team will review all allegations and resolve those to the extent possible within the team member's expertise.

- Technical allegations that are not resolved by the team will be referred to the technical divisions of NRR along with any relevant information available (e.g., previously closed allegations, NRC inspection reports, documents obtained from the alleger). The referral memo and reviewer checklist will accompany the allegations. The results of the technical staff review of safety issues will be provided to the team in a format similar to a safety evaluation. The technical staff may recommend that an inspection be performed of certain allegations. We anticipate that this may be accomplished by regional inspectors other than inspectors from Region IV. The nature and number of allegations to be inspected will determine the details of the inspection(s). If an inspection is warranted, standard inspection report format will be followed.

- Allegations of harassment and intimidation, falsification of documents which are required by regulation, or other wrongdoing matters will be referred to the Office of Investigations.

3. The team will meet with the ARB after each group of allegations has been initially reviewed. The purpose of these meetings is to familiarize the ARB with the new allegations and inform the ARB of referrals to various technical groups and OI.

4. The responses from the technical branches, OI, and the team's evaluations will be used to develop questions and answers for the upcoming congressional hearings and will be incorporated into the final report of the team.

5. NRR will contact the allegers by letter once the allegations have been evaluated and resolved, and will provide NRC's basis for the disposition of any allegations.

6. Issues related to NRC employee or contractor wrongdoing will be forwarded by the team to the Office of Inspector General.

7. Following completion of the team review, relevant documents, including the database, will be provided to the Office Allegations Coordinator.

Daniel D. Murphy / 9/16/94
Daniel D. Murphy / Date
OI Representative

L E Kokajko / 9/13/94
Lawrence E. Kokajko / Date
NRR Representative

Concurred: R. L. Spessard / 9/13/94
R. Lee Spessard / Date
Allegations Review Board Chairman

MEMORANDUM TO:

FROM: Lawrence E. Kokajko, NRR
Daniel D. Murphy, OI
STP Allegation Review Team Leaders

SUBJECT: REFERRAL OF TECHNICAL ALLEGATIONS FOR REVIEW

DATE:

Members of the NRC staff have met with congressional subcommittee staff members regarding allegations of safety concerns and harassment and intimidation at South Texas Project. In response to the subcommittee's concerns, Mr. Milhoan directed the Office of Investigations and NRR to form an Allegation Team to collect and review allegations. A copy of the plan for handling allegations, which was approved by the Allegations Review Board is attached.

The number and nature of allegations received thus far is larger and more significant than we had anticipated. Due to the technical nature of many of these allegations, we are requesting, with the approval of the ARB Chairman, that your staff review the attached allegation and associated documents. We need a determination of whether a safety concern exists; if additional information is necessary to determine safety significance; or, if the allegation can be closed, because: (1) insufficient evidence was provided, (2) the allegation does not involve a safety related item; or, (3) the allegation has been adequately corrected and evaluated.

The NRC's evaluation of these allegations will be used in support of a congressional hearing, which is anticipated during November 1994. Therefore, we request that you provide a response no later than four weeks from the date of this memo. A checklist is enclosed for you to respond. The results of the review of safety issues should be provided to the team in a format similar to a safety evaluation. If an inspection is required, the standard inspection report format will be followed.

If you have any questions, please contact Hai-Boh Wang or Donna M. Skay (Allegations Team members) at 504-2958 or 504-1322, respectively.

MEMORANDUM TO: Hai-Boh Wang, NRR
STP Allegation Review Team
Mailstop O-9-A-1

FROM:

SUBJECT: REVIEW OF ALLEGATION

DATE:

Allegation number:

We have reviewed the allegation and have determined that:

___ The allegation raises a safety concern (a written evaluation is required) and:

___ 1) an inspection should be performed to determine if adequate corrective actions are being taken by the licensee.

___ 2) an action (e.g., Order, violation) should be taken against the licensee.

___ 3) a technical evaluation is attached.

___ 4) additional review time is required. Our response will be provided by _____.

___ The allegation cannot be substantiated due to lack of specific information or lack of evidence (allegation is vague or unclear).

___ The allegation can be closed because it is not a safety related issue. (Please describe below why this allegation is not safety related.)

___ The allegation can be closed because the licensee has taken adequate corrective action. (A written response is required.)

___ Additional information is required before a determination of safety significance can be made. (Describe needed information below.)

NOTE: If the allegation has several parts, please indicate by number which response applies to each part of the allegation.

October 19, 1994

MEMORANDUM FOR: William T. Russell, Director
Office of Nuclear Reactor Regulation

FROM: Lawrence E. Kokajko, NRR Representative
Daniel P. Murphy, OI Representative
South Texas Project Allegations Review Team

SUBJECT: Charter Revision

In accordance with your instructions on October 17, 1994, we are hereby amending the South Texas Allegations Review Team charter to reflect that the inspection of the South Texas Project employee concerns program is no longer the responsibility of this team. Instead, it is understood that the review of the program is under the purview of the inspection effectiveness task force under the direction of Mr. W. Bateman. This team will maintain contact with Mr. Bateman to ensure that any insights or issues that we identify which could impact his activities are promptly transmitted to him.

Additionally, in regard to the seven individuals who are to be interviewed during an ongoing OI investigation, we have informed the appropriate personnel that they should not limit their interviews to the investigation at-hand. Instead, the investigators should ensure that the interviews are broad enough to capture other salient aspects of any allegations which may shed light on the operation of the South Texas Project facility.

Finally, as soon as we finalize arrangements on the projected meeting with Ms. B. Garde, we will inform Mr. R. Zimmerman on the status. If the meeting occurs as projected on October 21, 1994, we will inform Mr. Zimmerman on the outcome as soon as practical.

Docket Nos. 50-498
and 50-499

cc: W. Bateman

ALLEGATION REVIEW BOARD

SUMMARY

Allegation Number NRR-94-A-0029
TAC Nos. M89497; M89498

1. The NRR Allegation Review Board met on February 3, 1995, at 11:30 am.

2. Present at the meeting were: R. L. Spessard*
E. Adensam*
L. Kokajko
D. Murphy
H. B. Wang
D. Skay
A. Gautam*

3. Facilities/organizations involved: South Texas

4. Allegation title: (A) Multiple Technical Issues; (B) H&I; (C) Potential Wrongdoing by Licensee; (D) Potential OIG Issues

5. This allegation has been assigned by the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, to a Special Review Team (of PDIV-2 and OI) for resolution.

6. The ARB determined the allegation to be of low safety significance.

7. The ARB had previously assigned this allegation a Priority Level of 2 after consideration of its safety significance.

8. Attached is a copy of the Allegation Review Team Summary, approved by the ARB.

9. Additional comments: A draft report of the South Texas Project Allegations Review Team (NUREG-1517) is out for comment to program offices.

10. Prepared by: Anil S. Gautam, Acting Allegations Coordinator — 2/13/95 Date

11. Approved by: R. Lee Spessard, Chairman, ARB — 2/13/95 Date

*ARB Members

ALLEGATION REVIEW TEAM SUMMARY

In April 1994, James Milhoan, Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, met with the staff of the Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce to discuss the NRC's handling of problems at the South Texas Project (STP). The Congressional staff expressed concerns that there was "widespread discriminatory practices" at STP.

In May 1994, James Milhoan instructed the NRC staff to form an STP allegation review team (ART) with the objective to (1) interview individuals having safety concerns pertinent to the South Texas Project (STP), (2) disposition allegations received, and (3) identify any lessons learned from this effort.

In July 1994, the ART proceeded to receive and review allegations concerning technical and wrongdoing (harassment and intimidation, discrimination, falsification of records) concerns from present and former employees of STP.

Forty technical allegations were received, 12 were substantiated, 3 were partially substantiated, and 25 unsubstantiated. The substantiated/partially substantiated allegations were considered closed because the issue was not safety-related, or the licensee had identified the issue and had taken or is taking adequate corrective action.

Nine allegations involved discriminatory conduct by the licensee or its contractor. Four of the nine allegations are under active investigation by OI. Three allegations were consolidated into other ongoing OI investigations due to the supporting nature of the allegation involving a specific individual. Two allegations have been closed. Certain allegations have been referred to the NRC Region IV office for follow-up of licensee corrective action and potential enforcement action.

The ART is in the process of assessing lessons learned by the NRC from this effort.

ART CONCLUSION

Most allegations were not substantiated. Certain technical allegations of minor safety significance or regulatory concern were substantiated. The substantiated technical allegations were being tracked by the NRC and the licensee, and steps were taken by the licensee to correct deficiencies. No "widespread discriminatory practices" were identified. The substantiated allegations did not affect the safe operation of the plant.

APPENDIX B

CORRESPONDENCE REGARDING NRC CONTACT WITH BILLIE PIRNER GARDE, ESQ.

October 26, 1994	Letter from Billie Garde (Hardy & Johns) to Daniel Murphy (NRC).
November 23, 1994	Letter from William Russell and James Fitzgerald (NRC) to Billie Garde (Hardy & Johns). This letter includes: (1) the Conditions of Interview; (2) the J. Taylor memorandum dated August 22, 1994, entitled, "Informing Allegers of the Degree to which the NRC can Protect their Identity;" and, (3) the W. Russell and B. Hayes memorandum dated July 26, 1994, entitled, "Resolution of Differences Between the Approach of OI and NRR on Protecting Alleger Identity."
January 4, 1995	Letter from William Russell and James Fitzgerald (NRC) to Billie Garde (Hardy & Johns).
January 4, 1995	Letter from Billie Garde (Hardy & Johns) to William Russell and James Fitzgerald (NRC).
January 10, 1995	Letter from William Russell and Guy Caputo (NRC) to Billie Garde (Hardy & Johns).
January 18, 1995	Letter from Billie Garde (Hardy & Johns) to William Russell and Guy Caputo (NRC).
January 30, 1995	Letter from William Russell and Guy Caputo (NRC) to Billie Garde (Hardy & Johns).

HARDY & JOHNS
ATTORNEYS AT LAW
500 TWO HOUSTON CENTER
909 FANNIN AT McKINNEY
HOUSTON, TEXAS 77010-1095

BILLIE PIRNER GARDE
OF COUNSEL
ALSO ADMITTED IN WISCONSIN

DIRECT LINE
(713) 759-6430
(713) 222-0381
FAX: (713) 759-8650

October 26, 1994

Mr. Dan Murphy
Office of Investigations
Nuclear Regulatory Commission
Washington, D.C. 20515

RE: Investigation of the South Texas plant allegations

Dear Mr. Murphy,

This letter confirms our recent discussion regarding your interest in interviewing former employees of the South Texas Nuclear Plant. As both Ms. Timothy Sloan and I communicated to you during our meeting in my office, there is a great concern that the investigation undertaken by your office be conducted in a manner that generates accurate, complete, and thorough results. Based on your statements, it is my understanding that you have not yet started to interview any of the former employees, or persons who previously provided information to the NRC.

As I indicated to you in our conversation several months ago, I had already advised those clients and former clients that I am in regular touch with that the NRC may be contacting them, and to cooperate with that investigation. However, after our meeting I have very deep reservations about the direction this investigative effort is taking. Therefore, as Ms. Sloan and I proposed, and you agreed to the following conditions concerning the cooperation of my clients with the Office of Investigation's ("OI") investigation of the "old" South Texas allegations.

1. OI agrees to investigate the allegations of harassment, intimidation, falsification of records and other issues within OI's jurisdiction as if the allegations were new and current. In other words, OI will not conduct a "review" of other investigations, but begin a new investigative effort - including taking new statements of witnesses.

2. OI agrees that it will provide two copies (one for the client and one for the lawyer) of all information that the agency has in its files regarding investigating allegations previously raised by the witness, including any NRC investigations, inspections, reports to the Commission, or other documentation that the agency complied from the licensee or contractor in regards to that witnesses allegations.

3. OI agrees to provide all investigative interviews, documents, affidavits, or other material developed in the course of the investigation.

4. OI agrees that they will provide the same weight to the plaintiffs evidence and testimony as to the licensee's evidence and testimony.

5. OI agrees that prior to commencing any investigative effort that the witness will agree to the definition of the issues being raised by the witness.

6. OI agrees that its publicly released reports will shield the identity of the witness, i.e., names will not be used in issued reports.

We asked you to agree, but you indicated that you did not have the authority to agree to the following:

7. That, where either Ms. Sloan or myself cannot arrange to be physically present for an interview or we cannot arrange to have the client present for an NRC interview, that the NRC would arrange to bring the client to Texas for that interview; and

8. We must be able to review any final reports, and attach our rebuttal response to the investigation, prior to its being forwarded for final disposition to the Executive Director and/or the Director of Enforcement or Congress.

We look forward to receiving a confirmation letter regarding these agreements.

Sincerely,

Billie P. Garde

Billie Pirner Garde

BPG/asb

cc: Timothy Sloan

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

November 23, 1994

Billie Pirner Garde, Esq.
Hardy & Johns, Attorneys at Law
500 Two Houston Center
909 Fannin at McKinney
Houston, TX 77010-1095

Dear Ms. Garde:

On October 20, 1994, Mr. Daniel D. Murphy, Senior Investigator in the Office of Investigations, and Mr. Lawrence E. Kokajko, Senior Project Manager in the Office of Nuclear Reactor Regulation, met with Ms. T. Sloan and you in your office to discuss access to your clients in our work gathering allegations regarding the construction and operation of the South Texas Project, Units 1 and 2. During the meeting, Ms. Sloan suggested that you would be agreeable to let the NRC staff interview your clients if certain conditions were agreed to prior to the interviews. At Mr. Murphy's request, you formally submitted your conditions by letter dated October 26, 1994. After due consideration, this letter approves those conditions as noted in the enclosure.

Our objective is to interview your clients to uncover any new allegations or new information on old allegations, and to review those allegations to determine any substantive issues. You should know that this effort is a review by the NRC headquarters staff, and we will consider all credible evidence regarding both new and old allegations. The NRC headquarters staff will make the appropriate decisions regarding additional inspection or investigation of any allegation under review.

In order to meet our objective, we request you identify those individuals you believe have information concerning the construction and operation of the South Texas Project facility, and who would be willing to talk, on the record, to the NRC staff. The NRC staff will then select those individuals who we intend to interview. This selection will be based upon the determination that the information will fall into NRC jurisdictional boundaries, the safety significance of the subject matter, the relevancy to safe operation of the facility, and if the individual has already made a sufficiently comprehensive statement on the record.

Agreement to some of the enclosed conditions by this agency is highly unusual, but it should indicate to you the concern which this agency holds in regard to allegations. We are concerned personally, as we know you are, about the allegations regarding the construction and operation of the South Texas Project facility. With the aforementioned items in mind, we believe that we should now be able to work together to identify and resolve those issues important to the safety of the facility. Therefore, unless we hear otherwise, we will assume that you are in agreement with the terms of this letter.

Accordingly, we request that you contact Mr. Daniel D. Murphy [(301) 504-3485] to make the appropriate arrangements to begin the interview process with your clients within 10 days of receipt of this letter. If you have not contacted Mr. Murphy within that time, we will assume that you and your clients are no longer interested in discussing this matter with the NRC staff.

Sincerely,

William T. Russell, Director
Office of Nuclear Reactor Regulation

James A. Fitzgerald, Acting Director
Office of Investigations

Enclosure: Conditions of Interview

ENCLOSURE

CONDITIONS OF INTERVIEW

1. The Office of Investigations (OI) will investigate new allegations of harassment and intimidation, falsification of records and other issues within OI's jurisdiction. If new information is uncovered regarding an old allegation, OI will conduct an additional review of the matter or investigate as necessary. In regard to the verbal request that OI start over the Rex investigative case, you should be aware that the case is still open, and has not been closed. The NRC considers this to be sufficient to meet your request.

2. A copy of prior statements/transcripts that the NRC staff currently has in its possession for each individual client associated with you will be provided to the client prior to the interview.

3. The NRC staff will arrange for a court reporter. Each client who was interviewed will be allowed to inspect the transcript of the interview. A copy of the transcript will be provided at the end of any investigation or review.

4. The NRC staff considers all credible evidence in evaluating allegations. The NRC staff gives equal weight to both the alleger's evidence and testimony, and the licensee's evidence and testimony. Parenthetically, there are no plaintiffs in any case pending before the NRC at this time.

5. In accordance with NRC policy, the NRC staff will respond to each alleger, in writing, to ensure that the allegations identified in the interviews are accurately delineated.

6. In accordance with NRC policy, the NRC staff will remove the names of allegers in any final reports that are publicly available. In this vein, enclosed is a copy of NRC interim guidance in this area.

7. The NRC will reimburse your clients for travel to and from the NRC Region IV office plus lodging expenses while in Arlington, Texas in order to expedite the interviews. The expenses will be allowed to the extent allowed by law, and within the confines of standard government travel and lodging requirements. This will be advantageous to the government, and will improve government efficiency, by having all interviewees come to a central location for interviews. The NRC will not pay lost wages or income incurred by the interviewee, nor will it pay any attorney's fees.

8. The NRC staff will consider your request for a final report as a pre-filed Freedom of Information Act request, which will be processed at the conclusion of final agency action. The final report will be redacted as necessary in accordance with NRC policy. If you wish to comment on the final report you receive, you may do so at that time.

Attachment: Memo from James M. Taylor
dtd. 8/22/94

ENCLOSURE

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

July 26, 1994

MEMORANDUM FOR: James L. Milhoan
Deputy Executive Director
for Nuclear Reactor Regulation,
Regional Operations & Research

Hugh L. Thompson, Jr.
Deputy Executive Director
for Nuclear Materials Safety,
Safeguards & Operations Support

FROM: William T. Russell, Director
Office of Nuclear Reactor Regulation

Ben B. Hayes, Director
Office of Investigations

SUBJECT: RESOLUTION OF DIFFERENCES BETWEEN THE APPROACH OF OI AND NRR ON PROTECTING ALLEGER IDENTITY

This is in response to the memorandum from Hugh Thompson dated April 6, 1994, concerning recommendation II.B.16 of the January 7, 1994, "Report of the Review Team for Reassessment of the NRC's Program for Protecting Allegers Against Retaliation."

The attached responds to Review Team Recommendation II.B.16 concerning the resolution of policy differences between the Office of Investigations (OI) and the Office of Nuclear Reactor Regulation (NRR) on the protection of alleger identity (including confidentiality agreements) in inspection and investigation activities. The attached identifies the differences in the approach of OI and NRR on protecting alleger identity, and contains recommendations to reconcile these differences. We have not developed options, but rather have proposed an approach which we believe will resolve this issue. The most significant difference between the approach of OI and other regional and program offices is that OI may consciously disclose an alleger's identity in furtherance of a wrongdoing investigation while other regional and program offices protect the identity of allegers to the maximum degree possible. We believe there are valid reasons for this difference, and the most important point is that any alleger should clearly be told of the degree to which his or her identity can be protected. We propose to modify Management Directive 8.8, "Management of Allegations," to ensure that allegers are informed of the degree to which their identity can be protected and also include this information in the brochure for industry employees being developed in response to recommendation II.B.6 of the Review Team Report.

It is very difficult to investigate a wrongdoing issue without revealing and using the identity of the alleger in the investigation. In Harassment and Intimidation issues, it is, from a practical standpoint, not possible to

effectively investigate the issue while protecting the identity of the alleger. In the case of technical issues, however, it is generally possible to resolve the issue without the need to reveal the alleger's identity.

Unless you disagree with the recommendations in the attached we will proceed to implement them and include them in the revision of Management Directive 8.8, "Management of Allegations," currently being finalized. We will further ensure that the Management Directive is consistent with the Commission's Statement of Policy on Confidentiality which is attached for your information.

Please contact us if you have any questions.

William T. Russell, Director
Office of Nuclear Reactor Regulation

for Ben B. Hayes, Director
Office of Investigations

Enclosures: As stated

cc: J. Taylor, EDO
J. Lieberman, OE
K. Cyr, OGC
D. Williams, OIG
E. Jordan, AEOD
Regional Administrators

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

August 22, 1994

MEMORANDUM FOR: Thomas T. Martin, Regional Administrator, RI
Stewart D. Ebneter, Regional Administrator, RII
John B. Martin, Regional Administrator, RIII
L. Joe Callan, Regional Administrator, RIV
William T. Russell, Director, NRR
Robert M. Bernero, Director, NMSS
Karen D. Cyr, General Counsel
James Lieberman, Director, OE
James Fitzgerald, Acting Director, OI
Edward L. Jordan, Director, AEOD
Richard L. Bangart, Director, OSP

FROM: James M. Taylor
Executive Director for Operations

SUBJECT: INFORMING ALLEGERS OF THE DEGREE TO WHICH THE NRC CAN PROTECT THEIR IDENTITY

The purpose of this memorandum is to provide interim guidance regarding the degree to which the identity of individuals who provide allegations to the NRC can be protected. This is necessary since some allegers may incorrectly assume that the NRC will protect their identities under all circumstances. The guidance described below will remain in effect until incorporation in a future revision to Management Directive (MD) 8.8, "Management of Allegations." The current MD 8.8, except as modified by this memorandum, should be closely followed.

Individuals who have not been granted confidentiality by the NRC based on a written agreement between the NRC and the alleger in accordance with the Commission's Statement of Policy on Confidentiality (50 FR 48506, dated November 25, 1985) should be informed of the following:

(1) In resolving technical issues, the NRC in protecting the identity of allegers intends to take all reasonable efforts to not disclose their identity to any organization, individual outside the NRC, or the public unless:

(a) the alleger has clearly indicated no objection to being identified,
(b) disclosure is necessary to ensure public health and safety,
(c) disclosure is necessary to inform Congress or State or Federal agencies in furtherance of NRC responsibilities under law or public trust, or
(d) the alleger has taken actions that are inconsistent with and override the purpose of protecting the alleger's identity.

(2) Individuals providing allegations to the NRC should, in particular, be told that their identity could be disclosed for the reasons given in items (b), (c), and (d) above.

(3) For allegations involving harassment and intimidation, allegers should be told that NRC will disclose their identity during an NRC investigation. Allegers should also be told that the NRC normally will not investigate these cases from a confidential source because this type of case cannot be investigated if the alleger's name is kept confidential.

(4) For allegations involving wrongdoing, allegers should be told that their identity may be disclosed at the NRC's discretion in order to pursue the investigation.

(5) Allegers should be told that they are not considered a confidential source unless confidentiality has been formally granted in writing.

The above information should also be included in the acknowledgment letter issued to an alleger following receipt of the allegation.

If an individual requests and is granted confidentiality by the NRC based on a written agreement, there are still circumstances under which the individual's identity may not be protected. Thus, such individuals should be informed by letter of the following:

(1) The NRC will make its best efforts to protect their identity.

(2) If it is necessary because of an overriding safety issue to release the identity of a confidential source to a licensee, and the source agrees to this disclosure, consultation with the EDO will be made before disclosure. If the source does not agree to disclosure, the staff will contact the Commission for resolution.

(3) Where it is necessary to release the identity of a confidential source to the Tennessee Valley Authority (TVA) Inspector General (a statutory Inspector General) concerning a wrongdoing issue, and the source agrees to the disclosure, consultation with the Director, Office of Investigations will be made before disclosure. If the alleger does not agree to the disclosure, the staff will contact the Commission for resolution.

(4) Because a harassment and intimidation allegation cannot be investigated if the alleger's name is kept confidential, an alleger should be told that the NRC normally will not investigate a harassment and intimidation allegation from a confidential source. However, depending on the safety significance and with Commission approval, the NRC may conduct an investigation regardless of the alleger's desire.

Allegers should also be told that information provided under the Freedom of Information Act (FOIA) will, to the extent consistent with that act, be purged of names and other potential identifiers.

The enclosed memorandum from William T. Russell and Ben B. Hayes to James L. Milhoan and Hugh L. Thompson provides additional information on this subject.

Original signed by
James M. Taylor
James M. Taylor
Executive Director
for Operations

Enclosure:
As stated

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

January 4, 1995

Billie Pirner Garde, Esq.
Hardy & Johns, Attorneys at Law
500 Two Houston Center
909 Fannin at McKinney
Houston, TX 77010-1095

Dear Ms. Garde:

In our letter to you dated November 23, 1994, we requested that you identify those individuals you believe have allegations concerning the construction and operation of the South Texas Project facility. Additionally, we outlined the scope of our efforts and our conditions of interview. On December 7, 1994, you contacted Mr. Daniel Murphy by telephone, and stated that you accepted the conditions of the interview, but requested additional time to respond to the letter. Mr. Murphy, after consulting with us, replied to you in a telephone conversation on December 7, 1994, that we agreed to extend the initial deadline for response, but that we expected a formal written response accepting the conditions of interview and providing a schedule of interviews of your clients by December 23, 1994.

Since we have not yet heard from you, either in writing or by telephone, we would like to formally offer you one more opportunity to respond to our letter. We request that you formally accept our conditions of interview and provide a schedule of interviews of your clients within 14 calendar days from the date of this letter. As previously noted in our earlier letter, a special NRC headquarters team will receive and review these allegations; a team, we hasten to add, that is only in existence for this purpose and for a limited duration of time. If we have not heard from you within that time, we will assume that you and your clients are no longer interested in discussing this matter with the NRC.

However, this does not mean that the NRC will not accept allegations from you or your clients. As this special team will no longer be in existence, the normal NRC allegation management process will continue to receive and review allegations. Therefore, any information you or your clients may subsequently wish to provide related to the construction and operation of the South Texas Project facility may be transmitted to Mr. Russell Wise, NRC Region IV Allegations Coordinator, at telephone number (817) 860-8245, or to Ms. Jean Lee, the NRR Allegations Coordinator, at telephone number (301) 504-2918. Since you have been specifically involved in the Rex proceeding, any allegations related to that case by you or your clients may be referred directly to Mr. Len Williamson, NRC Region IV Office of Investigations, at telephone number (817) 860-8115.

If you have any questions regarding this or any related matter, you may contact Mr. Daniel Murphy, at telephone number (301) 504-3485.

Sincerely,

William T. Russell, Director
Office of Nuclear Reactor Regulation

James A. Fitzgerald, Acting Director
Office of Investigations

HARDY & JOHNS
ATTORNEYS AT LAW
500 TWO HOUSTON CENTER
909 FANNIN AT McKINNEY
HOUSTON, TEXAS 77010-1095

BILLIE PIRNER GARDE
OF COUNSEL
ALSO ADMITTED IN WISCONSIN

DIRECT LINE
(713) 759-6430
(713) 222-0381
FAX: (713) 759-9650

January 4, 1995

VIA FACSIMILE & REGULAR MAIL

Mr. William T. Russell, Director
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D.C. 20515

Mr. James A. Fitzgerald, Acting Director
Office of Investigations
U.S. Nuclear Regulatory Commission
Washington, D.C. 20515

Dear Messrs. Russell and Fitzgerald:

Please accept this letter in response to your November 23, 1994 letter to me. As you know, due to my trial schedule out of my office I did not receive the letter until December, 1994. At my request I was given until December 23, 1994 to respond. Unfortunately, due to the holidays and press of other business I did not respond by December 23.

However, I have endeavored to contact as many of the allegers as possible. The holidays also interfered with my being able to reach most of the allegers. I write to advise you that of those I contacted or have had some contact with all are interested in proceeding with the NRC investigation. I expect the others will feel the same.

Therefore, I suggest we start with those closest to the Houston/Bay City area and proceed to those in more remote locations. We still disagree with the terms and conditions of interviews being taken in Arlington, Texas for those allegers from out of state.

In order for me to provide you with the names of these allegers who have information not yet adequately investigated by the Agency, I request that you send me the previous NRC "close out" of the allegations initially investigated by the SSAT.

I look forward to your reply.

Very truly yours,

Billie P. Garde

Billie Pirner Garde

BPG/asb

cc: Dan Murphy

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

January 10, 1995

Billie Pirner Garde, Esq.
Hardy & Johns, Attorneys at Law
500 Two Houston Center
909 Fannin at McKinney
Houston, TX 77010-1095

Dear Ms. Garde:

We have reviewed your letter dated January 4, 1995, that was received in our office on January 5, 1995, which you stated was in response to our letter dated November 23, 1994. At the time of your letter, it appears that you did not have an opportunity to review our letter dated January 4, 1995, in which we requested that you formally accept our conditions of interview, as outlined in our November 23, 1994, letter, and provide a schedule of interviews of your clients within 14 calendar days from the date of that letter.

We are heartened to hear that all of your clients that you contacted are interested in discussing concerns regarding the construction and operation of the South Texas Project facility. However, we note that you did not accept our conditions of interview as noted in the third paragraph of your letter. Specifically, item 7 of the enclosure to the November 23, 1994, letter stated that the NRC would reimburse your clients for travel to and from the NRC Region IV office plus lodging expenses while in Arlington, Texas in order to expedite the interviews. We still believe this is advantageous to the government to have your clients come to a central location, preferably at one time, from the different parts of the country. As an alternative, the allegations review team may travel to the closest federal courthouse or to the residence of your clients to obtain interviews. If the alternative is accepted, no reimbursement for travel and lodging expenses incurred by your clients will be allowed.

Additionally, the fourth paragraph of your letter contains information that is apparently unrelated to your clients. We did not agree to provide this information. In item 2 of the enclosure to the November 23, 1994, letter, we agreed to provide a copy of prior statements/transcripts that the NRC staff currently has in its possession for each individual client associated with you prior to the interview.

It is our understanding that you and your clients had new allegations or new information on old allegations. We also understood that your clients were anxious to discuss this information with the NRC, and that a schedule of interviews could be arranged. If this is the case, we urge you to reply to our January 4, 1995, letter. Since our recent letter was an extension from the December 23, 1994, date (which in itself was an extension from the December 7, 1994, date), we await your written acceptance of the conditions of interview and the schedule of interviews by January 18, 1995.

As we previously stated, the NRC will accept allegations from you or your clients at any time. However, if the special allegations review team is no longer in existence, the normal NRC allegation management process will continue to receive and review allegations. Therefore, any information you or your clients may have related to the construction and operation of the South Texas Project facility may be transmitted to Mr. Russell Wise, NRC Region IV Allegations Coordinator, at telephone number (817) 860-8245, or to Ms. Jean Lee, the NRR Allegations Coordinator, at telephone number (301) 504-2918. Since you have been specifically involved in the Rex proceeding, any allegations related to that case by you or your clients may be referred directly to Mr. Len Williamson, Director, NRC Region IV Office of Investigations, at telephone number (817) 860-8115.

If you have any questions regarding this or any related matter, you may contact Mr. Daniel Murphy, at telephone number (301) 504-3485.

Sincerely,

William T. Russell

William T. Russell, Director
Office of Nuclear Reactor Regulation

Guy P. Caputo

Guy P. Caputo, Director
Office of Investigations

HARDY & JOHNS
ATTORNEYS AT LAW
500 TWO HOUSTON CENTER
909 FANNIN AT McKINNEY
HOUSTON, TEXAS 77010-1095

BILLIE PIRNER GARDE
OF COUNSEL
ALSO ADMITTED IN WISCONSIN

DIRECT LINE
(713) 759-6430
(713) 222-0381
FAX: (713) 759-6830

January 18, 1995

VIA FACSIMILE

William T. Russell
Office of Nuclear Reactor Regulations
U.S. Nuclear Regulatory Commission
Washington, D.C. 20535-0001

Gary P. Caputo, Director
Office of Investigations
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555-0001

Dear Messrs. Russell and Caputo:

As a preliminary matter I would like to object to your imposition of arbitrarily imposed deadlines on a matter in which I am acting as pro bono counsel, i.e., without pay, for unemployed, underemployed former South Texas employees in connection with the NRC's renewed interest in eight to ten year old problems at the South Texas nuclear power plant. It is obvious that your approach to this situation is solely for the purpose of attempting to create the inaccurate and misleading impression that the former South Texas employees either have no further concerns about the South Texas plant or do not wish to pursue those concerns. Please do not attempt to accomplish this misleading conclusion by creating false deadlines for me.

Your proposals attempt to put an impossible burden on my clients. It is not possible for them to know if their previous concerns were addressed, ignored, or adequately resolved if they do not have any idea of what the NRC did or didn't do toward investigating the allegations they previously provided to the agency. Mr. Dan Murphy made a commitment to me, as well as to the House staff investigators, last spring when we established our informal working arrangements. He never provided me any additional information regarding the employees whose names I provided to him at that time as being those employees who continued to be concerned about STP.

I assume that Mr. Murphy either did nothing to collect the information necessary to provide it to the employees or has since decided not to provide the information. However, the problem remains that without knowing what the NRC did with a particular allegation it is impossible to determine if the source of that allegation is satisfied. I know that the allegation management

program utilized by the agency maintains basic information such as I have asked for eight months ago, and I again request that prior to setting up interviews which will be a waste of time and money for the agency and my clients, that you send me (or my clients) a copy of the information reflecting the disposition of the allegations that they previously raised. After the materials are provided the clients will be able to schedule meaningful interviews.

I look forward to your response.

Very truly yours,

Billie Pirner Garde

Billie Pirner Garde

BPG/asb

cc: STP clients

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

January 30, 1995

Billie Pirner Garde, Esq.
Hardy & Johns, Attorneys at Law
500 Two Houston Center
909 Fannin at McKinney
Houston, TX 77010-1095

Dear Ms. Garde:

In response to your letter dated October 26, 1994, and in our letters to you dated November 23, 1994, January 4, and January 10, 1995, we offered you and your clients an opportunity to discuss concerns regarding the construction and operation of the South Texas Project facility. While it appeared that you would accept our conditions of interview and provide a schedule of interviews, as indicated by your December 7, 1994, telephone call, and your letter dated January 4, 1995, you did not formally agree to the conditions of interview or, more importantly, provide a schedule of interviews by the requested date of January 18, 1995. Instead, you provided a letter dated January 18, 1995, which did not address the aforementioned items.

We have reviewed your January 18, 1995, letter. Let us say at the outset, that Mr. D. Murphy made no commitment to you to provide you any additional information regarding employees who had concerns at the South Texas Project facility. In item 2 of the enclosure to the November 23, 1994, letter, we agreed to provide a copy of prior statements/transcripts that the NRC staff currently has in its possession to each individual client associated with you prior to the interview. In anticipation of this, Mr. Murphy did gather information regarding the various allegations at the South Texas Project facility. Your letter did not identify those clients with whom we could provide the requisite information.

Our objective, as we stated in our November 23, 1994, letter, was to interview your clients to uncover any new allegations or new information on old allegations, and to review those allegations to determine any substantive issues. We have not deviated from meeting this objective. It was our understanding that you (regardless of your status as pro bono counsel) and your clients had new allegations or new information on old allegations. We also understood that your clients were anxious to discuss this information with the NRC, and that a schedule of interviews could be arranged. Your recent letter provided neither formal acceptance of the conditions of interview, as outlined in our November 23, 1994, letter, nor did it provide a schedule of interviews with those individuals who wished to bring concerns to our attention.

It is our view that the opportunity we provided to you was reasonable. Inasmuch as you chose not to accept our offer and schedule interviews with your clients, we are advising you that the special allegations review team will no longer be accepting and reviewing allegations, and will begin culminating its work. We consider that our special offer to you, as outlined in our conditions of interview, has expired.

As we previously stated, the NRC will accept allegations from you or your clients at any time in accordance with standard NRC policy and practice. Therefore, any information you or your clients may have related to the construction and operation of the South Texas Project facility may be transmitted to Mr. Russell Wise, NRC Region IV Allegations Coordinator, at telephone number (817) 860-8245, or to Ms. Jean Lee, the NRR Allegations Coordinator, at telephone number (301) 504-2918. Since you have been specifically involved in the Rex proceeding, any allegations related to that case by you or your clients may be referred directly to Mr. Len Williamson, Director, NRC Region IV Office of Investigations, at telephone number (817) 860-8115.

Sincerely,

William T. Russell, Director
Office of Nuclear Reactor Regulation

Guy P. Caputo, Director
Office of Investigations

APPENDIX C

CORRESPONDENCE REGARDING CONTROL OF INFORMATION IDENTIFYING "WHISTLEBLOWERS"

October 6, 1994	Letter from James Lieberman (NRC) to William Cottle (HL&P)
November 1, 1994	Letter from William Cottle (HL&P) to James Lieberman (NRC), which includes letter dated November 1, 1994, Cottle (HL&P) to Hardt (CPS), Vaughn (CP&L), and Lanier (COA)

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

October 6, 1994

Houston Lighting & Power Company
ATTN: William T. Cottle, Group
Vice President, Nuclear
Post Office Box 289
Wadsworth, Texas 77483

Dear Mr. Cottle:

During the week of September 19, 1994, the NRC obtained a June 30, 1994 printout of an internal South Texas Project (STP) tracking system apparently utilized by your staff to track responses to, and maintain accountability on, requests for information (RFI) submitted to Houston Lighting & Power Company (HL&P). From a perusal of this document, it appears that this tracking system monitors, among other things, activities on information requests associated with current litigation between HL&P and other entities. It is not clear that this document was intended to be restricted in its distribution as there is no clear indication on the document itself that distribution is in any way controlled.

Request 51 in the document refers to ". . . potential liabilities associated with 'whistleblower' claims made by, or the administrative or court proceeding involving, the following South Texas Project 'whistleblower'." The tracking system entry then proceeds to name 11 individuals that have apparently filed complaints with the Department of Labor (DOL).

The NRC is concerned that identifying individuals who have filed DOL complaints, referring to these individuals as "whistleblowers", and then permitting the document containing this information to be available or accessible to HL&P employees could result in the perception that these individuals are viewed by HL&P in a negative manner. Further, referring to individuals in this manner could create the impression that these individuals are being discriminated against, or at minimum, being treated differently, because they are "whistleblowers". At bottom, we are concerned that identifying individuals as "whistleblowers" in such a document could cause other HL&P employees to avoid raising safety concerns out of fear that they will be labeled as "whistleblowers" and be subject to harassment, intimidation, and retaliation.

While it does not appear in this case that the preparation and maintenance of this tracking system/list constitutes a violation of 10 CFR 50.7 or that it was intended to be anything other than an information request action item tracking mechanism[1], we believe that identifying particular individuals as "whistleblowers" could undermine some of your recent efforts to improve your

[1]This matter appears to be similar to the situation that was addressed in the DOL's decision in G. Richard Howard v. Tennessee Valley Authority, Case No. 90-ERA-24.

employee concerns program and to remove a previous atmosphere of mistrust between some management and other members of your staff. Consequently, we would request that you consider the implications of such a listing, urge that you avoid any listing of individuals in light of its potential for a chilling effect on your employees, or if such a list is needed to perform your business, that it be tightly controlled so that it not be misused or misunderstood, and consider actions in this case that will ensure that any possible chilling effect from the subject listing is minimized. It is requested that you respond to this letter and describe any actions that you believe might be appropriate to minimize any possible chilling effect in this instance.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter will be placed in the NRC Public Document Room.

The response requested by this letter is not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

James Lieberman, Director
Office of Enforcement

Docket Nos. 50-498, 50-499
License Nos. NPF-76, NPF-80

cc:
Houston Lighting & Power Company
ATTN: James J. Sheppard, General Manager
Nuclear Licensing
P.O. Box 289
Wadsworth, Texas 77483

City of Austin
Electric Utility Department
ATTN: J. C. Lanier/M. B. Lee
721 Barton Springs Road
Austin, Texas 78704

City Public Service Board
ATTN: K. J. Fiedler/M. T. Hardt
P.O. Box 1771
San Antonio, Texas 78296

Newman & Holtzinger, P. C.
ATTN: Jack R. Newman, Esq.
1615 L Street, NW
Washington, D.C. 20036

Central Power and Light Company
ATTN: G. E. Vaughn/T. M. Puckett
P.O. Box 2121
Corpus Christi, Texas 78403

INPO
Records Center
700 Galleria Parkway
Atlanta, Georgia 30339-5957

Mr. Joseph M. Hendrie
[redacted]

Bureau of Radiation Control
State of Texas
1100 West 49th Street
Austin, Texas 78756

Office of the Governor
ATTN: Susan Rieff, Director
Environmental Policy
P.O. Box 12428
Austin, Texas 78711

Judge, Matagorda County
Matagorda County Courthouse
1700 Seventh Street
Bay City, Texas 77414

Licensing Representative
Houston Lighting & Power Company
Suite 610
Three Metro Center
Bethesda, Maryland 20814

Houston Lighting & Power Company
ATTN: Rufus S. Scott, Associate
General Counsel
P.O. Box 61867
Houston, Texas 77208

Egan & Associates, P.C.
ATTN: Joseph R. Egan, Esq.
2300 N Street, N.W.
Washington, D.C. 20037

The Light company
Houston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

November 1, 1994
ST-HL-AE-4914
File No.: G25
10CFR2

Mr. James Lieberman
Director, Office of Enforcement
U. S. Nuclear Regulatory Commission
Washington, DC 20555-0001

South Texas Project
Units 1 and 2
Docket Nos. STN 50-498, STN 50-499
Response to NRC Concern Regarding STP Tracking System

Dear Mr. Lieberman:

This is in response to your letter of October 6, 1994, concerning certain information contained in a litigation tracking system document used by Houston Lighting & Power.

As you may be aware, two of the co-owners of the South Texas Project, the cities of Austin and San Antonio, have sued Houston Lighting & Power for damages, alleging that Houston Lighting & Power has breached its duties to them. The co-owners' litigation is currently in discovery, and the document you cited fits the description of one prepared by our litigation support staff to track and respond to discovery requests filed by Austin and San Antonio. The document is used to provide responsible plant personnel with the precise question that they must respond to so that Houston Lighting & Power can discharge its obligations to the court in providing complete and accurate discovery responses. The language you quoted from the tracking document was a verbatim repetition of words the City of Austin had used in a Request for Production directed to Houston Lighting & Power, which is publicly available at the Harris County Courthouse.

While we do not know how it came into your possession, I can assure you that the document is not one routinely circulated at STP, though the breadth of Austin's discovery demands has necessitated fairly wide circulation of our materials in order to ensure that relevant documents are identified. In addition, the document has not been labeled as "confidential" since it simply repeats words used in publicly filed legal documents. Accordingly, it is unlikely that any actual "chilling effect" has occurred. We have renewed instructions that personnel participating in responding to discovery requests take care that the materials they handle be safeguarded from access by anyone who does not have a need to review or respond to those matters.

All of the individuals who were identified in Austin's request had already expressed their concerns publicly through docketed proceedings under Section 210/211 or otherwise. Nonetheless, we wish to assure that litigation activities do not adversely affect the willingness of individuals to raise concerns. Accordingly, we have taken the action discussed above. In addition, our counsel and litigation support personnel will attempt to review discovery requests prior to their circulation to others in order to ascertain if they contain any information that should be subjected to special protective measures in order to avoid potential adverse effects on our employee concerns program or on other areas.

I am proud that our recent survey of employees' willingness to express concerns has found a favorable climate at STP, and we certainly want to continue our progress to ensure that all employees feel free to identify concerns without fear of retaliation, whether they choose to do so anonymously or publicly. To that end, I have also discussed your letter with the management representatives of the other owners, both through a personal phone call and by the attached letter. In that effort I have reminded the other owners of the importance of our employee concerns efforts, which the other owners have fully supported, and that we should be sensitive in the litigation process to avoid activities which could have an adverse effect on our goals in that regard.

W. T. Cottle
Group Vice President, Nuclear

Attachment: Letter from W. T. Cottle to South Texas Project Co-owners dated November 1, 1994

The Light company
Houston Lighting & Power South Texas Project Electric Generating Station P. O. Box 289 Wadsworth, Texas 77483

November 1, 1994

M. T. Hardt
City Public Service
P. O. Box 1771
San Antonio, TX 78296

G. E. Vaughn
Central Power & Light Company
P. O. Box 1221
Corpus Christi, TX 78403

J. C. Lanier
City Of Austin
Electric Utility Dept.
721 Barton Springs Road
Austin, TX 78704

Gentlemen:

As discussed during our recent telephone conversation, enclosed is a letter we received from Jim Lieberman of the NRC's Office of Enforcement. Also enclosed is the reply I am sending to Mr. Lieberman along with a copy of this letter. As I said during our telephone conversation, Mr. Lieberman's letter expresses concerns that undue publicity to the names of individuals who have filed public concerns, when those individuals are identified as "whistleblowers" in the documents, could have a chilling effect on others at STP.

As I think all of you agree, we are strongly committed to maintaining an effective employee concerns environment at STP, and we have implemented new measures to improve that environment. So far, our efforts seem to be having a beneficial effect. Accordingly, we want to avoid activities that could undermine our program.

In Mr. Lieberman's letter and in telephone calls we have received from Nuclear Reactor Regulation personnel, NRC representatives have expressed concerns that the efforts that are underway in the litigation among the owners could undo those beneficial effects. NRC representatives have reminded us that all of our owners are licensees, and in the NRC's view, actions by one of the owners could result in enforcement action against STP as a whole.

MISC-94\94-300.003

Ideally, we would not find ourselves in the situation we are now in with litigation between us, but even so, it is incumbent on each of us to avoid actions in that litigation which could damage the value of our common asset and could adversely affect our ability to operate STP in accordance with our common goals. As we move forward in that litigation, therefore, I urge each of you to ensure that your counsel remain sensitive to our common obligations as licensees of these facilities.

Very truly yours,

W. T. Cottle

WTC/nol

c: Robert R. Carey, CEO Central Power & Light Co.
John Moore, CEO City of Austin Electric Utility
Arthur von Rosenburg, CEO City Public Service
D. D. Jordan

Attachments: Letter from James Lieberman to W. T. Cottle, dated October 6, 1994

Letter from W. T. Cottle to James Lieberman, dated November 1, 1994 (ST-HL-AE-4914)

APPENDIX D

SAMPLE LETTERS

Sample Initial Letter to Alleger. (This letter included memorandum dated August 22, 1994, Taylor to Martin, et al., "Informing Allegers of the Degree to Which the NRC Can Protect Their Identity," which is located in Appendix B).

Sample Letter to DOL Filer

Sample Close-out Letter to Alleger (draft)

This is a sample initial letter to the allegers, which characterizes the allegations, and provides the NRC policy on whistleblower protection.

Name
Address
City, State XXXXX

Dear :

On _____, 1994, we had the opportunity to discuss with you concerns regarding the South Texas Project. Your willingness to take the time to discuss these matters with us is greatly appreciated. As we noted in our letter to you dated _____, 1994, we agreed to notify you when your concerns were addressed. We understand your concerns to be the following: (1) allegation 1; (2) allegation 2; (3) allegation 3; and, etc.

If we have not correctly characterized your concerns, please promptly notify us. These concerns are currently being reviewed by our Nuclear Reactor Regulation staff for appropriate action. You will be notified when your concerns have been addressed.

The NRC revised the policy for protecting the identity of individuals bringing concerns to our attention. The policy is in the process of being approved by the Commission and published as a revision to Management Directive 8.8. To ensure that we afford as much protection as possible to those individuals raising concerns before full implementation of this new policy, the Executive Director for Operations has issued an interim policy statement. You will find a copy of this policy statement attached to this letter for your review.

Again, we appreciate that you have taken the time to discuss your concerns with us. If you have any questions regarding these concerns, or any other matters at the South Texas Project, feel free to call Daniel D. Murphy at (301) 504-3485, or Lawrence E. Kokajko at (301) 504-1309.

Sincerely,

Daniel D. Murphy, Senior Investigator
Office of Investigations

Lawrence E. Kokajko, Senior Project Manager
Office of Nuclear Reactor Regulation

Enclosure: As stated

This is a sample letter, with a sample return memorandum, to an individual who had a Department of Labor filing.

Name
Address
City, State XXXXX

Dear :

The U. S. Nuclear Regulatory Commission (NRC) has established an Allegation Review Team to look into the allegations submitted by concerned individuals regarding the South Texas Project nuclear facility. As a result of the review team's efforts to date, it has been determined that you submitted concerns related to the South Texas Project on _____, 19XX.

You were notified on _____, 19XX, regarding how your concern(s) was/were dispositioned by the NRC. If you have any problem with the manner in which your concerns were addressed, or if you have any other concerns relating to the South Texas Project, we would be interested in discussing them with you.

We are attempting to gather all available information relating to the individual concerns at the South Texas Project, and would appreciate any assistance you could render in achieving our goal. If you would complete the attached memorandum and return it in the enclosed self-addressed envelope, it would greatly assist us.

Thank you for your assistance in this matter.

Sincerely,

Daniel D. Murphy, Senior Investigator
Office of Investigations
Allegations Review Team Member

Lawrence E. Kokajko, Senior Project Manager
Office of Nuclear Reactor Regulation
Allegations Review Team Member

Re:

Please indicate your choice below and return this form to me:

1. _____ I am satisfied with the disposition of my concern.

2. _____ I am not satisfied with the disposition of my concern.

3. _____ I have some additional concerns and would like to be interviewed.

If you have any questions regarding this matter, feel free to contact Review Team Members Daniel D. Murphy (telephone No. 301-504-3485) or Lawrence E. Kokajko (telephone No. 301-504-1309).

_____

(Signature) (Date)

This is a sample follow-up letter to the allegers, which outlines the details of the NRC review and evaluation of the allegations.

Name
Address
City, State XXXXX

Dear :

On _____, 1994, we had the opportunity to discuss with you concerns regarding the South Texas Project. Your willingness to take the time to discuss these matters with us is greatly appreciated. As we noted in our letter to you dated _____, 1994, we agreed to notify you when your concerns were addressed.

In regard to the work of the Allegations Review Team, we have enclosed a final report, NUREG-1517, "Report of the South Texas Project Allegations Review Team," which provides you information on all allegations that the team reviewed. In regard to the specific allegations that you made to us on _____, 1994, we refer you to the following table that relate to your specific allegations that we characterized in our initial letter to you on _____, 1994, and the final team report.

Allegation	NUREG-1517 Section
Letter item 13.1.x *	
Letter item 23.2.x	
etc.etc.	

*If an active wrongdoing investigation is outstanding, details on the case are withheld. The NRC Office of Investigations, not the Allegations Review Team, may contact you separately on disposition of the case.

We would like to thank-you again for the opportunity to discuss your concerns about the construction and operation of the South Texas Project facility. As you may know, this special team was formed to specifically address allegations at the South Texas Project, and it will be disbanded upon completion of the project. One of the team's final activities is to provide this closure letter to you. However, if you have further information you would like to convey to the NRC, you may contact the Region IV Allegations Coordinator, Mr. Russell Wise, at telephone number (817) 860-8245, or contact the NRR Allegations Coordinator, Ms. Jean Lee, at telephone number (301) 415-2918.

Sincerely,

Daniel D. Murphy, Senior Investigator
Office of Investigations

Lawrence E. Kokajko, Senior Project Manager
Office of Nuclear Reactor Regulation

Enclosure: As stated

APPENDIX E

CORRESPONDENCE CONCERNING THE GENERAL ACCOUTING OFFICE AUDIT

May 18, 1994	Memorandum from James Blaha to Frank Miraglia, et al., "Entrance Brief with GAO on Power Reactor Inspection Program."
May 24, 1994	Memorandum from James Blaha to Frank Miraglia, et al., "Entrance Brief with GAO on NRC Power Reactor Inspection Program" (GAO No. 302122).

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

May 18, 1994

MEMORANDUM FOR: F. Miraglia, NRR
B. Hayes, OI
T. Barchi, OIG
K. Cyr, OGC
T. Madden, OCA

FROM: James L. Blaha, AO/OEDO

SUBJECT: ENTRANCE BRIEF WITH GAO ON POWER REACTOR INSPECTION PROGRAM

GAO has requested an entrance briefing regarding an audit they are initiating concerning the NRC power reactor inspection program. The audit was requested by Congressman Dingell, Chairman, House Energy and Commerce Committee. His interest is specifically in the South Texas plant so GAO plans a case study of this plant. Generally, GAO is interested in the following:

o A comparison of the way INPO looks at plants vs. the NRC. Strengths and weaknesses of each program.

o The relationship between the inspection program and SALP.

o How does the NRC inspection program assure the public that plants are operating safely.

GAO plans on providing some specific questions to be addressed at the entrance conference and during their audit but probably will not provide the questions until just prior to the meeting.

The entrance briefing will take place on Thursday, May 26, 1994 at 10:30am in OWFN 8 B 11.

Point of contact for additional information is Jim Turdici at 504-1728.

James L Blaha
James L. Blaha, AO/OEDO

cc: J. Taylor
H. Thompson
J. Milhoan
D. Morris
F. Gillespie
T. Gody

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

May 24, 1994

MEMORANDUM FOR: F. Miraglia, NRR
B. Hayes, OI
T. Barchi, OIG
K. Cyr, OGC
T. Madden, OCA

FROM: James L. Blaha, AO/OEDO

SUBJECT: ENTRANCE BRIEF WITH GAO ON NRC POWER REACTOR INSPECTION PROGRAM (GAO no. 302122)

GAO has provided the attached questions and document requests associated with the subject audit. All of these questions are not expected to be answered during the entrance briefing but those that can should be summarized and presented. Those documents that are available and releasable should also be provided.

The entrance briefing will take place on Thursday, May 26, 1994 at 10:30am in OWFN 8 B 11.

Point of contact for additional information is Jim Turdici at 504-1728.

James L. Blaha, AO/OEDO

Attachment:
As stated

cc: J. Taylor
H. Thompson
~~J. Milhoan~~
D. Morris
~~F. Gillespie~~
T. Gody

QUESTIONS AND DOCUMENT REQUEST FOR MAY 26, 1994
ENTRANCE MEETING WITH NRC OFFICIALS

INSPECTION OF NUCLEAR POWER PLANTS

1. What are the roles, and responsibilities of headquarters staff, regional staff, and resident inspectors for inspecting nuclear power plants.

2. Is the inspection process the primary method for identifying deficiencies or problems? Are there other methods?

3. How does NRC's inspection program relate to NRC's systematic assessment of licensee performance (SALP)? What criteria does NRC use to rate a licensee either 1, 2, or 3 in the maintenance category of the SALP reports?

4. Explain purpose, scope, and frequency of the different types of inspections for operating nuclear reactors (e.g., core, area-of-emphasis, and discretionary). Has there been a cut back in any of the different type of inspections? What are the reasons if there were cut backs in inspections? Is the inspection process prioritized? If yes, how?

5. What areas of a plant are inspectors required to physically verify and what areas are record checks conducted.

5a. Are inspectors required to verify all information provided by plant personnel. If not, what information should be verified?

6. Once a deficiency, problem or violation is identified, how does NRC ensure that corrective action is implemented?

7. Which types of inspections are announced or unannounced? Why are some inspections announced and others unannounced?

8. What is the purpose and criteria for conducting a Diagnostic Evaluation Team (DET) report? Please provide a copy of DET criteria.

9. Why were numerous problems cited in the DET report for South Texas Project when NRC's inspection program is designed to detect deficiencies early and prevent deficiencies from occurring? What were the causes?

10. Does NRC maintain compilation of all DET results and lessons learned from DETs conducted. If maintained, please provide documentation of results and lessons learned.

11. Are lessons learned from DETs incorporated into NRC's inspection process for improving NRC's inspection program.

12. Does NRC review its inspection process for improving it? What? (e.g., special project team reviews of NRC inspection process)

13. What are the number of violations found by each regional office since 1985 on an annual basis?

14. Please provide number of core inspections, area-of-emphasis inspections and discretionary inspections for the South Texas Project and Fermi since these plants became operational on an annual basis.

15. Please provide the total number of core inspections, area-of-emphasis inspections, and discretionary inspections conducted annually since 1988.

NRC DOCUMENTS REQUESTED

1. A copy of the current inspection manual and guidance for implementing inspections of nuclear power plants

2. Copies of nuclear power plant inspection policies, procedures, guidelines, checklists, etc.

3. Copies of NRC actions taken based on results of DET reports.

4. Copies of all SALP reports for the South Texas Project and Fermi plants.

5. A copy of NUREG-0948 (January 1983 Quadrex Report)

6. Copy of all NRC senior management meeting minutes and Quarterly Plant Performance Reviews on the South Texas Project and Fermi since these plants became operational.

7. A copy of NRC's analysis of the Public Citizen report which compared the Institute of Nuclear Power Operation's reports to NRC's SALP reports on nuclear power plants.

8. 1979 NRC Special Team report on harassment of construction crews.

9. NRC's documentation of the South Texas Project's unit 1 shutting down in February 1993 as a result of a forced outage and NRC's approval for restart.

10. NRC's inspection budget and resource allocation since fiscal year 1988 including full-time equivalents (FTEs).

11. Names, addresses, and telephone numbers of all NRC resident inspectors who worked at the South Texas Project and Fermi plants.

12. Names, addresses, and telephone numbers of all NRC project managers involved with the South Texas Project and Fermi plants.

13. NRC's list of problem plants since inception of program, including date plant initially listed and dropped from list.

APPENDIX F

REFERENCES

Houston Lighting & Power Miscellaneous Documents

MPR Associates, Inc., Report MPR-1309, "Evaluation and Comparison of Tin Transfer in the Emergency Diesel Generators at Nine Mile Point Unit 2," September 1992.

MPR Associates, Inc., Report MPR-1475, "South Texas Project Emergency Diesel Generator Number 22 Piston Failure Trip Report," May 1994.

Ricardo Consulting Engineers Ltd., Report DP 91/1245, "Piston Tests at SMLP and Contact Patch Analysis," September 1991.

Cooper Energy Services Report, "Emergency Diesel Generator 22 (SN7193) No. 4R Piston Failure," March 28, 1994.

NRC Miscellaneous Documents

Code of Federal Regulations, Title 10, "Energy," U.S. Government Printing Office, Washington, D.C., 1982 through 1994 editions.

NRC Memorandum from W. Dircks to Office Directors and Regional Administrators, "Proposed NRC Manual Chapter 0517, 'Management of Allegations'," September 19, 1984.

NRC Memorandum from W. Dircks to Office Directors and Regional Administrators, "Procedure for Requesting OI Investigations," July 5, 1985.

NRC Memorandum from S. Chilk to V. Stello, "Staff Requirements--SECY-85-369, 'Threshold and Priorities for Conducting Investigations'," January 10, 1986.

NRC Manual Chapter 0517, "Management of Allegations," June 20, 1987.

NRC Manual Chapter 0517, "Management of Allegations," April 3, 1990.

NRC Management Directive 8.8, "Management of Allegations," April 14, 1993.

NRC Inspection Manual, Temporary Instruction 2515/109, "Inspection Requirements for Generic Letter 89-10, Safety-Related Motor-Operated Valve Testing and Surveillance," June 14, 1993.

NRC Inspection Manual, Temporary Instruction 2515/115, "Verification of Plant Records," May 29, 1992.

NRC Inspection Manual, Inspection Procedure 0350, "Staff Guidelines for Restart Approval," September 30, 1993.

NRC Inspection Manual, Inspection Procedure 40500, "Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems," October 3, 1994.

SECY-94-089, "Response to the Report of the Review Team for Reassessment of the NRC's Program for Protecting Allegers Against Retaliation," March 29, 1994.

NRC Memorandum from J. Hoyle to J. Taylor, "SECY-94-089--Response to the Report of the Review Team for Reassessment of the NRC's Program for Protecting Allegers Against Retaliation," June 2, 1994.

SECY-94-303, Draft Policy Statement, "Freedom of Employees in the Nuclear Industry to Raise Safety and Compliance Concerns Without Fear of Retaliation," December 19, 1994.

NRC Memorandum from J. Hoyle to J. Taylor, "SECY-94-303--Draft Policy Statement, 'Freedom of Employees in the Nuclear Industry to Raise Safety and Compliance Concerns Without Fears of Retaliation,'" January 24, 1995.

"Freedom of Employees in the Nuclear Industry to Raise Safety Concerns Without Fear of Retaliation; Draft Policy Statement," Federal Register, Vol. 60, No. 26, pp. 7592-7596, February 8, 1995.

NRC Generic Letters

Generic Letter 81-07, "Control of Heavy Loads," February 3, 1981.

Generic Letter 89-04, "Guidance on Developing Acceptable Inservice Testing Programs," April 3, 1989.

Generic Letter 89-06, "Task Action Plan Item I.D.2 - Safety Parameter Display System - 10 CFR §50.54(f)," April 12, 1989.

Generic Letter 89-10, "Safety-Related Motor-Operated Valve Testing and Surveillance," Supplements 1 through 6, June 28, 1989 through March 8, 1994.

NRC NUREG-Series Reports

NUREG-0781, "Safety Evaluation Report Related to the Operation of South Texas Project, Units 1 and 2," and its supplements, April 1986 through March 1989.

NUREG-0800, "Standard Review Plan for the Review of Safety Analysis Reports for Nuclear Power Plants," July 1981.

NUREG-0948, "Special Inspection Report of the Quadrex Corporation Report on Design Review of Brown and Root Engineering Work for the South Texas Project, Units 1 and 2," January 1983.

NUREG-1304, "Reporting of Safeguards Events," February 1988.

NUREG-1306, NRC Safety Significance Assessment Team Report on Allegations Related to the South Texas Project, Units 1 and 2," March 1988.

NUREG-1346, "Technical Specifications, South Texas Project, Unit Nos. 1 and 2, Appendix "A" to License Nos. NPF-76 and NPF-80," March 1989.

NUREG-1499, "Reassessment of the NRC's Program for Protecting Allegers Against Retaliation," January 1994.

NRC Regulatory Guides

Regulatory Guide 5.62, "Reporting of Safeguards Events," November 1987.

NRC Inspection Reports

NRC Inspection Report 50-498/79-19; 50-499/79-19, April 30, 1980.

NRC Inspection Report 50-498/84-11; 50-499/84-11, September 5, 1994.

NRC Inspection Report 50-498/86-03; 50-499/86-03, August 28, 1986.

NRC Inspection Report 50-498/91-21; 50-499/91-21, November 5, 1991.

NRC Inspection Report 50-498/92-07; 50-499/92-07, June 1, 1992.

NRC Inspection Report 50-498/92-20; 50-499/92-20, July 9, 1992.

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STP Station Problem Report 940777, March 22, 1994.

STP Station Problem Report 941460, July 25, 1994.

APPENDIX G

STP ART CORRESPONDENCE FOR FOLLOW-UP ACTIVITY

February 1, 1995	Letter from Thomas Alexion (NRC) to William Cottle (HL&P).

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

February 1, 1995

Mr. William T. Cottle
Group Vice President, Nuclear
Houston Lighting & Power Company
South Texas Project Electric Generating Station
P.O. Box 289
Wadsworth, TX 77483

SUBJECT: NRC FOLLOW-UP ACTIONS RESULTING FROM REVIEW OF ALLEGATIONS AT SOUTH TEXAS PROJECT

Dear Mr. Cottle:

In March 1994, members of the NRC staff met with congressional staff members from the Subcommittee on Oversight and Investigations of the U. S. House of Representatives Committee on Energy and Commerce. In response to congressional staff concerns that significant safety issues existed at STP, the NRC formed a team to collect and review allegations from those individuals who had been in contact with the congressional subcommittee staff. The results of the team's review will be documented in a future report, NUREG-1517, entitled, "Report of the South Texas Project Allegations Review Team." The team found that, although some allegations had been substantiated, there were no significant safety issues that had not been adequately addressed.

In some instances, the team closed allegations based on programs, procedures, or actions by HL&P that have not been fully evaluated by the NRC. These allegations are considered closed, but certain actions need to be verified to confirm that HL&P's corrective actions ensure long-term closure. The following list contains these activities that will need to be reviewed by the NRC. Some of these items are already designated inspection follow-up items as noted in certain inspection reports. The NRC, most likely the Region IV office, will inspect these areas at some time in the future.

(1) The effectiveness of the new Condition Reporting Process, procedure number OPGP03-ZX-0002, Revision 5.

(2) The 10 CFR 50.59 program, including follow-up to a commitment made to develop and provide training on the requirements for a 10 CFR 50.59 evaluation, as documented in an HL&P letter dated October 27, 1994.

(3) Resolution of pressure locking and thermal binding of motor-operated valves following issuance of a future generic letter as stated in Inspection Report 94-32, Section 1.3.

(4) An HL&P commitment to develop standardized guidelines for the preparation of motor-operated valve maintenance work instructions as documented in Inspection Report 93-13, Section 1.2.2.

(5) Completion of a bases document for the inservice testing program as committed to in HL&P's response to a violation dated August 18, 1994, related to Inspection Report 94-19.

Since this letter is to inform you of activities that will be inspected by the NRC in the future, it does not require a response.

Sincerely,

Thomas W. Alexion

Thomas W. Alexion, Project Manager
Project Directorate IV-1
Division of Reactor Projects III/IV
Office of Nuclear Reactor Regulation

Docket Nos. 50-498
and 50-499

cc: See next page

APPENDIX H

COMPOSITE CHRONOLOGY OF SIGNIFICANT EVENTS

Upon approval of the ART charter on May 31, 1994, the team commenced review activities. During the course of these activities, the ART, either collectively or individually, attended various meetings with Congressional staff, briefed senior NRC managers, coordinated with GAO investigators, interviewed allegers, performed and assisted in the conduct of an OI investigation, and other assigned duties. The following is a composite chronology of those activities.

Meetings Between Congressional and NRC Staffs Regarding STP

On the below listed dates, meetings were held between staff members of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce and members of the NRC staff. On the dates indicated, the Congressional staff members were briefed on the status of the South Texas Project. The Congressional staff members brought numerous concerns to the attention of the NRC staff who agreed to pursue the issues and give them a response. The vast majority of these concerns dealt with falsification of records, employee discrimination, and lack of oversight by the NRC. The dates of the meetings were as follows:

March 31, 1994
April 29, 1994
June 20, 1994
August 18, 1994
September 27, 1994
December 19, 1994 (Only senior NRC managers met with the Congressional staff.)

Briefing of Senior NRC Staff

During the conduct of ART activities, various meetings were held with senior NRC managers to keep them apprised of the ART's progress and to solicit recommendations regarding future ART actions. On the dates indicated, ART met with the listed NRC managers.

May 5, 1994 (Milhoan; prior to team formation, but related to startup of team)
June 3, 1994 (Milhoan, Chandler)
June 16, 1994 (Milhoan, Reyes, Mitchell, & Callan (phone))
June 17, 1994 (Miraglia, Reyes)
July 7, 1994 (Milhoan, Chandler, Hayes, Zimmerman)

September 19, 1994 (Russell, Miraglia, Zimmerman, Roe, Bateman)
September 19, 1994 (Russell, Jordan, Miraglia, Bateman)
October 17, 1994 (Russell, Zimmerman, Roe, Adensam, Beckner)
November 8, 1994 (Miraglia, Zimmerman, Roe, Bateman)
December 2, 1994 (Miraglia, Bateman)
December 15, 1994 (Russell, Miraglia, Zimmerman, Roe)
December 20, 1994 (Miraglia, Bateman, Roe)
January 3, 1995 (Russell, Miraglia, Roe, Beckner, Bateman, Fortuna)
January 4, 1995 (Miraglia)
January 5, 1995 (Miraglia)
January 9, 1995 (Miraglia)
January 20, 1995 (Miraglia)
February 9, 1995 (Miraglia, Fortuna)

Meetings With GAO Staff Members

During the conduct of ART activities, numerous discussions (meetings or telephone conversations) were held to discuss issues of interest to the GAO team regarding NRC regulatory activity. Some of the most significant contacts were as follows:

May 26, 1994 (GAO entrance meeting; prior to charter approval)
June 6, 1994 (Zavala, Olsen)
July 5, 1994 (Zavala)
July 7, 1994 (Olsen)
July 19, 1994 (Zavala)
July 21, 1994 (Zavala)
September 29, 1994 (Zavala)
October 3, 1994 (Zavala, Olsen)
October 4, 1994 (Olsen)
November 5, 1994 (Olsen)
November 18, 1994 (Zavala, Olsen)
November 21, 1994 (Olsen)
December 12, 1994 (Zavala)
December 21, 1994 (Zavala)
January 27, 1995 (Zavala)
January 31, 1995 (Zavala)
February 6, 1995 (Olsen)
February 10, 1995 (Zavala)

Interview of Allegers Represented by Attorneys Tanner Garth, Timothy Sloan, and Billie Garde

During the initial meeting with the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce, the Congressional staff members indicated that several attorneys would be able to put us in contact with individuals who had concerns regarding the South Texas Project. Shortly after ART contacted Mr. Garth and Ms. Garde, Ms. Timothy Sloan, who was associated in the same law firm as Ms. Garde, contacted the team and indicated that she also had several clients interested in voicing their concerns to the NRC. On the below listed dates, clients of

Mr. Garth and Ms. Sloan were interviewed by ART. Attempts to interview individuals represented by Ms. Garde is addressed separately.

Dates of Interviews of Individuals (or Associated with Individuals) Represented by Mr. Garth

July 12, 1994 (Two individuals - interviews transcribed by Court Reporter)
July 13, 1994 (One individual - interview transcribed by Court Reporter)
September 12, 1994 (Telephonic interview of one previously interviewed individual)
September 16, 1994 (Telephonic interview of one previously interviewed individual; Note: discussed material previously supplied by alleger which identified two individuals who supported alleger)
November 8, 1994 (Telephonic interview of one individual)
November 14, 1994 (Telephonic interview of one individual)
November 17, 1994 (Telephonic interview of one previously interviewed individual)
November 18, 1994 (Continuation of telephonic interview of individual from call made on November 14)
November 29, 1994 (Telephonic interview of previously interviewed individual; subsequently provided written information)

Dates of Interviews of Individuals Represented by Ms. Sloan

July 12, 1994 (Four individuals - interviews transcribed by Court Reporter)
August 31, 1994 (One individual - interview recorded)

Efforts to Interview Allegers Represented by Ms. Garde

Shortly after ART was formed, several efforts were made to interview those individuals represented by Ms. Garde. All efforts by ART proved unsuccessful. On October 20, 1994, at the suggestion of Ms. Sloan, a meeting was held with Ms. Garde and Ms. Sloan in Houston, Texas, in an attempt to make arrangements to interview Ms. Garde's clients. Although it appeared that Ms. Garde was not inclined to let ART interview her clients, Ms. Sloan presented a list of conditions under which Ms. Garde would consider allowing ART to interview her clients. Although ART did not agree to these conditions, Ms. Garde and Ms. Sloan were asked to address their conditions in a letter to the NRC.

On October 26, 1994, a letter was received from Ms. Garde outlining the conditions under which she would allow ART to interview her clients. Although the NRC did not agree to these conditions, the NRC sent a letter to Ms. Garde on November 23, 1994, outlining conditions for interviews which were acceptable to the NRC. This was an attempt to reach a middle ground with Ms. Garde. The NRC letter set a 10-day response time for acceptance of the conditions outlined by the NRC.

On December 6-7, 1994, Ms. Garde contacted a member of ART and requested an extension of her 10-day response time. In addition, she verbally agreed to the conditions stated in the November 23, 1994, NRC letter. Ms. Garde was granted an extension until December 23, 1994.

Although Ms. Garde did not respond by December 23, 1994, she did send a letter to the NRC dated January 4, 1995. In this letter, Ms. Garde outlined more conditions, which after evaluation, were unacceptable to the NRC.

The NRC also sent a letter dated January 4, 1995, which again requested that Ms. Garde should agree to the conditions of interview and arrange a schedule of interviews. Ms. Garde also failed to meet the conditions which she had previously verbally accepted.

On January 10, 1995, the NRC sent a letter to Ms. Garde reiterating the NRC's interest in interviewing her clients and reemphasizing the need for Ms. Garde to meet the conditions in the November 23, 1994, letter.

On January 18, 1995, Ms. Garde sent a letter to NRC in which she took exception to the conditions placed on her for the interview of her clients and again failed to meet the conditions outlined in the NRC's November 23, 1994, letter.

On January 30, 1995, the NRC sent a letter to Ms. Garde indicating the special conditions outlined in the NRC November 23, 1994, letter had expired. The letter informed Ms. Garde that the NRC is still interested in interviewing her clients, but that she would have to use the normal allegation submittal process.

Interviews of Previous Resident Inspectors at STP

During an August 18, 1994, meeting with members of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce, it was suggested that some past NRC resident inspectors at STP had concerns regarding the manner in which the NRC handled allegations at STP. As a result, ART interviewed the resident inspectors listed below on the dates indicated.

Name	Dates as Resident	Date of Interview
Claude E. Johnson	3/85-2/87	8/25/94
Robert J. Evans	10/88-7/93	8/25/94
Joseph I. Tapia	7/88-8/93	8/26/94
Terrance Reis	9/86-8/87	9/23/94

None of the individuals interviewed had any significant concerns about how the NRC Resident Inspectors performed their functions at STP.

Interview of Individuals Regarding OI Investigation 4-94-037

During the period October 25 through November 18, 1994, ART assisted members of OI's Region IV Field Office in interviewing 13 individuals having information related to an allegation identified by the ART.

Inspection Efforts Related to Allegations Obtained by ART

On-site inspections regarding allegations surfaced by ART were conducted during the period October 31 through November 4, 1994.

APPENDIX I

ABBREVIATIONS

AEOD	Office for Analysis and Evaluation of Operational Data
AFW	auxiliary feedwater (system)
AFWST	auxiliary feedwater storage tank
aka	also known as
ALJ	Administrative Law Judge
AMS	Allegations Management System
ARB	Allegations Review Board
ARP	Allegations Review Panel
ART	Allegations Review Team
B&W	Babcock and Wilcox Corporation
CAL	confirmatory action letter
CCW	component cooling water
CFR	Code of Federal Regulations
CP&L	Central Power and Light Company
COA	City of Austin, Texas
CPS	Central Public Service Board of San Antonio
DCN	design change notice
DEDO	Deputy Executive Director for Operations
DET	Diagnostic Evaluation Team (NRC)
DG	diesel generator
DOL	U.S. Department of Labor
ECP	employee concerns program
EDG	emergency diesel generator
EDO	Executive Director for Operations (and Office of)
FCR	field change request
FFD	fitness for duty
GAP	Government Accountability Project
GAO	General Accounting Office
GL	generic letter
H&I	harassment and intimidation
HL&P	Houston Lighting and Power Company
HVAC	heating, ventilation, and air conditioning

IATI	Integrated Assessment Team Inspection
IN	information notice
INPO	Institute of Nuclear Power Operations
IR	inspection report
ISEG	Independent Safety Engineering Group
ISI	inservice inspection
IST	inservice testing
IVSS	individual valve survey sheet
LER	licensee event report
LLRT	local leak-rate test
M&TE	measuring and test equipment
MOV	motor-operated valve
MOVATS	Motor Operated Valve Analysis and Test System
NCR	non-conformance report
NNI	Newport News, Inc.
NOV	Notice of Violation
NRC	U.S. Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
OAC	Office Allegation Coordinator
OE	Office of Enforcement
OI	Office of Investigations
OIG	Office of Inspector General
OQAP	Operational Quality Assurance Plan
ORAT	Operational Readiness Assessment Team (NRC)
PCF	plant change form
PM	preventative maintenance
PRG	Problem Report Review Group
PSP	Physical Security Plan
QA	quality assurance
QC	quality control
RFA	request for action
RFI	request for information
RHR	residual heat removal
RI	resident inspector (NRC)
RIV	NRC Region IV
SDG	standby diesel generator
SI	safety injection (system)
SPR	station problem report
SR	surveillance requirement
SRI	senior resident inspector (NRC)
SSAT	Safety Significance Assessment Team
SSC	safety-related structure, system or component
STP	South Texas Project
STPEGS	South Texas Project Electric Generating Station

TDAFWP	turbine-driven auxiliary feedwater pump
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
VPDS	valve packing data sheet

NRC FORM 335 (2-89) NRCM 1102, 3201, 3202

U.S. NUCLEAR REGULATORY COMMISSION

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Lawrence E. Kokajko, Office of Nuclear Reactor Regulation
Donna M. Skay, Office of Nuclear Reactor Regulation
Hai-Boh Wang, Office of Nuclear Reactor Regulation
Daniel D. Murphy, Office of Investigations

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10. SUPPLEMENTARY NOTES

11. ABSTRACT *(200 words or less)*

This report provides the results of the South Texas Project Allegations Review Team of the U.S. Nuclear Regulatory Commission. This team was formed to obtain and review allegations from individuals represented by three attorneys who had contacted Congressional staff members. The allegers were employed in various capacities at South Texas Project Electric Generating Station, licensed by Houston Lighting and Power Company, et al.; therefore, the allegations are confined to this site. The South Texas Project Allegations Review Team reviewed, referred, and dispositioned concerns related to discriminatory issues (harassment and intimidation), falsification of records and omission of information, and various technical issues. The team was able to substantiate certain technical issues of minor safety significance or regulatory concern at the South Texas Project facility, but it did not find widespread discriminatory practices such as harassment and intimidation.

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