August 8, 2000

EA 00-165

Mr. Samuel L. Newton
Vice President, Operations
Vermont Yankee Nuclear Power Corporation
185 Old Ferry Road
Brattleboro, Vermont 05302-7002

SUBJECT: **NRC OFFICE OF INVESTIGATIONS CASE NOs. 1-1998-029 & 1-1999-027**

Dear Mr. Newton:

This letter refers to an investigation initiated at the Vermont Yankee Nuclear Power Plant by the Nuclear Regulatory Commission (NRC), Office of Investigations (OI). The first investigation (No. 1-1998-029) was initiated to determine whether contract valve technicians deliberately failed to adhere to a maintenance procedure and falsified corresponding documents regarding work on safety-related motor operated valves (MOVs) during the 1995, 1996 and 1998 refueling outages at Vermont Yankee. Based on the OI investigation, the NRC did not substantiate that the contract valve technicians deliberately failed to adhere to the maintenance procedure or falsified the maintenance documents in question. A synopsis of that investigation is enclosed.

On September 27, 1999, a second investigation was initiated to determine whether a manager deliberately failed to comply with Vermont Yankee (VY) procedural requirements concerning the control of contract valve technicians during the 1998 refueling outage. The evidence developed by OI indicates that the manager deliberately caused a violation of the VY procedure governing the control of contracted services. As such, an apparent violation has been identified and is being considered for enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600.

During the 1998 refueling outage, contract valve technicians performed work on a safety-related valve in the reactor core isolation cooling (RCIC) system. These technicians failed to properly perform required work when they did not adequately chamfer the wedge seat and body guides of MOV 13-20. The inadequate chamfer was later identified by your staff and corrected prior to the return to service of the valve. The evidence developed by OI supports the conclusion that the manager communicated to a supervisor, who was assigned to oversee the technicians, that the technicians could work independently and sign-off on the inspections of safety-related MOVs because the purchase order for their services had been changed. However, the manager, in fact, knew that the procurement order had not been changed and that the technicians could not work independently. Others, including another supervisor, also believed the contract technicians could perform the valve work independently. Therefore, the technicians were not adequately supervised as required, which is considered a failure to adequately control the quality of work performed by a contractor, and is violation of 10 CFR 50, Appendix B, Criterion VII, “Control of Purchased Equipment, Materials and Services. Additional details regarding this OI case are provided in the enclosed factual summary of OI case 1-1999-027.
Based on the above information, we are requesting a predecisional enforcement conference

with you and your staff in order for the NRC to make an enforcement decision in this matter. We also request that the manager in question attend this enforcement conference as well in order that he might provide additional, clarifying details in this matter. The tentative date for this conference is the week of August 21, 2000. When this conference is held, it will be transcribed and closed to public observation. The decision to hold a predecisional enforcement conference does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference is being held to obtain information to enable the NRC to make an enforcement decision based on a common understanding of the facts, root causes, missed opportunities to identify the apparent violation sooner, corrective actions, significance of the issues and the need for lasting and effective corrective action. In addition, this is an opportunity for you to point out any errors and for you to provide any information concerning your perspectives on 1) the severity of the violation, 2) the application of the factors that the NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.C.2 of the Enforcement Policy, and 3) any other application of the Enforcement Policy to this case, including the exercise of discretion in accordance with Section VII.

We note that you may also submit, within 30 days of the date of this letter, additional documentation that addresses the results of any inquiry you conduct in this matter as well as the apparent violation discussed in this letter and its enclosure. If you choose to provide a response, it should be clearly marked as a "Response to Apparent Violation Based on Office of Investigations Report Nos. 1-1998-029 and 1-1999-027" and should include for the apparent violation: (1) the reason for the apparent violation, or, if contested, the basis for disputing the apparent violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that have been or will be taken to avoid further violations, and (4) the date when full compliance was or will be achieved. Your response should be submitted under oath or affirmation and may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. Where good cause is shown, an extension of time for submitting the response will be granted by the NRC. In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publically Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Reading Room). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the Public Document Room without redaction.

In addition, please be advised that the characterization of the apparent violation described in this letter and its enclosure may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

Please contact Mr. Glenn Meyer of my staff at (610) 337-5211 if you have any questions in this matter. Mr. Meyer will also contact you in the near future to finalize the date and time of the predecisional enforcement conference.

Sincerely,

/RA/

A. Randolph Blough, Director
Division of Reactor Projects

Docket No. 50-271
License No. DPR-28

Enclosure: Summary of the Findings of OI Investigations 1-1998-029 and 1-1999-027

cc w/encl:
R. McCullough, Operating Experience Coordinator - Vermont Yankee
G. Sen, Licensing Manager, Vermont Yankee Nuclear Power Corporation
D. Rapaport, Director, Vermont Public Interest Research Group, Inc.
D. Tefft, Administrator, Bureau of Radiological Health, State of New Hampshire
Chief, Safety Unit, Office of the Attorney General, Commonwealth of Massachusetts
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G. Bisbee, Esquire
J. Block, Esquire
T. Rapone, Massachusetts Executive Office of Public Safety
D. Katz, Citizens Awareness Network (CAN)
M. Daley, New England Coalition on Nuclear Pollution, Inc. (NECNP)
State of New Hampshire, SLO Designee
State of Vermont, SLO Designee
Commonwealth of Massachusetts, SLO Designee

Distribution w/encl.: **(VIA E-MAIL)**
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SUMMARY OF FINDINGS OF OI INVESTIGATIONS 1-1998-029 AND 1-1999-027

The Office of Investigations (OI), Region I Field Office, initiated an investigation on June 8, 1998, to determine whether contract valve technicians deliberately failed to adhere to a Vermont Yankee (VY) Nuclear Power Station maintenance procedure and falsified the corresponding maintenance documents regarding safety-related motor operated valves (MOVs) during the 1995, 1996 and 1998 refueling outages (RFOs) at VY. As noted in the OI synopsis for report 1998-029, OI could not substantiate, based upon the evidence developed during its investigation, that the contract valve technicians deliberately failed to adhere to a VY maintenance procedure and falsified the corresponding maintenance documents regarding safety-related MOVs during the 1995, 1996 and 1998 RFOs at VY.

However, as a result of other information developed during that investigation, OI initiated another investigation on September 27, 1999, to determine if the former Mechanical Maintenance Manager at VY deliberately failed to comply with VY procedural requirements concerning the control of contract valve technicians during the 1998 RFO at VY. The evidence developed by OI indicates that the former Mechanical Maintenance Manager deliberately caused a violation of the VY procedure requiring control of contracted services.

Purchase order VY-98-58550-00, dated April 7, 1998, procured valve repair services from BW/IP International Inc. as non-nuclear safety-related (NNS). VY administrative procedure AP-0847, "Control of Contracted Services," Revision 1, Appendix D, Section D.8, requires that services performed by contractors procured under NNS purchase orders be supervised by plant staff members who are qualified by experience and/or training to judge the technical adequacy and quality of the work. However, on April 14 and 19, 1998, the contract valve technicians performed independent work when they implemented VY operation procedure form OPF-5201.04, "GL 89-10 Gate Valve Inspection Sheet," Revision 16, in that they performed work on a safety-related MOV in the reactor core isolation cooling system (V13-20). Their work was considered independent, in accordance with the definition of independent work as stated in the definitions section of procedure AP-0847, because it was not verified by plant personnel, either directly through continuous supervision, or indirectly through physical inspection of key attributes. In fact, there is no evidence that certain key attributes were verified; subsequent reinspection of the valve internals found that the chamfers on the wedge seat and body guides of V13-20 did not meet procedural requirements, indicating a lack of adequate supervision of this work by qualified VY personnel. As such, this independent work by these NNS contractor technicians is considered unsupervised by the NRC and represents a violation of 10 CFR 50, Appendix B, Criterion VII, "Control of Purchased Equipment, Material and Services," and Procedure AP-0847.

The evidence supports that this violation resulted from the deliberate actions of the former Mechanical Maintenance Manager who communicated to the day-shift first line supervisor that the contract valve technicians could work independently and sign-off on the inspections of safety related MOVs because the purchase order for their services had been changed, even though he knew that the purchase order had not changed and that the valve technicians could not work independently. The Mechanical Maintenance Manager testified to OI that he knew that the procurement order had not changed to a safety related procurement order.

He also testified to OI that he did not think the contractor valve technicians had the necessary training to work independently. However, the day shift supervisor testified that he was told by

the Mechanical Maintenance Manager that the procurement order had been changed from NNS to safety related, and that the contractors could sign off on the paperwork, which led him to believe that the contractor technician could work independently. Afterwards, others, including the night shift supervisor, also understood that the contract technicians could perform the work independently. The Mechanical Maintenance Manager, when interviewed by OI, could not deny that he had told the first line supervisor that the procurement order had changed from NNS to safety related.