UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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ARLINGTON, TEXAS 76011

√1 PHILLIPS WORKING COPY

MEMORANDUM FOR: File

FROM: H. S. Phillips, Senior Resident Inspector

SUBJECT: EXECUTIVE SUMMARY OF RESULTS OF INTERVIEW AND REVIEW OF INDIVIDUAL ['X'] FILES

The Office of Investigation (OI) requested technical assistance on June 1, 1984, and the Regional Administrator assigned H. S. Phillips to assist OI.

Individual ['X'] was contacted by the NRC investigators during the Waterford 3 Task Force effort which was initiated April 2, 1984, and the onsite inspection effort was completed May 25, 1984. This individual had several concerns regarding the EBASCO site audit program. The individual signed an agreement for anonymity, but refused to sign a statement.

On June 4, 1984, Messrs. D. Driskill, NRC investigator, and H. S. Phillips, NRC inspector, interviewed Individual ['X'], who provided the following concerns:

Assigned / Status

- OI — Individual ['X'] was laid off because problems were identified to LP&L during their interview of workers. ~ in Progress
- OI — LP&L misrepresented Individual ['X'] concerns on the LP&L Interview Form and in a letter responding to these concerns. ~ "
- OI — LP&L promised that concerns would be acted upon and identity of Individual ['X'] would be protected. Individual ['X'] thought that LP&L revealed their identity and concerns were not corrected. ~ "
- OI — Audits were watered down by EBASCO management and in some cases findings were eliminated. ~ ① Audit review complete ② Interviews
- TECH — Corrective action was not taken by EBASCO concerning audit findings that dealt with hardware during startup activities.
- OI — Two EBASCO QA supervisors directed that audit deficiencies not be documented.
- OI — One of the EBASCO auditors would buy off on anything.

OI o EBASCO did not verify corrective action in the field prior to 1983, but accepted written responses.

OI o EBASCO auditors documented audits without going to the area audited.

OI o EBASCO auditors were not allowed to perform multi-criteria audits. – No requirement

OI o EBASCO auditors performed as lead auditors without being qualified. ~~Inspection Auditors~~

TECH o The adequacy of Sline audits were questioned.

TECH o The adequacy of Sline QA records were questioned.

TECH o The EBASCO NCR system was questioned because draft NCR were submitted to the QA manager and were destroyed leaving no record of the potential deficiency or justification for rejection. TASK FORCE CLOSED OUT

OI o The current EBASCO QA manager ordered Individual ['X'] to close an NCR.

TECH o Several hardware concerns were identified relative to EBASCO Startup Group, Mercury Company, and Tompkins Beckwith; i.e., motors, instrumentation tubing. T & B, and Mercury NCR's, see below.

TECH o Individual ['X'] had concerns about material heat traceability and conditional releases. TASK FORCE CLOSE OUT

TECH o After audit deficiencies were identified at B&B Insulation Inc., Individual ['X'] was advised that they were not required to meet 10 CFR 50, Appendix B requirements because the work they were doing was not safety-related.

NRC Review of 63 Packages (in files) June 5, 6, and 9

The Regional Administrator assigned Messrs. H. S. Phillips and A. L. Johnson, Region IV Inspectors, to review the personal files of Individual ['X'] which were provided to the NRC at the end of the interview. The packages contained the draft and final reports of audits conducted by Individual ['X'] at Waterford 3. The following is a summary of the results of the NRC inspectors' reviews:

- o Only one significant document was found that was not disclosed during the interview. This was a note or memo to EBASCO QA supervision that requested that a 10 CFR 50.55(e) report be made to the NRC regarding the breakdown in their QA program, i.e., maintenance work on completed systems by vendors that was not controlled by EBASCO.

- o The files were incomplete, therefore, the official files onsite must be reviewed to assure responses/corrective action was completed.

- At least one additional example was identified concerning a breakdown in the Mercury QA program. See audit SW-82-5-1 for this breakdown in document control which is in addition to the breakdown in the QA Records system identified in SW/DS 82-6-5 and finally in LP&L 50.55(e) report.

Attached are eight task sheets which characterize the allegations, give steps for resolution, and estimate resources needed.

H. S. Phillips
Senior Resident Inspector

Attachments:
As stated

OI

Draft 1
6/18/84

Task: 1

Reference No.:

Characterization: LP&L interviews were conducted in January 1983 to answer allegations and were conducted as employees exited the site to determine if they knew of problems or were able to do their job. An individual involved in this process stated the following:

a) Their answers given in the January 1983 interview were misrepresented in the exit interview by giving positive answers when they were really negative answers; i.e., indicating no concerns or problems when there were and then referencing the January interview.

b) The interviewee stated that their identity appeared to be compromised by LP&L because the LP&L corporate QA manager gave the answers to Ebasco, the employer, to mail to the interviewee.

c) The interviewee felt that Ebasco laid them off because LP&L identified the interviewee and because the interviewee always identified QA and technical problems.

d) The interviewee felt that the concerns had been purposely misinterpreted and were not corrected.

Initial Assessment of Significance: This item is highly significant because the integrity of LP&L and Ebasco management is questioned. It also brings into question the interviews with all other employees. This interview process identified a number of areas where interviewees stated there were falsified documents and hardware deficiencies. The failure to properly followup and correct these deficiencies could adversely affect the safe operation of the plant.

Source: An Alleger.

Approach to Resolution:

1. Perform a technical review of the results of interviews and followup to correct areas reported deficient. Also review other related material such as LP&L correspondence files, reports, and NRC reports on the same subject.

2. Review all results of interviews conducted in January 1983 versus exit interviews of employees leaving site to determine if there are additional instances where misleading answers were marked on the results of interview form by LP&L interviewers.

3. Interview the employees who identified concerns or problems during the interviews.

4. Interview LP&L and Ebasco management concerning potential misrepresentations, breach of confidentiality, and "whitewashing" problems.

5. Refer examples of wrongdoing to the team leader or task leader.

6. Evaluate data gathered concerning this allegation for generic/safety implication.

7. Report on the results of review/evaluation of these allegations.

Status:

Review Lead: OI

Support: HQ Presently Supporting

Estimated Resources:

Estimated Completion Date:

Closure:

OI

Draft 1
6/18/84

Task: 2

Reference No.:

Characterization: (a) Ebasco auditors were directed by Ebasco QA supervisors to not document deficiencies, (b) Ebasco management or supervision "watered down" two internal audits of the Ebasco organization, (c) Ebasco management would not allow auditors to perform multi-criteria audits, i.e., audit more than one 10 CFR 50, Appendix B, criterion and (d) Ebasco management allowed auditors to perform as lead auditors without being qualified; i.e., the auditor went out and performed the audit alone (without a lead auditor) and then the lead auditor just signed off the audits, (3) auditors wrote audit reports without ever going to the area audited and one auditor would buy off on anything.

Initial Assessment of Significance: The failure to document deficiencies, or perform effective audits with qualified personnel would represent a break down in their QA program which could result in inadequate design, procurement, construction, inspection, testing, problem identification/correction, and documentation of all these activities.

Source: An Alleger

Approach to Resolution:

1. Review background material package; i.e.; Waterford 3 Task Force work previously done on audits, NRC inspection reports, if any, and other related information.

2. Review Ebasco audit procedures, correspondence files, and audit files for: (1) directives to lessen or "soft pedal" audit deficiencies, (2) changes to audits, (3) directives or instructions to perform only single criterion audits, and (4) directives or instructions concerning lead auditors.

3. Interview Ebasco auditors concerning (a), (b), (c), and (d) described under characterization.

4. Interview Ebasco management concerning (a), (b), (c), and (d) above.

5. Refer examples of wrongdoing to the team leader or task leader.

6. Evaluate the data gathered concerning these allegations for generic/safety implications.

7. Report on the results of review/evaluation of these allegations.

Status:

Review Lead: OI

Support: ( ) Technical Support Required

*Estimated Resources: 40 man days (2 investigators and 2 technical personnel for 10 full work days) NOTE: Tech; 5 man days; Interviews: 35

Estimated Completion Date:

Closure:

*This task would probably take half this time if all Ebasco management and auditors were still on site. This may be a conservative estimate if travel is extensive. This also included the interview of personnel during Task 3 (see Task 3, resolution 4).

TECH

Draft 1
6/18/84

Task: 3

Reference No.:

Characterization: (a) The Ebasco QA organization did not perform field verifications of corrective action concerning deficiencies identified during audits and surveillances, but simply accepted written responses describing corrective action, and (b) the Ebasco NCR system effectiveness was questioned because NCRs were submitted in draft and if rejected, these drafts were not maintained as records but were destroyed.

Initial Assessment of Significance: This item is very significant if true, and if hardware deficiencies still exist, because safety related systems necessary for safe shutdown may be adversely affected.

Source:

Approach to Resolution:

1. Review background material if available.

2. Review audit and surveillance procedures, correspondence files, and audit/surveillance files of contractors on site for: (1) deficiencies identified, (2) correction of the specific problem and (3) repetition of the same or similar deficiencies.

3. Review NCR and CAR procedures, correspondence files, NCRs, CARs, logs, trend analyses, and other appropriate material for: (1) deficiencies identified, (2) correction of the specific problem, and (3) repetition of the same or similar deficiencies.

4. Interview auditors, inspectors, and managers concerning (a) and (b) above.

5. Refer examples of wrongdoing to the team leader or task leader.

6. Evaluate the data gathered concerning these allegations for generic/safety implications.

7. Report on the results of review/evaluation of these allegations.

Status:

Review Lead: ( ) Technical - except for ~~4~~ 4. above.

Support: None unless interviews conducted

Estimated Resources: Tech Review - 20 man days (4 technical personnel for one week Interviews - This can be accomplished at the same time Task 2 is.

Estimated Completion Date:

Closure:

TECH

Draft 1
6/18/84

Task: 4

Reference No.:

Characterization: (a) Sline, the coating contractor, had no QA records system and the records were all "messed" up (b) their audit program was also questionable.

Initial Assessment of Significance: This item is significant because if the coating or paint system fails it could affect the ~~operation of the removal of~~ recirculation by stopping up the sump liquids at the bottom of containment if a primary pipe or component break occurs. Cleanup after an accident would also be complicated if concrete was exposed to radioactive liquids.

Source:

Approach to Resolution:

1. Review background material such as the documented allegation, NRC reports, licensee and Ebasco reports, correspondence files, and consultant reports concerning this allegation.

2. Review Sline procedures, audits and surveillance reports, inspection records, nonconformance reports, corrective action reports, logs, and trend analyses for objective evidence of a QA records system and an effective audit program. Also review a sample of turnover packages.

3. Interview LP&L and Ebasco QA, construction, and engineering personnel responsible for overview of Sline work activities.

4. Since Sline has left the site, identify any Sline personnel who may be still at Waterford but are working for another contractor.

5. After performing steps 1-4 above, and evaluating the data, determine if offsite interviews will be necessary. Interview, if necessary.

6. Examine the coating to determine the quality of the surface. Also review test records which support the adequacy of the coating process.

7. Refer examples of wrongdoing to the team leader or task leader.

8. Evaluate the data gathered concerning these allegations for generic/safety implications.

9. Report on the results for review/evaluation of these allegations.

Status:

Review Lead: ( ) Technical

Support:

Estimated Resources: 5 man days

Estimated Completion Date:

Closure:

TECH

Draft 1
6/18/84

Task: 5

Reference No.:

Characterization: (a) Ebasco Startup Group failed to control off site vendors who came on site to work on completed systems, (b) Ebasco quality control was bypassed or did not perform required inspections; i.e., receipt inspections of new parts and materials brought on site, inspections of assembly/disassembly of safety related pumps and other components, and indicate acceptance on service form ESU-82-8-9, (c) the Startup Group management failed to correct deficiencies after deficiencies were identified in audits CEB-81-9-7 (Sep 81), SW/GD/RM-82-8-1 (Aug 82) and SW/RBC-82-9-1 (Sep 82), (d) 38 motors were worked on without proper QC controls as described above and their acceptability was indeterminate because of this, and (e) the audits described above showed that a QA breakdown had occurred in this area and three auditors recommended that a 10 CFR 50.55(e) construction deficiency report be made to the NRC.

Initial Assessment of Significance: This item is very significant because it indicates a QA breakdown that relates to important safety related pumps and other components. Also such deficiencies may not manifest themselves until the equipment is used.

Source:

Approach to Resolution:

1. Review background material concerning this or similar allegations. Also 50.55(e) evaluations/reports.

2. Review the startup program, procedures, correspondence files, maintenance records, deficiency reports, and other related material.

3. Interview startup, maintenance QA/QC, and engineering personnel.

4. Examine any current maintenance in progress and/or evaluate maintenance/test records.

5. Refer any examples of wrongdoing to the team or task leader.

6. Evaluate the data gathered concerning these allegations for generic/safety implications.

7. Report the results of review/evaluation of these allegations.

Status:

Review Lead: ( ) Technical

Support: None

Estimated Resources: Tech Review - 10 man days

Estimated Completion Date:

Closure:

OI

Draft 1
6/18/84

Task: 6

Reference No.:

Characterization: (a) The present Ebasco QA manager is in bed with construction and (b) this same manager ordered that NCR 1040 be closed and the individual responsible closed it by referring it to another group but doubts that corrective action was effective and was completed.

Initial Assessment of Significance: Significance cannot be readily determined regarding NCR 1040 until it is reviewed; however, if this was a practice as inferred serious deficiencies in hardware and material could still exist because problems were not corrected.

Source:

Approach to Resolution:

1. Review background material such as this allegation or similar allegations.

2. Review NCR 1040 to determine the technical nature and significance. Evaluate the corrective action.

3. Interview Ebasco personnel who would have knowledge of this NCR.

4. Interview Ebasco QA/QC personnel relative to the QA manager being "in bed" with construction.

5. Refer examples of wrongdoing to the team or task leader.

6. Evaluate the data gathered for generic/safety implications.

7. Report on the results of review/evaluation of these allegations.

Status:

Review Lead: OI

Support:

Estimated Resources: OI_____ Tech: 1/2 man day

Estimated Completion Date:

Closure:

TECH

Draft 1
6/18/84

Task: 7

Reference No.:

Characterization: Traceability of materials at Mercury and Tompkins Beckwith were questioned.

Initial Assessment of Significance: This item does not appear to be significant because it appears that the W3 Task Force effort will answer this.

Source:

Approach to Resolution:

1. Coordinate with W3 Task Force members concerning NCRs furnished to assure that the specific area was reviewed; i.e., NCR W3-1419, W3-7494, and W-5974.

2. If the specific NCR was not evaluated, followup on the specific problem.

3. If no further problem is found concerning the specific NCR, close out this item based on the generic review by the W3 Task Force.

4. Evaluate and report on the results of this allegation.

Status:

Review Lead: ( ) Technical

Support: None

Estimated Resources: 4 man days

Estimated Completion Date:

Closure:

TECH

Draft 1
6/18/84

Task: 8

Reference No.:

Characterization: B&B Insulation Inc. was audited. Inspectors were not qualified per ANSI N45.2.6 and B&B informed the auditor that they did not have to follow the requirements of this LP&L commitment because the work they were doing was not safety related.

Initial Assessment of Significance: This item appears to have little safety significance because most of the insulation work is nonsafety related.

Source:

Approach to Resolution:

1. Review background material package i.e., results of interview

2. Review Ebasco contract with B&B to determine the scope of work and quality requirements.

3. Review all Ebasco audits of B&B if they performed safety related work. Only review a small sample of the audits (to include Audit Nos. SW 82-10-3/4/5/6; 82-11-1/2; 82-12-1/2/3; and 83-9-1) if this work was nonsafety related work.

4. Interview Ebasco QA personnel where questionable actions or corrective action exists.

5. Refer examples of wrongdoing to the team leader or task leader.

6. Evaluate the data gathered concerning this allegation for generic/safety implication.

7. Report on the results of review/evaluation for this allegation.

Status:

Review Lead: Technical

Support: None

Estimated Resources: 1 man day

Estimated Completion Date:

Closure:

6/12/84

Executive Summary

INDIVIDUAL [X] WAS CONTACTED BY THE NRC INVESTIGATORS DURING THE WATERFORD III TASK FORCE EFFORT WHICH WAS INITIATED APRIL 2 AND THE ON SITE EFFORT WAS COMPLETED MAY 25. THIS INDIVIDUAL HAD SEVERAL CONCERNS REGARDING THE SITE AUDIT PROGRAM. THE INDIVIDUAL SIGNED AN AGREEMENT FOR ANONIMITY.

THE OFFICE OF INVESTIGATION (OI) REQUESTED TECHNICAL ASSISTANCE ON JUNE 1, 1984 AND THE REGIONAL ADMINISTRATOR ASSIGNED H. S. PHILLIPS, WHO WORKED ON THIS AREA DURING THE TASK FORCE EFFORT ON SITE.

ON JUNE 4, 1984 INDIVIDUAL [X] PROVIDED THE FOLLOWING CONCERNS:

- INDIVIDUAL [X] WAS LAID OFF BECAUSE PROBLEMS WERE IDENTIFIED TO LP&L DURING THEIR INTERVIEW OF WORKERS.
- LP&L MISREPRESENTED INDIVIDUAL [X] CONCE... ON THE LP&L INTERVIEW FORM AND IN A LETTER RESPONDING TO THESE CONCERNS.
- LP&L PROMISED THAT CONCERNS WOULD BE ACTED UPON AND IDENITY OF INDIVIDUAL [X] WOULD BE PROTECTED. INDIVIDUAL [X] THOUGHT THAT LP&L REVEALED THEIR IDENTITY..
- AUDITS WERE WATERED DOWN AND IN SOME CASES FINDINGS WERE ELIMINATED.
- CORRECTIVE ACTION WAS NOT TAKEN CONCERNING AUDIT FINDINGS THAT DEALT WITH HARDWARE DURING STARTUP ACTIVITIES

- TWO EBASCO MANAGERS DIRECTED THAT AUDIT DEFICIENCIES NOT BE DOCUMENTED.
- INDIVIDUAL [A], AN AUDITOR, WOULD BUY OFF ON ANYTHING.
- EBASCO DID NOT VERIFY CORRECTIVE ACTION IN THE FIELD PRIOR TO 1983 BUT ACCEPTED WRITTEN RESPONSES.
- EBASCO AUDITORS DOCUMENTED AUDITS WITHOUT AUDITING THE AREA AUDITED.
- EBASCO AUDITORS WERE NOT ALLOWED TO PERFORM MULTI CRITERIA AUDITS
- AUDITORS PERFORMED AS LEAD AUDITORS WITHOUT BEING QUALIFIED
- THE ADEQUACY OF SCINE AUDITS WERE QUESTIONED
- THE ADEQUACY OF SCINE QA RECORDS WERE QUESTIONED
- THE EBASCO NCR SYSTEM WAS QUESTIONED BECAUSE DRAFT NCR WERE SUBMITTED TO THE QA MANAGER AND WERE DESTROYED LEAVING NO RECORD OF THE POTENTIAL DEFICIENCY OR JUSTIFICATION FOR REJECTION.
- THE CURRENT EBASCO QA MANAGER ORDERED INDIVIDUAL [X] TO CLOSE AN NCR.
- SEVERAL HARDWARE CONCERNS WERE IDENTIFIED; i.e., Motors, instrumentation tubing
- INDIVIDUAL [X] STILL HAS CONCERNS ON MATERIAL HEAT TRACEABILITY AND CONDITIONAL RELEASES

NRC Review of 63 packages (in files) JUNE 5, 6, and 9

The Regional Administrator assigned Messrs H.S. Phillips and A. Johnson, Region II Inspectors, to review

The personal files of Individual [X]. The packages contained the draft and final reports of audits conducted by an EBASCO auditor at Waterford. The follow is a summary:

- Only one significant document was found that was not disclosed in the interview. This was a note or memo to EBASCO QA supervision that requested that a WCER 50.55(e) report be made to the NRC regarding the breakdown in their QA program i.e. maintenance work on completed systems by vendors was not controlled.

- The files were incomplete, therefore, the official files must be reviewed to assure responses/corrective action was completed.

- At least one addition example was identified where the Mercury QA program broke down see audit SW-82-5-1. This is in addition to the breakdown in the QA Records system identified in SW/DS 82-6-5 and finally in LP&L 50.55(e) report.

TASK 1

REFERENCE No.

CHARACTERIZATION: LP&L interviews were conducted in January 1983 to answer allegations and were conducted as employees exited the site to determine if they knew of problems or were able to do their job. An individual involved in this process stated the following:

a) Their answers given in the January 1983 interview were misrepresented in the exit interview by giving positive answers when they were really negative answers; i.e., indicating no concerns or problems when there were and then referencing the January interview.

b) The interviewee stated that their identity appeared to be compromised by LP&L because the LP&L corporate QA manager gave the answers to EBASCO, the employer, to mail to the interviewee.

c) The interviewee felt that EBASCO laid them off because LP&L identified the interviewee and because the interviewee always identified QA and technical problems.

d) The interview felt that the concerns had been purposely misinterpreted and were not corrected.

Initial Assessment of Significance: This item is highly significant because the integrity of LP&L and EBASCO management is questioned. It also brings into question the interviews with all other employees. This interview process identified a number of areas where interviewees stated there were falsified documents and hardware deficiencies. The failure to properly followup and correct these deficiencies could adversely affect the safe operation of the plant.

Source: An alleger.

Approach to Resolution:

1. Perform a technical review of the results of interviews and followup to correct areas reported deficient. Also review other related material such as LP&L correspondence files, reports and NRC reports on the same subject.
2. Review all results of interviews conducted in January 1983 versus exit interviews of employees leaving site to determine if there are additional instances where misleading answers were marked on the results of interview form by LP&L interviewers.
3. Interview the employees who identified concerns or problems during the interviews.
4. Interview LP&L and EBASCO management concerning potential misrepresentations, breach of confidentiality, and "white washing" problems.

5. Refer examples of wrongdoing to the team leader or task leader.
T-1 6. Evaluate data gathered concerning this allegation for generic/safety implication.
7. Report on the results of review/evaluation of these allegations.

Status:

Review Lead: OI
Support : NQ Presently Supporting
Estimated Resources: _____
Estimated Completion Date
Closure

TASK 2

REFERENCE NO.

CHARACTERIZATION: (a) EBASCO auditors were directed by EBASCO QA supervisors to not document deficiencies, (b) EBASCO management or supervision "watered down" two internal audits of the EBASCO organization, (c) EBASCO management would not allow auditors to perform multi-criteria audits; i.e., audit more than one 10CFR 50, Appendix B, Criterion and (d) EBASCO management allowed auditors to perform as lead auditors without being qualified; i.e., the auditor went out and performed the audit alone (without a lead auditor) and then the lead auditor just signed off the audits, (e) auditors wrote audit reports without ever going to the area audited and one auditor would buy off on anything.

Initial Assessment of Significance: The failure to document deficiencies, or perform effective audits with qualified personnel would represent a break down in their QA program which could result in inadequate design, procurement, construction, inspection, testing, problem identification/correction, and documentation of all these activities.

Source: An Alleger

Approach to Resolution

1. Review background material package; i.e. Waterford 3 Task force work previously done on audits, NRC inspection reports, if any, and other related information.
2. Review EBASCO audit procedures, correspondence files and audit files for: (1) directives to lessen or "soft pedal" audit deficiencies, (2) changes to audits, (3) directives or instructions to perform only single criterion audits, and (4) directives or instructions concerning lead auditors.
3. Interview EBASCO auditors concerning (a) (b) (c) and (d) described under Characterization.
4. Interview EBASCO management concerning (a) (b) (c) and (d) above.
5. Refer examples of wrongdoing to the team leader or task leader.
6. Evaluate the data gathered concerning these allegations for generic/safety implications.
7. Report on the results of review/evaluation of these allegations

STATUS:
REVIEW LEAD: OI
SUPPORT :( )TECHNICAL SUPPORT REQUIRED
*ESTIMATED RESOURCES: 40 Man Days (2 investigators and 2 technical personnel for 10 full work days)
ESTIMATED COMPLETION DATE:
NOTE: TECH 5 Man days
INTERVIEWS: 35

* This task would probably take half this time if all EBASCO management and auditors were still on site. This may be a conservative estimate if travel is extensive. THIS ALSO INCLUDED THE INTERVIEW OF PERSONNEL DURING TASK 3 (SEE TASK 3 resolution 4)

TASK 3

REFERENCE No.

CHARACTERIZATION: (a) The EBASCO QA organization did not perform field verifications of corrective action concerning deficiencies identified during audits and surveillances but simply accepted written responses describing corrective action, and (b) the EBASCO NCR system effectiveness was questioned because NCR's were submitted in draft and, if rejected, these drafts were not maintained as records but were destroyed.

Initial Assessment of Significance: This item is very significant if true and if hardware deficiencies still exist because safety related systems necessary for safe shutdown may be adversely affected.

Approach to Resolution:

1. Review background material if available.
2. Review audit and surveillance procedures, correspondence files and audit/surveillance files of contractors on site for (1) deficiencies identified, (2) correction of the specific problem, and (3) repetition of the same or similar deficiencies.
3. Review NCR and CAR procedures, correspondence files, NCRs, CARs, logs, trend analyses and other appropriate material for: (1) deficiencies identified, (2) correction of the specific problem, and (3)

repetition of the same or similar deficiencies.
4. Interview auditors, inspectors, and managers concerning (a) and (b) above.
5. Refer examples of wrongdoing to the team leader or task leader.
6. Evaluate the data gathered concerning these allegations for generic/safety implications.
7. Report on the results of review/evaluation of these allegations

Status:
REVIEW LEAD: ( ) Technical except for A. above.
SUPPORT : None unless interviews conducted
ESTIMATED RESOURCES: TECH REVIEW - 20 man days (4 technical personnel for one week)

INTERVIEWS - THIS CAN BE ACCOMPLISHED AT THE SAME TIME TASK 2 IS.

Task 4

Reference No.

Characterization: (a) Sline, the coating contractor, had no or records system and the records were all "messed" up (b) their audit program was also questionable.

Initial Assessment of Significance: This item is significant because if the coating or paint system fails it could affect the operation of the removal of liquids at the bottom of containment if a primary pipe or component break occurred. Cleaning after an accident would also be complicated if concrete were exposed to radioactive liquids.

Approach to Resolution

1. Review background material such as the documented allegation, NRC reports, licensee and EBASCO reports, correspondence files, and consultant reports concerning this allegation

2. Review Sline procedures, audits and surveillance reports, inspection records, nonconformance reports, corrective action reports, logs, and trend analyses for objective evidence of a QA records system and an effective audit program.

3. Interview L&L and EBASCO QA ~~and~~, construction, and engineering personnel responsible for overview of Sline work activities.

4. Since Sline has left the site, identify any Sline personnel who may be still be at Waterford but are working for another contractor.

5. After performing steps 1-4 above and evaluating the data, determine if off site interviews will be necessary. Interview if necessary.

6. Examine the coating to determine the quality of the surface. Also review test records which support the adequacy of the coating process.

7. Refer examples of wrongdoing to the team leader or task leader.

8. Evaluate the data gathered concerning these allegations for generic/safety implications.

9. Report on the results of review/evaluation of these allegations.

Status:
Review Lead: ( ) Technical
Support :
ESTIMATED RESOURCES: 5 man days
ESTIMATED COMPLETION:
CLOSURE:

Task 5

Reference No.

CHARACTERIZATION: (a) EBASCO Startup Group failed to control off site vendors who came on site to work on completed systems, (b) EBASCO quality control was by passed or did not perform required inspections; i.e., receipt inspection of new parts and materials brought on site, inspections of assembly/disassembly of safety related pumps and other components, indicate acceptance on Service form ESU-82-8-9, (c) the Startup Group management failed to correct deficiencies after deficiencies were identified in audit, CEB-81-9-7 (Sep 81), SW/GO/RM-82-8-1 (Aug 82) and SW/RBC-82-9-1 (Sep 82), (d) 38 motors were worked on without ~~out~~ proper QC controls as described ~~in (b)~~ above and their acceptability was indeterminate because of this, and (e) the audits described above showed that a QA breakdown had occurred in this area and three auditors recommended that a 10CFR 50.55(e) construction deficiency report be made to the NRC.

Initial Assessment of Significance: This item is very significant because it indicates a QA breakdown that relates to important safety related pumps and other components. Also such deficiencies may not manifest themselves until the equipment is

Approach to Resolution:

1. Review background material concerning this or similar allegations. Also 50.55(e) evaluations/reports.
2. Review the Startup program, procedures, correspondence files, maintenance records, deficiency reports, and other related material.
3. Interview startup, ~~engineering~~ ~~personnel~~, maintenance ~~and~~ QA/QC, ~~ops~~ and engineering personnel.
4. Examine any current maintenance in progress and/or evaluate maintenance/test records.
5. Refer any examples of wrongdoing to the team or task leader.
6. Evaluate the data gathered concerning these allegations for generic/safety implications.
7. Report the results of review/evaluation of these allegations.

Status:

Review Lead: ( ) Technical

Support : None

Estimated Resources: TECH REVIEW - 10 mandays

Task 6

Reference No.

CHARACTERIZATION: (a) THE PRESENT EBASCO QA MANAGER IS IN BED WITH CONSTRUCTION and (b) this same manager ordered that NCR 1040 be closed and the individual responsible closed it by referring it to another group but doubts that corrective action was effective and was complete d.

Initial Assessment of Significance: Significance can not be readily determined regarding NCR 1040 until it is reviewed; however, if this was a practice as inferred serious deficiencies in hardware and material could still exist because problems were not corrected.

Approach to Resolution:

1. Review background material such as this allegation or similar allegations
2. Review NCR 1040 to determine the technical nature and significance. Evaluate the corrective action
3. Interview EBASCO personnel who would have knowledge of this NRC.
4. Interview EBASCO QA/QC personnel relative to the QA manager being "in bed" with construction.
5. Refer examples of wrong doing to the team or task leader
6. Evaluate the data gathered for generic/safety implications
7. Report on the results of review/evaluation of these allegations

Status:

Review Lead:

Support:

Estimated Resources: OI ____

TECH: ½ man day

TASK 7

REFERENCE NO.

CHARACTERIZATION: TRACEABILITY OF MATERIALS AT MERCURY AND TOMPKINS BECKWITH WERE QUESTIONED

INITIAL ASSESSMENT OF SIGNIFICANCE: This item does not appear to be significant because it appears that the W3-Task force effort will answer this

Approach to Resolution

1. Coordinate with W3 Task force members concerning NCRs furnished to assure that the specific area was reviewed.

2. If the specific NCR was not evaluated following on the specific problem.

3. If no further problem is found concerning the specific NCR, close out this item based on the generic review by the W3 Task force.

4. Evaluate and report on the results of this allegation

STATUS

REVIEW LEAD: ( ) TECHNICAL SUPPORT: NONE

ESTIMATED RESOURCES: 4 man-days

MGT ✓ 1. LP&L Interviews

a. Misrepresentation of initial versus exit interview and corrective action.

b. Possible inadequate corrective action on hardware concerns identified in the LP&L Results of Interviews.

c. LP&L possibly compromised the identity of interviewee and was laid off because of concerns identified.

2. NRC Followup

OI responsibility for misrepresentation and identity.
NRC headquarters is following up on hardware deficiencies.

MGT ✓ 2. Two EBASCO QA Supervisors directed that deficiencies not be documented.

NRC followup
OI Responsibility.

Auditor ✓ 3. Individual [A], an EBASCO auditor, would buy off on anything.

NRC followup
OI responsibility.

QA organization
MGT ✓ 4. EBASCO did not verify corrective action in the field prior to 1983 but simply accepted written responses to problems identified in audits.

NRC followup
NRC inspection responsibility.

AUDITOR
✓ 5. EBASCO Audits were performed and documented without going to the area audited.

NRC Followup
NRC inspection responsibility.

MGT
✓ 6. EBASCO auditors were not allowed to perform multi criteria audits.

NRC Followup
NRC inspection responsibility.

MGT
✓ 7. EBASCO auditors performed as lead auditors but were not qualified as lead auditors.

NRC Followup
NRC inspection responsibility.

QUAL 8. The adequacy of Sline audits were questioned.
NRC Followup
NRC inspection responsibility.

QUAL 9. The adequacy of Sline records were questioned.
NRC followup
NRC inspection responsibility.

✓ 16. The EBASCO NCR system was ~~was~~ questioned because draft NCR's were submitted, rejected but were not retained as a record.
NRC Followup of find
NRC inspection responsibility.

MGT 11. The current EBASCO QA manager ordered an NCR to be closed and intimidated the individual to the point where it was closed.

NRC Followup
OI and inspection responsibility.

STARTUP 12. EBASCO Startup Group did not control vendor maintenance work on various components.

NRC Followup
NRC inspection responsibility

STARTUP 13. EBASCO QA and startup failed to take corrective action relative to audit findings concerning maintenance on components and equipment i.e. the specific and potential generic issues were not properly addressed

NRC Followup
NRC inspection responsibility

ACT RELOAD ✓ 14. An EBASCO audit of Mercury was altered, that is, white out was used to change the finding marked (X) reject to accept.

NRC Followup
OI responsibility.

MLT
✓ 15. EBASCO management watered down an audit.
Note: The documentation reviewed substantiated this.

NRC Followup
OI

Inspection of hardware identified in the report must be inspected by NRC.