UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

PETITION FOR IMMEDIATE ACTION TO PROTECT PUBLIC HEALTH AND SAFETY FROM UNDUE RISKS POSED BY LACK OF QUALITY ASSURANCE COMPLIANCE AT WOLF CREEK GENERATING STATION, BURLINGTON, KANSAS.

Submitted by: KANSAS CHAPTER, SIERRA CLUB
P.O. Box 272
Wichita, KS 67201-0272

Date: January 30, 1989

DF01

UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

I. Jurisdiction

This petition to the Nuclear Regulatory Commission (NRC) is filed pursuant to 10 CFR §2.206 by the Kansas Chapter of the Sierra Club, which has more than 2,000 members within 200 miles of Wolf Creek Generating Station in Burlington, Kansas. 10 CFR §2.200 and 10 CFR §2.206 authorize "any person" to file a petition to request that the Director of the Office of Inspection and Enforcement of the Nuclear Regulatory Commission institute a proceeding pursuant to 10 CFR §2.202 to modify, suspend or revoke a license or for such other action as may be proper.

II. Action Requested

This petition requests immediate NRC action to prevent undue risks to public health and safety posed by the operation of the Wolf Creek Generating Station in Burlington, Kansas. This petition requests that the operating licenses for the Wolf Creek Generating Station be suspended until corrective actions to achieve assurance of adequate protection of public health and safety have been taken. The grounds for these requests are summarized in the body of this petition.

III. Applicable Laws

A. Appendix B to 10 CFR Part 50

This Appendix is entitled "Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants." The text of the Appendix outlines its applicability to the Quality First Program carried out by the Kansas Gas & Electric Company at Wolf Creek Generating Station in Burlington, Kansas:

> "Nuclear power plants and fuel reprocessing plants include structures, systems, and components that prevent or mitigate the consequences of postulated accidents that could cause undue risk to the health and safety of the public. This appendix establishes quality assurance requirements for the design, construction and operation of those structures, systems and components. The pertinent requirements of this appendix apply to all activities affecting the safety-related functions of those structures, systems and components; these activities include handling, shipping, storing, cleaning, erecting, installing, inspecting, testing, operating, maintaining, repairing, refueling and modifying. As used in this appendix, "quality assurance" comprises all those planned and systematic actions necessary to provide adequate confidence that a structure, system or component will perform satisfactorily in service."

The Appendix sets forth procedural requirements as to who is responsible for quality assurance:

> "The authority and duties of persons and organizations performing activities affecting the safety-related functions of structures, systems, and components shall be clearly established and delineated in writing."

The Appendix makes it clear that Quality Assurance involves much more than merely creating a program and a flowchart of authority:

> "The quality assurance functions are those of (a) assuring that an appropriate quality assurance program is established and effectively executed and (b) verifying, such as by checking, auditing, and inspection, that activities affecting the safety-related functions ahve been correctly performed."

In addition, independent professional judgments and corrective actions are essential:

> "The persons and organizations performing quality assurance functions shall have sufficient authority and organizational freedom to identify quality problems, to initiate, recommend or provide solutions; and to verify implementation of solutions. Such persons and organizations performing quality assurance functions shall report to a management level such that this required authority and organizational freedom, including sufficient independence from cost and schedule when opposed to safety considerations, are provided."

The Appendix requires documentation:

> "This program shall be documented by written policies, procedures, or instructions and shall be carried out throughout plant life in accordance with those policies, procedures or instructions."

The Appendix also requires periodic review of the overall Quality Assurance effort"

> "The program shall provide for indoctrination ad training of personnel performing activities affecting quality as necessary to assure that suitable proficiency is achieved and maintained. The applicant shall regularly review the status and adequacy of the quality assurance program. Management of other organizations participating in the quality assurance program shall regularly review the status and adequacy of that part of the quality assurance program which they are executing."

Even if these regulations were not a part of the Code of Federal Regulations in 1984, common sense would cause any competent manager of a nuclear power plant to meet each and every one of these requirements to assure the health and safety of that manager's own employees as well as that of the general public.

Radioactive materials are inherently dangerous. The law has traditionally required a greater degree of care from those managing inherently dangerous activities.

B. 10 CFR Part 50.55(e)

This regulation requires a report to the NRC of each deficiency found in design and construction "which were it to have remained uncorrected, could have affected adversely the safety of operations of the nuclear power plant at any time throughout the expected lifetime of the plant, and which represents (1) a significant breakdown in any portion of the quality assurance program required by the Nuclear Regulatory Commission", or (2) a significant deficiency in the final design so that it does not conform to the safety analysis report or construction permit, or (3) a significant deficiency in construction or significant damage to a structure, system or component that will require extensive evaluation, redesign or repair to

conform to the safety analysis report or construction permit, or to otherwise establish its adequacy to perform its intended safety function, or (4) a significant deviation from performance specifications that will require extensive evaluation, redesign or repair to establish its adequacy to perform its intended safety function or to conform to the safety analysis report or construction permit.

The construction permit holder is to inform the NRC of each reportable deficiency within 24 hours of its dixcovery and submit a written report within 30 days. The written report is to contain "sufficient information to permit analysis and evaluation of the deficiency and of the corrective action."

C. NRC's Longstanding Requirement of Management Competence and Integrity

NRC has periodically found management of nuclear power plants to be culpably negligent in failing to instill a sense of respect and integrity in quality assurance programs, failing to fix precisely within a company the responsibility for carrying out quality assurance programs, and failing to apply quality assurance concepts. See for example 16 NRC 281 (1982).

A pervasive scheme of quality assurance management practices that have made it impossible for management to provide adequate confidence that a structure, system or component of a nuclear power plant will perform satisfactorily in service would fall into the category of culpable negligence as that term has been used by NRC in imposing penalties. Management activities and omissions which resulted in closing hundreds of quality assurance investigative files with only superficial investigative efforts, transparently limited documentation, meaningless verification of corrective action and premature closures of issues which merited further investigation (in the words of NRC's investigator H. Brooks Griffin) would fall into the category of culpable negligence as that term has been used by NRC in imposing penalties and suspending operating licenses.

Management with superior knowledge, skill and intelligence in the nuclear power industry is held to a higher standard of behavior than the reasonably prudent person, but even common knowledge and ordinary judgment would recognize unreasonable danger in management actions and omissions described in this petition that occurred and may continue to occur at Wolf Creek Generating Station. Every reasonable precaution suggested by experience or prudence is required in the handling of ultrahazardous materials such as nuclear fuel. Some management actions and omissions described in this petition may rise to conscious indifference to consequences, amounting to a willingness that they shall follow.

Dr. Robert Peter Gale and Thomas Hauser, in their book Final Warning, The Legacy of Chernobyl (Warner Books, Inc. 1988) state that one inhaled plutonium atom which decays and emits an alpha particle inside the human body is able to cause cancer. The public cannot afford to risk the consequences of the defective quality assurance program at Wolf Creek Generating Station, which has been managed with a callous indifference to human life and to human health.

IV. Grounds for Relief

A. From the inception of its Quality Assurance program to date, management at the Wolf Creek Generating Station, Burlington, Kansas has ignored real.safety concerns.

This petition relies on NRC's Office of Investigation Case No. 4-86-004, FOIA 87-811 (also known as FOIA 87-800) for specific facts noted herein. Petitioner has access only to the expurgated version of this case report. That version includes censored transcripts of interviews of Robert L. Scott, Charles Snyder and Glenn Koester conducted by H. Brooks Griffin of the NRC Office of Investigations. Also included are Mr. Griffin's censored summaries of the allegations that triggered the NRC's investigation as well as censored summaries of interviews he conducted with Charles Hill and John Johnson. Mr. Griffin's analysis of the results of his investigation is also included.

Petitioner wishes to note that the materials available to it apparently minimize the deficiencies in the Quality First Program as it was managed from August, 1984, through March, 1985, due to the large portions of censored information in the version of Case No. 4-86-004 available to it. Examples of information not available to the public are the names of persons in Griffin's discussion of wrongdoers, names of many persons mentioned by those Griffin interviewed, names of Quality First investigators who were fired or transferred out of Quality First, paragraphs of Griffin's summaries of interviews, and paragraphs of Griffin's discussion of allegations bearing on his conclusions regarding wilfulness and intent (a third of a page or more was censored on at least ten of these fifteen pages).

Petitioner submits this petition based on an expurgated version of the case investigation which does not describe the full extent of the problems in the Quality First Program. If Petitioner had access to the unexpurgated version of Case No. 4-86-004, as does the NRC, an even stronger case for relief could no doubt be presented. Petitioner urges the NRC to consider the entire unexpurgated report of this investigation in its evaluation of this petition.

H. Brooks Griffin of the Office of Investigations concluded:

1. Little corrective action related to Quality First investigations had occurred by the original fuel load date of December, 1984.

2. Verification of corrective action by Quality First "was not meaningful."

3. "In many instances" safety concerns were closed after "superficial investigative effort and transparently limited documentation, all of which was accepted by QI supervision."

4. Interviews of those raising safety concerns were summarized in one or two sentences resulting in too little information to launch a meaningful investigation in many cases.

5. Meaningless investigations occurred which resulted in "premature closures of issues which merited further investigation."

6. Failure to evaluate the pipe cleanliness issue was inconsistent with the

objective need to effectively investigate that issue.

7. Kansas Gas & Electric Company managers changed investigative conclusions of their staff members in at least two significant cases.

8. Quality First essentially dropped allegations of harassment, intimidation, falsification, discrimination and drug use on the site and did not investigate them for their potential adverse effect on plant safety nor did it penalize wrongdoers.

9. Some investigators were removed from their jobs by Kansas Gas & Electric Company managers as a result of their aggressive Quality First Program investigations when they refused to limit the scope of their investigations after related or additional safety concerns surfaced in the course of an investigation.

Despite these and other findings which will be described in more detail below, the NRC's Office of Investigations ultimately concluded that "[d]espite substantial shortcomings identified in the Q1 program, it is concluded that the evidence gathered does not substantiate wrongdoing on the part of KG & E management in their conduct of this voluntary program." The word "wrongdoing" was not defined. According to Appendix B to 10 CFR Part 50, quality assurance is not voluntary but mandatory.

Background

Kansas Gas & Electric Company (KGE) created the Quality First Program (Q1) in March, 1984, choosing Owen THERO, a contract employee of KGE, to be Team Leader of the program. THERO reported to KGE Quality Assurance (QA) Manager, William RUDOLPH. In mid-February the Atomic Safety and Licensing Board Panel had concluded licensing hearings for Wolf Creek Generating Station. During those hearings, the Nuclear Awareness Network, a registered intervenor, had produced former site employees with allegations concerning construction deficiencies. THERO said RUDOLPH asked him to investigate those witnesses' concerns in a timely manner to determine whether they would delay licensing. After further discussions with THERO, RUDOLPH established Q1 to conduct exit interviews of site employees regardless of which firm had employed them. A written Q1 procedure was approved by Glenn KOESTER, KGE's Vice President, Nuclear, who retains that title but no longer has day-to-day responsibility for Wolf Creek. KOESTER is now also Chairman of the Board of Directors of Wolf Creek Nuclear Operating Corporation. A videotape explained Q1 to exiting employees about to be interviewed. An allegation hotline and walkin interviews were also available to employees.

The NRC investigative record shows a lack of agreement as to the purpose of Q1. KOESTER told NRC that Q1 was created to investigate safety allegations made by employees and to identify deficiencies that needed to be corrected before Wolf Creek was licensed. The license was granted July 2, 1984, but Q1 continued. THERO said Q1 was also to determine the root cause of problems and to determine the full extent of the potential problems, not just to deal with the symptoms. He saw Q1 as an independent investigative organization. THERO came to believe KGE management wanted quick resolution of problems and did not wish to broaden investigations based on new information developed during an investigation. THERO said Q1 was not created to cover up issues but to encourage employees to bring concerns about safety to the licensee first for possible corrective action

instead of to NRC or to intervenor groups, buts its mission changed.

1. Documents Shredded; Blackballing

In early August, 1984, Richard GRANT, KGE Manager of Quality, was made interim supervisor of Q1, replacing RUDOLPH. KOESTER said NRC had encouraged him to remove RUDOLPH from Q1 because of a potential conflict of interest between RUDOLPH's supervision of both Q1 and QA. RUDOLPH remained in charge of QA. THERO and Charles HILL, the first Q1 investigator hired, thought a document shredding incident had lead to RUDOLPH's replacement at Q1. They told NRC that while an inspector was in the Q1 trailer making allegations during his exit interview, RUDOLPH, supervisor of Q1 at the time, ordered Security to search the inspector's truck for documents. RUDOLPH called THERO into his office later that day and, laughing, told THERO the inspector was going to have a hard time proving anything because Security had found some documents in his truck and destroyed them after RUDOLPH had read them. Another KGE employee wrote a report on RUDOLPH's actions. RUDOLPH was later accused of blackballing the same inspector so that he was not hired at Arizona Public Service (APS), as verified by APS employees. A Q1 investigator substantiated that the blackballing had occurred in tape recorded interviews of two APS employees. HILL said within 24 hours of those interviews, KOESTER ordered that all Q1 tape recorders be turned in to him. At the time NRC reviewed the blackballing file, the conclusion had been changed to "unsubstantiated" without the knowledge of the Q1 investigator. THERO told NRC that KOESTER had ordered removal of the tape recorders after an employee alleged sexual harassment by a senior KGE manager.

2. Q1 Management Reorganized

Q1 had hired about ten more investigators by August, 1984, including Robert L. SCOTT, who was brought in by GRANT. SCOTT had been employed by Bechtel Power Corporation since 1973 as was hired at Wolf Creek as a Bechtel employee to be a Q1 investigator. SCOTT was assigned to one case, which he did not complete, before Q1 was reorganized later that month. HILL said the Q1 investigators referred to SCOTT as "Bechtel Bob" because he always searched for means to invalidate allegations instead of investigate them. In August, 1984, Q1 was split into two groups, an interview group supervised by THERO, and an investigator groups supervised by SCOTT. Charles SNYDER was then named Manager of Q1, assuming control from RUDOLPH and reporting directly to GRANT. SCOTT and SNYDER controlled the course of the Q1 investigations. THERO was told KGE wanted a permanent KGE employee to head Q1. THERO was a contract employee and so was SCOTT. SNYDER, on the othr hand, had been employed by KGE since 1980 as a project construction engineer. He had represented KGE at its rate case hearings in early 1984. KOESTER chose him to be Q1 Manager while SNYDER was himself the subject of allegations under Q1 investigation regarding pipe cleanliness. THERO believed there was a conflict of interest to SNYDER's being named to manage Q1 while that investigation was pending.

3. Case Closure Rate Leaped

At SNYDER's first meeting with Q1 staff, many investigators heard him say he had a mandate to close all of the open Q1 investigations by December, 1984, so they would not interfere with the fuel load date. He was also heard to say to the group that if anyone present could not do the work SNYDER's way, they should seek other employment. SCOTT did not recall hearing this and SNYDER denied saying it. KOESTER said no pressure was placed on Q1 management or investigators to close the cases by December. Nevertheless, Griffin of NRC discovered that prior to August, the average case closure rate per investigator was four cases a month

and by November it was eleven cases per investigator with a staff of about 24 investigators. Some investigators in November closed one or more Q1 files each day. Griffin stated to SCOTT that a single harassment case usually took him about three months to close. SCOTT's response was that the streamlined procedures and better tools available to the Q1 investigators by November explained the increased closure rate. SNYDER said some investigators were particularly knowledgeable and did not have to expend as much effort to resolve the issues. Griffin noted that many of the files contained very little documentation to support the conclusions one way or another and told SCOTT that the investigations were not meaningful or thorough. When Griffin asked him what amount of documentation he required as a supervisor, SCOTT said he could not answer that without a specific case example. When he was asked if documents were ever purged from the files, SCOTT said he had at one point asked his investigators to throw anything not relevant to the case away to eliminate the need for extra file cabinets. SNYDER said it was never his intent to require full documentation of investigations. Many Q1 investigators thought the program had been streamlined to the point it was meaningless, superficial, and had no integrity. Griffin found that although there were still some open cases left in December, 1984, the vast majority had been closed by December, 1984. Griffin concluded that an "inordinate number" of cases were closed in a very brief period of time and that was why the Q1 program had undergone three NRC reviews since 1984.

4. Tape Recorders Confiscated

KOESTER confiscated the tape recorders after Q1 was reorganized. He told NRC that he had learned Q1 had tape recorded interviews with people who had not known they were being recorded under THERO's management of the program. KOESTER said when he heard about this, he asked KGE Legal about it and they suggested Q1 stop the practice of tape recording interviews. KOESTER denied that they were confiscated as a result of an allegation of sex discrimination or to decrease the specificity and detail of allegations made to Q1 interviewers. Griffin noted that many of the files contained one or two sentence descriptions of the allegation made by an employee, even though the interviews took up to an hour. No interview notes were present in most of the files created after the tape recorders were confiscated. Detail that might have aided investigation was missing. As a result, some of the investigators said there was not enough information about some allegations to be able to investigate and files were closed for that reason. SCOTT responded that he wanted the interviews distilled to make the allegations as specific as possible, although sometimes that lead to vagueness in the files. Griffin noted that some information was apparently lost forever because it was not documented and investigators no longer had access to existing employees.

5. Investigators Hamstrung

SNYDER made fundamental changes to the Q1 program. He narrowed the scope of the program to address only issues he or SCOTT deemed directly related to the original allegation made to the Q1 interviewer. He and SCOTT ordered Q1 investigators to refer their investigative findings concerning any new problems to the subcontractor or department involved for whatever action it deemed appropriate. The referral was made by a newly created form, which allowed the Q1 file to be closed. No mention of the additional findings was to be included in the Q1 file. The other options Q1 investigators had concerning new problems they discovered in the course of an investigation were to refer them to QA, which was managed by RUDOLPH, or to call Q1 and make a new allegation to the program run by SNYDER. This narrowed focus was carried to ridiculous extremes; for example, each weld was dealt with separately rather than a length of pipe inspected to determine the extent of the

welding problem. Corrective action was verified only if a QI file recommended it. Both SCOTT and SNYDER denied they limited the amount of time allowed for investigations, an allegation made by many QI investigators. Under SNYDER, QI referred a number of allegations to other departments or organizations which resulted in the closing of the QI files because SNYDER did not follow up on allegations he transferred out of QI to make sure they were investigated and either substantiated or found to be without merit. SNYDER admitted to NRC that some subcontractors were reluctant to respond to QI forms raising new allegations.

6. Falsification Mishandled

SNYDER did not assign QI investigators to determine how extensively falsifications adversely affected plant safety. For example, color-coded drawings of welds had been falsified. SNYDER said a reevaluation of encased bolted and welded connections and of lot and heat numbers had occurred, but QI did not attempt to learn why the inspection supervisors had falsified the drawings or whether they had falsified any other inspection drawings. Apparently, QI did not follow through to ensure that the supervisors were penalized for falsifications. A second instance of falsifications involved the Crawford Company sending the same acid etch test with its order of fittings for four years, although procedures required a new acid etch test with each order. KGE's engineering department subsequently recommended deletion of the acid etch test requirement, which SNYDER apparently accepted without question. No punishment was meted out to Crawford Company for violating the procedures for the four years prior to deletion of the acid etch test requirement.

7. Investigators Muzzled

SCOTT and SNYDER also prohibited QI investigators from discussing their cases with each other. To explain this, SNYDER told NRC each investigator was qualified to perform the job alone and the prohibition was to make them mroe productive. SNYDER said investigators could still draw on the technical expertise of fellow employees. Investigators told Griffin they had understood the prohibition to be total, applying both on and off the job site. SCOTT said the prohibition was to cut down on wasted time and that if they needed the technical assistance of a co-worker to resolve a case they could go through SCOTT to get it. SCOTT could not provide an example of a situation in which he had investigators work together.

8. Wrongdoers Ignored

NRC's investigator Griffin noted that about 100 QI investigations between August and December, 1984, dealt with "wrongdoing", which included harassment, intimidation, falsification, discrimination and relatd activities. Griffin concluded QI usually dropped these issues as QI concerns, based on his review of many files that documented only a denial of the allegation by the accused and no further investigation. One allegation SNYDER was questioned about involved an electrical supervisor who allegedly set quotas for his inspectors. The file showed only that the supervisor denied it, although another substantiated allegation in a separate file had shown significant problems with welds related to work inspected by that group. SNYDER said to NRC that the investigation should have been more extensive. Apparently wrongdoers were not disciplined as a result of findings in QI investigations. Only hardware problems were perceived as safety threats under SNYDER's management.

9. Investigators' Conclusions Changed; Investigators Fired

SNYDER admitted changing the conclusion regarding RUDOLPH's alleged blackballing of an individual inspector to "unsubstantiated" based on his own review of the facts. QI and KGE's Legal Department had also jointly investigated allegations that RUDOLPH was taking kickbacks, according to SNYDER. SNYDER said they concluded RUDOLPH had received money under a contract for services related to another nuclear site.

Another example of an investigator's conclusions being changed involved the only case SCOTT had been assigned prior to reorganization of the QI program in August, 1984. It concerned one subcontractor's Corrective Action Report (CAR) program, specifically a charge that forty-one (41) CARs had been revised at the request of management to change the portions that were no longer effective. SCOTT narrowed the scope of the investigation to those CARs that had been revised and did not look at the CAR program as a whole. He was more than halfway through his investigation when QI was reorganized, and he told NRC that up to that point he had not seen any evidence of management pressure to revise CARs and said they were logical revisions. CARs were a higher-tiered document than QI forms, and the QI program closed its file if a CAR existed on the same topic. The concern was reassigned to a new QI investigator who chose a different investigative approach. When SCOTT periodically reviewed the status of the investigation with the new investigator, whose name has been censored from the public report, SCOTT stated he did not see the relevance of the broadened scope of the investigation, which continued for over a month. SCOTT told NRC this investigator at tone point said, "man, just tell me what you want, and I'll write anything you want." SCOTT had answered that he wanted conclusions based on facts and a systematic approach, he told NRC. SCOTT did not perceive the investigator's statement as an expression of frustration. Shortly thereafter, the investigator turned in his draft report, which was handwritten. SCOTT read it and concluded this investigator was not capable of handling or did not understand his assignment and SCOTT fired the investigator that same day with SNYDER's concurrence. SCOTT put the handwritten report into a file with SCOTT's notes on the termination and gave it to SNYDER. The CAR case was then reassigned to yet another investigator, who concluded that the original allegation was substantiated based on one CAR that had been repeatedly revised.

NRC found that KGE Legal had a copy of the handwritten report of the terminated investigator, which had also substantiated the allegation and found some other procedural inadequacies which SCOTT thought were irrelevant. SCOTT chose not to give credence to the findings of the terminated investigator because of the manner in which he scoped the investigation and not to give access to that handwritten report to the next investigator assigned to the case. SCOTT denied any intent to bury the terminated investigator's conclusions, noting that the next investigator reached the same conclusion that the original allegation had merit. SCOTT had instructed the terminated investigator to report his broader concerns as new allegations and transfer them to the responsible firms for followup, but he had instead continued to investigate those concerns himself. NRC concluded that significant findings of the terminated investigator were never addressed as a result of SCOTT's actions. SCOTT did not know if anyone had ever followed up on the terminated investigator's findings. SNYDER said since Legal had a copy of the handwritten report, it could not be considered discarded.

Another aggressive investigator who determined that records required by the American Welding Society related to traceability were incomplete, missing or inaccurate for up to 70% of the steel used at Wolf Creek was removed from QI and placed back in QA. The issue was transferred to Bechtel to be resolved by walkdown inspections and sampling, according to HILL. HILL and THERO thought this demotion had intimidated most of the remaining QI staff and inhibited their independence.

The structural steel traceability allegation had been made by two different allegers, one of whom told HILL later that he had subsequently been fired for tardiness. HILL said that another QI investigation had demonstrated that the tardiness charge was untrue, after which KGE telephoned the terminated employee and asked him to drop his harassment allegation. The result was that both allegers were removed from QI.

10. Conflicts of Interest Allowed

A continuing theme in the NRC investigation was conflicts of interest. THERO had hired investigators with backgrounds in quality assurance. SNYDER told NRC that he did not believe quality assurance auditors were very good investigators. He had hired engineers. SNYDER told NRC he thought the best investigators for construction activities were construction employees, the best for startup activities were startup employees, and the best for operational activities were operational employees. He said he believed these investigators could exercise objectivity even when they investigated their own departments.

Before SNYDER took over management of QI, he supervised the construction group. Dissolvo tape had been used to construct argon dams inside the pipes. Dissolvo tape has a high halide concentration, which is recognized as tending to cause stress corrosion cracks in stainless steel under pressure and heat. THERO said the allegation was that an extensive amount of the tape had been left inside the pipes. HILL had written a Quality Program Violation Report on the issue, with which SNYDER disagreed. As head of QI, SNYDER was responsible for investigating his own previous work as construction supervisor, which was not conducive to objectivity. HILL said the construction records were so poor SNYDER could not demonstrate that the pipes had been cleaned, so he gave in to HILL and agreed to correct the problem but took no actual corrective action. SNYDER told NRC the issue was addressed on a higher-tiered document which would resolve all related allegations. He also said THERO's ability to comprehend the issues was limited. THERO said KGE had started hot functional testing prior to the resolution of this issue, which THERO thought improper. He believed SNYDER had been told to close the issue so it would not prevent licensing. NRC concluded QI should have further evaluated existing and related concerns about internal pipe cleanliness regardless of the existence of the higher-tiered document.

11. Drug Allegations Buried

The handling of drug use allegations was the final area explored by NRC. SCOTT said when he joined QI he was told one particular investigator with a criminal investigation background would handle all drug allegations. SCOTT said he could not recall whether he had assigned all drug allegations to that individual or whether SNYDER did the assigning or just how they were handled or who else handled them or whether they were transferred outside QI for handling. THERO said drug allegations were referred to Security or to Gary FOUTS, KGE Construction Manager, but that THERO had no indicati;ons that these drug use allegations were actually

investigated. Some of these allegations were made against senior KGE management and quality control employees of another firm. HILL said FOUTS asked Security to run criminal record checks on the alleged users and if no record existed, FOUTS dropped the information. SNYDER said Q1 interviewers took drug allegations but referred them to FOUTS, KGE Operations, or to Security for investigation. SNYDER believed Security eventually handled all drug allegation investigations after they had first passed through other departments. Q1 closed its file upon transfer.

John JOHNSON began as Chief of Security at Wolf Creek Generating Station in 1980. He recalled that in 1984 he had been asked to run criminal record checks on ten subcontractor supervisors for Q1. None had criminal records. At the time, Security had not been informed about the drug allegations so no investigation was done by Security. The name of the person to whom the results of the record checks was referred is censored in the public report.

In late 1984 JOHNSON said he received no instructions from his superiors as to what to do with other drug allegations he received from FOUTS, Q1 or elsewhere. No requirement was in place that he refer the results of any drug investigation back to Q1. He was to informally let FOUTS know is Security verified a drug allegation. JOHNSON said Security had searched some vehicles and some work areas and about a dozen employees had been terminated as a reault. About one month after Q1 began to refer drug allegations to Security, FOUTS asked for formal feedback from Security. Thereafter, JOHNSON's department made handwritten responses to FOUTS, which JOHNSON thought might have been placed in Q1 files to close them out. NRC did not find those reports in closed files on drug allegations.

JOHNSON said when Security received a drug allegation from only one source, Security did not investigate the allegation. If a second independent source of the allegation surfaced, Security would usually follow up with investigation. Employees were only terminated if drugs were actually found by Security. Employees were tested for drugs on site beginning in 1986, well after the March, 1985 actual fuel load date. Security also exchanged information with the local sheriff's department. JOHNSON said the work of any individual who had performed quality-related work who was terminated for drug use was reviewed to see if someone else had had to sign off on the employee's work. If no secondary reviews had occurred, JOHNSON thought the employee's work was reinspected. Note that the Q1 files showed no followup on drug allegations files and no corrective action. NRC concluded that Q1 did not investigate drug allegations prior to fuel load. All Q1 seemed to do was shuffle paper when drug allegations were involved. Q1 viewed reports of drug use as information Security may have wished to add to its files and use in its own limited response to drug use problems in 1984 and early 1985.

B. From the inception of operations at Wolf Creek Generating Station in Burlington, Kansas, management has repeatedly failed to safeguard the integrity of its quality assurance programs and has failed to demonstrate management competence to address and resolve real safety concerns.

In a 1982 decision involving Metropolitan Edison Company at its Three Mile Island Nuclear Station Unit 1, 16 NRC 281 (1982) the NRC found that licensee to be culpably negligent in failing to install in its operating staff a sense of respect for its training and testing program (page 296); that "...there was a failure to fix precisely within the company the responsibility for preserving the integrity of the training and testing program, and in particular, there was a failure to extend quality assurance and quality control concepts to the training program" (page 297);

"...that the cognizant officials in the Nuclear Assurance Division failed to recognize that training is an activity which must comport to the concepts of operational safety quality control as set out in Appendix B to Part 50" (page 300) and NRC fined the operator $100,000 for its failure to safeguard the integrity of its program.

The cumulative impacts of various management activities and omissions described in NRC's Office of Investigation Case No. 4-86-004 and summarized in this petition demonstrate clearly lack of management competence and failure on the part of management to preserve the integrity of the quality assurance programs at Wolf Creek.

Not only did these management inadequacies occur in 1984 and 1985, but according to various subsequent NRC reports and newspaper interviews they continue to be a problem at Wolf Creek Generating Station.

On March 22, 1988, the Kansas City Times quoted from an NRC notice of violation to Kansas Gas and Electric and Kansas City Power and Light that accompanied a demand for a $100,000 fine: "In addition...we are concerned that your management oversight for the evaluation of the root cause of problems and taking prompt and effective corrective actions as demonstrated by several examples of repetitive Licensee Event Reports in similar areas has been inadequate."

On April 8, 1988, the Kansas City Star reported that Wolf Creek had been cited for three violations in 1988: violating procedures for controlling access to restricted areas, inadequately inspecting reactor seals that developed leaks which caused the plant to shut down for three weeks, and failing to develop proper procedures for inspecting seals.

On June 26, 1988 the Kansas City Star reported that Wolf Creek had received the lowest mark possible for its quality control programs in an annual NRC report. The article in the Kansas City Star also said: "The report also criticizes the plant's Quality Assurance program for failing to identify safety-related problems on a timely basis. For instance, managers failed to ensure the repair of defective equipment designed to make sure high levels of chlorine didn't seep into the control room."

On July 21, 1988, Joe Callan, director of the division of reactor projects for NRC Region IV was quoted in the Kansas City Star/Times as saying that it appeared that Wolf Creek management had improperly sought "short-term" solutions to safety problems without determining the underlying causes of problems. He told the newspaper that corrective actions "were often superficial and didn't get to the root cause of the problem."

On January 14, 1989, the Kansas City Times reported that Joe Gilliland of NRC Region IV had said on January 13th that NRC had been concerned about the failure of Wolf Creek operators to notify federal officials about problems with diesel generators.

The inescapable conclusion is the Wolf Creek Generating Station is still not in full compliance with Appendix B to 10 CFR Part 50 or 10 CFR Part 50.55(e) specifically.

C. NRC's actions to date provide no reason to conclude that the acknowledged safety problems at Wolf Creek Generating Station have been resolved or will be resolved within a reasonable period of time.

Despite instructions from NRC Region IV and one $100,000 fine, management at Wolf Creek Generating Station as recently as January, 1989, has failed to comply with NRC regulations regarding quality assurance and safety of operations, including reporting requirements. Nearly four years after the initial fuel load Wolf Creek management still fails to identify root causes of problems that impact operating safety and still fails to take prompt and effective corrective action according to NRC Region IV spokespersons and NRC 's annual Systematic Assessment of Licensee Performance reports.

According to the conclusions of H. Brooks Griffin in NRC's Office of Investigation Case No. 4-86-004, nearly 66% of the conclusions used to close QI complaints about alleged wrongdoing could not be supported by facts or documentation. The NRC investigation showed that management at Wolf Creek Generating Station failed and apparently continuesto fail to ensure that persons performing quality assurance functions have sufficient independence from cost and schedule that they have sufficient authority and organizational freedom to identify quality problems; to initiate, recommend or provide solutions; and to verify implementation of solutions. There is no indication that the management of Wolf Creek Generating Station has reopened each of its quality assurance files which do not comply with Appendix B to 10 CFR Part 50 to bring them into compliance and determine for once and for all which operating safety concerns still require corrective action in 1989. Despite detailed information developed by its own investigators showing the clear potential for jeopardy to operating safety caused by wrongdoing which included, among other activities, shredding of documents; transfer and discharge of investigators; drastic increases in case closure rates; falsification of records; confiscation of tape recorders; prohibition of investigator interaction; removal of documents from investigative files; limitation of scope of safety problem investigation at the express orders of management; lack of factual or documentary support for investigative findings; failure to discipline supervisors found to have harassed, intimidated, falsified, discriminated or to have used drugs on the site; alteration of investigative conclusions without justification; conflicts of interest; and routine burying of allegations of drug use on the site, incredibly NRC concluded in Case No. 4-86-004 that this activity did not substantiate "wrondoing" that threatens operating safety. NRC continues to find that irregularities it notes in its reports do not rise to the level that they must be specifically addressed or penalized by fines, according to news reports described in the preceding section of this petition.

The NRC's obligation to ensure operating safety continues after the license is issued. The United States Supreme Court held that "...public safety is first, last and a permanent consideration in any decision on the issuance of a construction permit or a license to operate a nuclear facility." Power Reactor Development Corp. v. Int'l Union, 367 U.S. 396, 402, 81 S.Ct. 1529,1532 (1961). NRC retains jurisdiction after a plant is licensed to operate "...to ensure that the highest safety standards are maintained." 367 U.S. 402, 81 S.Ct. 1532. In 1977, the NRC responded to a petition by the Union of Concerned Scientists that:

> "Where the information demonstrates an undue risk to public health and safety, the Commission will, or course, take prompt remedial action, including shutdown of operating facilities, as it has in the past."

Petition for Emergency and Remedial Action, CLI-78-6, 7 NRC 400 at 405 (1978).

NRC may not simply assert that Wolf Creek Generating Station is safe enough to operate; it must provide a sound technical reason why it advances that assertion. Petition for Emergency and Remedial Action, CLI-80-21, 11 NRC 707, 715(1980). A statement concluding that no wrongdoing is found without any explanation of why hundreds of pages of documents and the investigator's own specific findings do not result in any threats to operating safety, such as Mr. Griffin's conclusion at the end of Case No. 4-86-004, does not satisfy this requirement.

D. For all of these reasons, the following relief is requested:

1. suspension of the operating license for Wolf Creek Generating Station, Burlington, Kansas;

2. prior to reinstating the operating license:

a. the NRC should reopen its Office of Investigations Case No. 4-86-004 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate in spite of all of its investigative conclusions regarding quality assurance problems;

b. the NRC should review all of its information on quality assurance at Wolf Creek developed subsequent to the issuance of Case No. 4-86-004 and covering operations at Wolf Creek through 1989 to provide sound technical reasons for its conclusion that this nuclear power plant is safe enough to operate;

c. all corrective actions determined by NRC to be necessary to achieve a level of operating safety that complies with federal regulations should be incorporated as conditions of the operating license and if they are not met the operating license should be revoked;

d. that the following persons whose activities were detailed in Mr. Griffin's report of Case No. 4-86-004 so as to show their failure to safeguard the integrity of Wolf Creek quality assurance programs and their lack of competence to identify and resolve real safety concerns, be barred from any and all involvement or participation in activities at Wolf Creek Generating Station whether as a salaried employee, a contract employee, a consultant, a volunteer, a management or any other position:

(i) William Rudolph

(ii)Glenn Koester

(iii)Robert L. Scott

(iv) Charles Snyder

(v) any other individual whom the NRC determines has prevented Wolf Creek Generating Station from complying with federal quality assurance regulations in a culpable manner.

Respecfully submitted,

KANSAS CHAPTER OF THE SIERRA CLUB