

EDO Principal Correspondence Control

FROM: DUE: 04/05/10

EDO CONTROL: G20100128
DOC DT: 03/02/10
FINAL REPLY:

Mike Mulligan
Hinsdale, New Hampshire

TO:

Borchardt, EDO

FOR SIGNATURE OF :

** GRN **

CRC NO:

Leeds, NRR

DESC:

ROUTING:

2.206 - Vermont Yankee Surrounding the Maintenance
and Testing of High Pressure Coolant Injection
(EDATS: OEDO-2010-0176)

Borchardt
Virgilio
Mallett
Ash
Mamish
Burns/Rothschild
Collins, RI
Burns, OGC
Mensha, NRR
Marco, OGC
Baggett, OEDO

DATE: 03/04/10

ASSIGNED TO:

CONTACT:

NRR

Leeds

SPECIAL INSTRUCTIONS OR REMARKS:

Template: EDO-001

ERIDS: EDO-01

EDATS

Electronic Document and Action Tracking System

EDATS Number: OEDO-2010-0176

Source: OEDO

General Information

Assigned To: NRR

OEDO Due Date: 4/5/2010 11:00 PM

Other Assignees:

SECY Due Date: NONE

Subject: 2.206 - Vermont Yankee Surrounding the Maintenance and Testing of High Pressure Coolant Injection

Description:

CC Routing: RegionI; OGC; tanya.mensha@nrc.gov; Catherine.Marco@nrc.gov

ADAMS Accession Numbers - Incoming: NONE

Response/Package: NONE

Other Information

Cross Reference Number: G20100128

Staff Initiated: NO

Related Task:

Recurring Item: NO

File Routing: EDATS

Agency Lesson Learned: NO

OEDO Monthly Report Item: NO

Process Information

Action Type: 2.206 Review

Priority: Medium

Signature Level: NRR

Sensitivity: None

Urgency: NO

Approval Level: No Approval Required

OEDO Concurrence: NO

OCM Concurrence: NO

OCA Concurrence: NO

Special Instructions:

Document Information

Originator Name: Mike Mulligan

Date of Incoming: 3/2/2010

Originating Organization: Citizens

Document Received by OEDO Date: 3/4/2010

Addressee: R. W. Borchardt, EDO

Date Response Requested by Originator: NONE

Incoming Task Received: E-mail

Jaegers, Cathy

From: Michael Mulligan [steamshovel2002@yahoo.com]
Sent: Tuesday, March 02, 2010 3:31 PM
To: Kim, James
Cc: NRC Allegation
Subject: 2.206 petition concerning HPCI and torus cooling: 05000271/2009005

March 2, 2010

Executive Director for Operations
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

10 CFR 2.206 PETITION

Dear sir,

I request a 2.206 on Vermont Yankee surrounding the maintenance and testing of High Pressure Coolant Injection of Dec 4, 2009...the breakage of LPCI redundancy.

Entergy in cold blood disregarded procedures and plant operator licensed training per the inference of the NRC inspection report 05000271/2009005 . There is the stench of falsification and withholding of information with Entergy, NRC and the industry for economic reasons. This is a operator centric (individual and corporate) integrity and credibility violation...a big ethical violation and violation of public trust to disclose the truth. I request the NRC force VY do a comprehensive investigation of said events...then release the results. I request the NRC independently verify Entergy's internal investigation. I request a independent investigation of the on site NRC resident inspectors...seeing how the NRC is in the center of this, I have issues whether the agency can investigate itself. I request the Entergy be fined \$1.00 for improperly using torus cooling and lying about it to the community.

I have information that the NRC totally misrepresented and downplayed this violation. In a very reckless manner Entergy set the plant up into having a prohibited maneuver, with increasing the risk of a accident to the community. If Vermont Yankee would have had a designed base accident with both LPCI running it would create a worst than expected accident. We could even have been a much worst accident if the licensed operator are institutionalize into secretly and covertly not follow their procedures....their training. This is an intentional activity where they chose to not follow extensive safety training... the well worn path of approved procedures and procedure precautions and prior nuclear operator training. The outcome is there is a unacceptable risk of containment failing during all accidents. They have chosen to pick up this community risk solely for convenience...for economic reasons and the well worn trail of organization dysfunction.

To test or perform maintenance on HPCI with the component in operation and adding heat to the torus water ...you have to know what is the torus temperature and have a professional awareness or estimation with how long the machine can run without over heating the torus water. Overheating the torus water temperature limit is where the containment becomes not assured...maintaining the torus temperature as low as possible assures the public with the greatest safety. They usually have point in the mind before they even start the machine, with how high they will allow the water to become...the point where they have to shut down the machine so they won't over heat the water. They usually start up one side of torus cooling immediately when they start up HPCI...or before. That lengthens the period where HPCI can run to its torus water temperature operational limit...not emergency limit. I am certain they ran into the some maintenance or operational issue the HPCI. They just kicked in the another torus cooling side to increase the torus water cooling...wanted to finish the maintenance and testing period for some reason. Maybe they knew it was going to be long maintenance adjustment, that is why they had both sides on. Was the torus water heated up for some reason like RCIC operation or such prior the HPCI operation. The point of it; it was a choice for a benefit for some reason. They chose to degrade the operation of LPCI for convenience. They should have stopped the operation of HPCI...then restated it when the torus water was cooled. They estimate how much the torus water temperature can rise while adding heat into the torus for before entering a emergency procedure. They say this is how long we can run HPCI before we enter a emergency period. We are sure they violated the safety precepts and prohibitions of the normal LPCI operation, for torus cooling while intentionally adding heat to the torus. I am sure it states use only one side of torus cooling can be used ...then stop the testing or maintenance activity before it enters emergency procedure...high torus temperature. What are they doing in a "emergency procedure" when it is a preplanned maintenance and testing activity.

I am telling you, it is important to get into the habit of taking the conservative path on these little things. You set a pattern and habit of being honest and conservative in the little things, the little things are more important than the big things when you know everyone is watching you...not taking shortcuts and not doing economical or organizational accommodations. You teach all the employees by doing these little things, the little things are more important than the infrequent big situations. When the big complex situation and accident comes to the forefront, parts of you shift into automatic, the important parts of you...you automatically default into pure honesty and conservatism. The big deal here, in these enormously complex machines and organizations, is keeping the complexity of the operation of the unit down onto manageable levels on a day by day bases. These guys collectively for ideological, cultural and for economic reasons...in accommodations for original plant design defects...they have been trading real time (today) hard work and money for the amplification of complexity in a crisis or plant emergency.

It reminds me of my buddy "Popeye the Sailor man". Popeye's buddy "J Wellington Wimpy" famous phrases are:

"Cook me up a hamburger. I'll pay you Thursday"

"I would gladly pay you Tuesday for a hamburger today".

As a general concern, the NRC isn't comprehensively reporting in their ROP and regular inspection activities to the community and public....a more serious concern is they aren't sending a message to the rest of the plants and they aren't keeping all the rest of the plants' informed with things going on at the locale. The purpose of the ROP and event reporting is two fold, to

informed the communities and keep the rest of the industry informed of local problems at a particular local. The NRC are suppose to be telegraphing to the rest of the plants this is how these guys got into trouble, don't you get in trouble like them. I stated this in my last HPCI 2.206. If the community can't figure out what is going on; that means the NRC doesn't know what is going on! If you are withhold information from outsiders; all you are doing is withholding information from yourselves.

I request the NRC do a comprehensive investigation of the NRC and Vermont Yankee concerning the pubic reporting of this event.

1. Discuss in detain what was the maintenance issues and explain what actually occurred with HPCI during the event...a timeline...considering my last HPCI 2.206 is there unacceptable operational degradation with HPCI?
2. Outline the conditions around the torus temperature...how did they plan for the maintenance period...in a timeline detail all the events as torus temperatures increased.
3. Outline the normal operation procederes of torus cooling...outline what is the conservative safety philosophy with adding heat to the torus for testing and maintenance issues? How do they limit entering a emergency procedure for convenience...what is the safety philosophy behind that? Can they intentionally enter a "emergency procedure" for convenience...as a strategy to preserve and save money.
4. Because this was a optional activity...why didn't they shutdown adding heat to the torus and end the operation of HPCI, continued reducing the temperature of the torus to it lowest point...then restart adding heat, or restart the HPCI maintenance and testing activity? What is the big rush/
5. The issue is the NRC sees this through a maintenance rule perspective...why don't they see it though licensed operator centric perspective or operation's professionalism. I don't think the NRC has adequate skills and operational experience relative to the licensed operators, to see this through the typical experience of the licensed operator initial and continual training From a operator's perspective this was grossly obscene and unprofessional. Why is the NRC maintenance centric and not licensed operator centric? Is operator's licensed training and retaining a hurdle you have to get over...playing the game...or do they teach you a way of life when you are actually running and operating a nuclear reactor?
6. This hints there is significant systemic issue with licensed operator training....certainly inadequate LPIC system limitations and operational accommodations...the proper use of normal and emergency procedures.
7. I'd be interested how the NRC discovered this?
8. Hmm, you know HPCI spends most of it time in standby. You had recent issues with HPCI electrical contacts...now some maintenance issue that hasn't been disclosed...it sounds like you have secret reliability issues with HPCI.
9. Has the plant shifted from a licensed operator centric operating philosophy...operation's centric organization...into a not operation's centric organization. Does the plant serve the licensed operators...operations...or do the operator's serve the rest of the plant. Who is in control?
10. I just got issues that the NRC inspectors...local and outside...they don't have the professional capability to see events through the plant operation's centric model....licensed operators. Do they have the expertise for that? You get the feeling if they dinged the plant operators...tried to make them better...the inspection reporting of this would gain ammunition to anti nukers.

Other plants have had lots of problems with operating torus cooling...or needing to run torus intermittently or continuously because up stream safety components were known to be degraded. They were stupid enough to run safety systems for economic convenience without ever compensating for the added wear and tear...the increased maintenance. Generally relief valve leakage from the reactor has forced utilities to improperly use torus cooling and abuse safety equipment. This is a well worn trail through inspection activities across decades of problems and inspection documentations.

We know through nuclear reactor operator relicensing and initial licensing of the employees...the issues of the design limitations of the LPCI and torus cooling has been repeatedly discussed and tested on. The issue of; what is the problem with using both sides of torus cooling at the same side in a non emergency. This has to be on the tip of the tongue of every licensed operator. I am sure they have been tested on it many times. We know the troops have spent a lots of time discussing normal and emergency torus cooling...torus water temperature. Why they are supposed to use only one side in a non emergency. Though the memory of their training and testing...repeatedly...they should have known without even cracking open a procedure that they were entering into dangerous bureaucratic territory. I am certain they knew the were "throwing the dice" with getting into trouble internally and within the NRC...with using both sides of torus cooling...allowing the entry into a emergency procedure in support of a optional maintenance. This is a object and gross failure of safety licensed operator training...the idea of translating that training into operation's support and usage. Oh, I see, the NRC would rather violate Entergy on same arcane maintenances functional risk failure, that the public has no idea with what you are talking about, instead violating operation's training and the operator's training in support of plant operations and safety. With the fundamental nuclear operational and safety training they went into the torus cooling issues with eyes wide open, chose to walk past fundamental nuclear safety principles and conservative operating procedures. Vermont Yankee and Entergy has a pattern of lying about the problems they get themselves into....the lackadaisical and arrogant attitude that the rules don't apply to them. The rules that applies to nuclear employee are risk informed infractions to Entergy and the NRC....some rule or principle violation are insignificant and you don't have to obey rules...or at least we won't punish you for it.

Let it be known, it is safer for the NRC to downplay events with the licensee than to completely cover it up. Creating a complete cover-up gives enormous power to a disgruntled whistleblower. He gets to disclose to the public the NRC should have known about this, a potential active cover-up...he gets to report on a regulatory violation that wasn't documented or reported on. Does the NRC approve of a licensee violating a rule for mere convenience...not report on this. That is very dangerous for the NRC and the nuclear industry. A whistleblower to a complete NRC cover-up is like Popeye to spinach...everyone knows this. I certainly know that by my real experiences....seen it with my own eyes!

So this event happened on Dec 4, 2009. We know raising tritium levels from leaking pipes were a grave concern to Vermont Yankee and the NRC since Nov 2009. Everyone knew prior to Jan 7, 2010 the undisclosed pipes and the tritium leak was the existential tsunami that would end up challenging plant operation and beyond. Within a few days of Jan 7 the missing pipes leaking tritium was a certainty with rocking the whole state of Vermont. The NRC had a discussion with plant management staff on Jan 12, 2010 over this inspection report and HPCI. The report was completed before Jan 25, 2010. The NRC was well aware of the lying detonation public relations bomb of, that there was no radioactive piping out on the plant yard and the massive releases of

reactor coolant. The NRC had this knowledge...yet the inspection report wasn't completed or revisions could be made until the release on Jan 25, 2010. The NRC had the opportunity to craft, shade or game HPCI. They had knowledge that the Vermont Yankee problem was going to create and threaten the Nuclear Renaissance. This is the NRC's testimony that there are no radioactive pipes out in their agency's yard...this is the credibility leakage of tritiated reactor coolant water leaking from their NRC headquarters. This is NRC agency saying you can't put our employee's under oath...we are afraid of talking and testifying under oath!

In the name of altruism...protecting tens of thousands of jobs and a trillion dollar Nuclear Renaissance program under unprecedented siege...the NRC basically falsified the reporting of the HPCI maintenance problem and the misuse of the torus cooling. Falsification can be a cold blooded to you face bold lie...it could be the simple managing of the release of information or withholding information and telling a partial truth. It is a falsification either way...and you don't get off the hook by saying you are just following the procedure or rules. There is a responsibility of a United State citizen to always tell the truth, especially if it is concerns us all. To be a citizen of the USA confers a special responsibility...to always strive to tell the truth. We are suppose to be a exceptional nation...to live up to that and lead the world towards truthfulness! What happened to us? The NRC and Entergy gave us a intentionally incomplete and fragmentary explanation in the report on this HPCI event. The NRC does this all the time justifying it on risk base regulatory philosophy and the rules they write. The NRC shifted the event into some obscure maintenance rule risk violation they knew nobody would understand. Instead of the more complete explanation that Vermont Yankee cold bloodily violated known procedures and fundamental plant operator licensing training safety principles....took a mind blowing risk to take a shortcut that benefited no one outside the security fence. Operating both sides of torus cooling in a non emergency...the potential of inoping LPIC redundancy....are burnt into the DNA of the licensed operators. It is inconceivable the operator's wouldn't have this on the top of their brains. The LPCI safety components and systems has a known inadequate design, and with their accommodations...with the precaution of only running one torus cooling side at a time because in a accident this breaks redundancy. You get what is going on here, they have no absolute certainty of proof...they don't have proof if it is safe with both side of torus cooling running, then create their worst LOCA. There is always this shadow of not testable uncertainty. I don't care how many times you run it through the computer models.

Safety system redundancy equates to public safety. If you don't get what is going on, the poor and inadequate LPCI design in the operational accommodation has ramped up complexity by placing in procedures the requirement that only one side of torus cooling can be used in a non emergency. When can I run with both sides and when am I prohibited from running with it. They further injected excessive complexity into the operation of the plant by knowing violating plant procedures and training...into a potential future accident. It could make the accident sequence too complex to understands in a LOCA. If they do this all the time, in many systems and repeatedly, you will have a accident that will be too complex to understand. You will never have a opportunity to prevent or mitigate a accident because the complexity makes you unable to understand the accident and its development.

One thing that is known with the NRC on their inspection activities...it is ideological regulatory forbearance...it is a big fault. They never get into the murky "emotional" business of figuring out the motivations of the employees and management on a event like this. Why did they do it, what is to gain or lose by following the procedures and nuclear professionalism? Why doesn't the NRC explain to the community what are the motivation of taking a short cut like this? You see, if the

NRC plumed the murky depths of emotions, motivations and incentives, it would have a huge affect on the industry. This is the artifact of a old style male centric engineering culture. We want to simplify this to the rules with how a machine mechanically works. If everything was as simple as driving and keeping up the maintenance on a car. We...mostly men, mostly manly engineers... don't want to develop a language with talking about emotions and motivations. It is just too messy and sticky for the male centric nuclear engineering organizations. Besides, talking in the simplified machine male centric model it confers a advantage to us...we don't have to explain wants and needs, and the resulting behaviors of us men. We don't to tell you what is going on underneath our hides... real needs and wants...what you don't know about us you can't stop!

I'd like to know why they had to use both sides of torus cooling in this maintenance and testing issue. I don't see any past abuse as this. Why not in the past, why did they have do this on Dec 5, 2009? Do they have any unreported history of using both sides of torus cooling for non emergency purposes? Industry wide!

It should be remembered this event is very similar to my June 8, 2009 HPCI 2.206. The not conservative and improper start up of the plant in 2007. It is the idea that everyone are weaseling around nuclear power plant ethics...ethical behavior. I consider it a falsification...a false distinction between a buried pipe and or a pipe placed in a concrete trench or underground concrete encasement. If you are giving incomplete and distorted information to the public...it is falsification. Following the rules, policies or cultural customs doesn't absolves you from being ethical or moral...from being a morally conscience human being that has a since of knowing right from wrong outsides of all of bureaucracies...out side all of our rules, policies and customs. We all have a responsibly to sit outside our family, our bureaucracy, our national identity, our planet's identity someday, our organizations and religions identity, at least a small part of our minds. We are supposed to make a independent determination of what we are doing is right or wrong. God and involution made us independent beings. We have a enormously and startling beautify complexity in our brains. Our intelligence is almost beyond comprehension...our living, changing adapting genes and DNA. Our intelligence gives us the power to be independent...we have the power of our intelligence to be the masters of destiny. We have the power to be the masters of our organizations and bureaucracies...instead of our organizations and bureaucracies mastery over us. We all have a responsibility to "out" our problems...man up, and just tell the truth...we have a responsibility learn from our problems and be better people. Hiding problems doesn't serve anyone. Your behavior must by guided by a higher ethical principle than just following a rule...the rules have to serve us all for the higher good. If a member of the community ask that they don't understand why the NRC took this action...I think you owe it to the community to comprehensively explain the agency's actions and report comprehensively it...or what did any plant do. Remember the paradox of; what you tell the community, you tell yourself...if you have clear communication to the community, you will have clear communication within a organization.

We all know on this first HPCI 2.206 the agency basically told me to drop dead...we are not required to give any more information by our rules. That was a completely different answer than if the agency told me everything...we are open, accountable and responsible. The majority of what is going on here is language abuse...the gaming of the meaning of words and phrase, their meanings and definitions...it is actualized "double speak". It has been a large scale abuse of language for a selfish ends! I get that though; but mike, the rules and the enforced customs of the organization I work for, they told me I have to lie to you...and everyone surrounding Vermont

Yankee. That is a intolerable working situation they got you in buddy...don't kid yourself, it is not sustainable for the long term! It will rip you and your community apart in the end! Believe me, I do understand your burdens of you have to feed and provide for you family. We are much bigger than any of our organizations....truth and honesty stands above organizations. But your first responsibility to the yourself and world is you have to strive to be a decent and honest person...it has to come first...to always try to walk towards perfection!!!

I don't come to this preceding as a saint. I come to this preceding as a liar and terrible sinner myself. This is what I learned through my sinning...the suffering and tears I have cried. Is there a wish here for atonement and redemption? Do we all seek redemption...is redemption and a new birth one of our rights in this cosmos? It should be...it should be a guarantee upon birth...as many redemption as necessary to become that mythological honest man. I am here to extol the virtues of that mythological honest man and women!

Quotes from the blockbuster movie 'Shutter Island' :

Chuck Aule: How we doing this morning?

Teddy Daniels: Good, and you?

Chuck Aule: Can't complain.

Teddy Daniels: So what's our next move?

Chuck Aule: You tell me.

Teddy Daniels: I gotta get off this rock, Chuck. Get back to the mainland. Whatever the hell's going on here, it's bad. Don't worry partner, they're not gonna catch us.

Chuck Aule: That's right, we're too smart for em.

Teddy Daniels: Yeah, we are, aren't we. You know, this place makes me wonder.

Chuck Aule: Yeah, what's that, boss?

Teddy Daniels: Which would be worse, to live as a monster or to die as a good man?

Chuck Aule: Teddy.

This is the phrase or sentence that encompasses our existential works of the 21st century:
"Which would be worse, to live as a monster or to die as a good man"?

Sincerely,

Mike Mulligan
PO Box 161
Hinsdale, NH 03451
steamshovel2002@yahoo.com
1-603-336-8320

<http://www.burlingtonfreepress.com/vermontyankee>

On Jan. 7, Vermont Yankee officials reported elevated levels of the radioactive isotope tritium in a monitoring well on the plant grounds that have since reached 28,900 picocuries/liter. On Jan. 13, Vermont Yankee reported levels reaching 2.1 million picocuries/liter of tritium in water inside a concrete vault-like trench connected to a radioactive waste building as well as heightened levels of cobalt-60 and zinc-65. Crews from Vermont Yankee and the NRC are searching for the source of the leak and the state has increased monitoring of nearby drinking water wells.

January 25, 2010

Entergy Nuclear Operations, Inc.

Vermont Yankee Nuclear Power Station

Vernon, VT 05354

SUBJECT: VERMONT YANKEE NUCLEAR POWER STATION - NRC INTEGRATED INSPECTION REPORT 05000271/2009005

...On December 31, 2009, the U.S. Nuclear Regulatory Commission (NRC) completed and inspection at your Vermont Yankee Nuclear Power Station. The enclosed inspection report documents the inspection results, which were discussed on January 12, 2010, with you and other members of your staff.

IR 05000271/2009005; 10101/2009 - 12/31/2009; Vermont Yankee Nuclear Power Station; Maintenance Risk Assessments and Emergent Work Control.

Green. The inspectors identified a non-cited violation (NCV) of 10 CFR 50.65 paragraph (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy did not assess and manage the increase in risk that resulted from maintenance activities that impacted the availability of the low pressure coolant injection subsystem (LPCI). On December 4, 2009, Entergy conducted a test of the high pressure coolant injection (HPCI) system as a retest following maintenance activities. Operations placed both trains of the residual heat removal (RHR) system in the torus cooling mode. This alignment impacted the ability of the LPCI subsystem to automatically perform its function in some design basis accident scenarios. However, the inspectors noted that the LPCI subsystem was not included as part of the risk assessment, and that subsystem was not maintained as available in accordance with Entergy procedures. Entergy entered this issue into the corrective action program (CAP), and initiated a preliminary investigation to review the effectiveness of Maintenance Rule accounting for LPCI unavailability while in the torus cooling mode.

The finding is more than minor because Entergy's risk assessment did not consider risk significant structures, systems, and components (SSCs) (i.e. LPCI subsystem) that were unavailable during the maintenance activity. The finding is associated with the Configuration Control attribute of the Mitigating Systems cornerstone, and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is of very low safety significance because the incremental core damage probability deficit was less than 1.0E-6. This finding has a cross-cutting aspect in the Human Performance cross-cutting area, Work

Control component, because Entergy did not appropriately plan and incorporate risk insights in work activities that impacted the availability of the LPCI subsystem. [H.3(a)] (Section 1 R13)

1 R13

b. Findings

Introduction: The inspectors identified a Green NCV of 10 CFR 50.65 paragraph (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy did not assess and manage the increase in risk that resulted from maintenance activities that impacted the availability of the LPCI subsystem.

Description: On December 4, 2009, Entergy conducted a test of the HPCI system as a retest following maintenance activities. Operations personnel placed both trains of the RHR system in the torus cooling mode to maintain the torus within limits contained within the emergency operation procedures. Because this alignment made the LPCI mode inoperable, Operations personnel entered the appropriate Limiting Condition of Operation in the Technical Specifications (TS) for this condition. However, the inspectors noted that the LPCI subsystem was not included as part of the risk assessment, and questioned its accuracy. The condition of concern was a loss of coolant accident followed by a loss of normal power and the failure of one emergency diesel to start. This would result in a loop drain condition to the torus for one train of LPCI, and that train would not be fully available to perform its coolant injection function. The inspectors noted that there was no dedicated operator, and the recovery actions were not proceduralized as required by EN-WM-104, "On Line Risk Assessment," to maintain availability. Entergy entered this issue into the CAP (CR 2009-4234), and initiated a preliminary investigation to review the effectiveness of Maintenance Rule accounting for LPCI unavailability while in the torus cooling mode.

Analysis: The performance deficiency is that Entergy did not conduct an adequate risk assessment for maintenance activities that impacted the availability of the LPCI subsystem. This issue was within Entergy's ability to foresee and correct, and should have been prevented. Traditional Enforcement did not apply, as the issue did not have actual or potential safety consequence, had no willful aspects, nor did it impact the NRC's ability to perform its regulatory function. A review of NRC Inspection Manual Chapter (IMC) 0612, Appendix E, "Minor Examples," revealed that the finding is similar to Example 7.f, in that, the elevated overall plant risk when correctly assessed would put the plant into a higher risk category. The LPCI subsystem is considered risk significant because it is identified as such in Table 2 of the NRC's Phase 2 Significance Determination Process notebook for Vermont Yankee.

Using IMC 0612, "Power Reactor Inspection Reports," Appendix B, Section 3, Item 5(a), the finding is more than minor because Entergy's risk assessment did not consider risk significant SSCs (i.e., LPCI subsystem) that were unavailable during the maintenance activity. The finding is associated with the Configuration Control attribute of the Mitigating Systems cornerstone, and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Because this finding involves the licensee's assessment and management of risk associated with performing maintenance activities under all plant operating or shutdown conditions, the inspectors used IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," to evaluate this finding. The inspectors determined that the finding is of very low safety significance (Green) because the incremental core damage probability deficit was

less than 1.0E-6. This finding has a cross-cutting aspect in the Human Performance cross-cutting area, Work Control component, because Entergy did not appropriately plan and incorporate risk insights in work activities that impacted the availability of the LPCI subsystem. [H.3(a)]

Enforcement: 10 CFR 50.65 paragraph (a)(4) states, in part, that "the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activities." Contrary to the above, on December 4, 2009, Entergy did not assess and manage the increase in risk that resulted from maintenance activities that impacted the availability of the LPCI subsystem. Because this violation is of very low safety significance (Green), and has been entered into the CAP (CR 2009-4234), this issue is being treated as an NCV, consistent with the NRC Enforcement Policy.

(NCV 0500027112009005-01: Inadequate Risk Assessment Associated with the Low Pressure Coolant Injection Subsystem)

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June 8, 2009

Executive Director for Operations
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

10 CFR 2.206 PETITION

I request a 2.206 on Vermont Yankee. Vermont Yankee operated their reactor illegally and unsafely coming out of their start-up after a outage from June 6, 2007 until June 12, 2007. With the cost of a shutdown being \$750,000 a day times 7 days, I request Vermont Yankee pay a fine of \$5,250,000 for operating the reactor illegally and falsifying paperwork submitted to the NRC.

- 1) SUBJECT: VERMONT YANKEE NUCLEAR POWER STATION - NRC INTEGRATED INSPECTION REPORT 05000271/2007004 (Closed) LER 05000271/2007002-00, High Pressure Coolant Injection System Valve Failed to Open (1 sample)

"On June 8, 2007, with the reactor at 81 percent power, Entergy identified that the HPCI pump injection valve (V23-19) did not open on a manual signal from the control room during a surveillance test. Entergy entered the condition into their corrective action program and a root cause evaluation was performed. Entergy determined that one of the

motor operated valve (MOV) contacts (72/C) was in the intermediate position, causing electrical and mechanical interlocks that prevented the open contactor (82/O) from energizing. Entergy identified that the 72/C contacts were pitted and worn, causing the contact surfaces to overheat and weld together. Entergy determined that the PM performed on the valve control circuitry was inadequate, in that it did not contain sufficient guidance on how to determine contact wear and when the contacts should be replaced. The inadequate PM activity constituted a performance deficiency.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of assuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspector conducted a Phase 2 SDP analysis, using the following assumptions, and the Risk-Informed Inspection Notebook for Vermont Yankee Nuclear Power Station, Revision 2: the exposure time was approximately six days and no operator recovery credit provided.”

2) So the NRC says it is a 6 day exposure from 06/06/07 to 06/12/07...but the violation began on 06/05 when the mode switch was place to start-up.

“05/31/07: Electrical Maintenance inspected the HPCI V23-19 valve starter LOCAL-23-19 cubicle. The contactors were noted to be carbonized and pitted. This was an expected condition due to the load on these contacts during MOV operation. The contacts were cleaned and no unusual indications were observed.” (Vermont Yankee LER 2007-002-01)

1) Vermont Yankee operated with OP-5210, "MCC Inspections" procedure that didn't meet 10 CFR 50, Appendix B, Criterion V. Having procedures that didn't meet the intent of 10 CFR 50, Appendix B, Criterion V illegally gave Vermont Yankee non conservative operational flexibility and this involved a lot of money.

2) “This was an expected condition due to the load on these contacts during MOV operation.” This is evidence that Vermont falsified their paperwork and reporting to the NRC.

3) According to “10 CFR 50, Appendix B, Criterion V” on 5/31/07 (shutdown) HPCI wasn't capable of performing its intended function with such a damaged relay.

On June 5, 2007 at around 2 am Vermont Yankee illegally and contrary to technical specification began starting up the nuclear reactor knowing they had a inoperable HPCI. Correction, on some unknown time on June 5, 2007 Vermont Yankee contrary to technical specification positioned their mode switch to start-up and began commencing a improper reactor start-up.

In and around June 6, 2007, after they made the reactor system's pressure exceed 150 psig, Vermont Yankee was required within 24 hours to make the HPCI fully operational or be below shutdown. They were required to do HPCI line-ups, a full flow test and valve operation timing. That is how you make HPCI operational. There was indications that V23-19 was not functional on 6/06...dimming lights and other indications. In the last operation of V23-19 on June 6, 2007 a relay was welded shut, thus making HPCI inoperable. It is at this point that Vermont Yankee didn't meet their 24 hour tech spec requirement of having HPCI operational upon start-up. They should have begun a immediate shutdown according to tech specs.

"06/08/07: Operations attempted to open V23-19 as part of normally scheduled surveillance activities for the HPCI System. V23-19 failed to open on a manually initiated signal from the Control Room." (Vermont Yankee LER 2007-002-01)

1) Vermont Yankee and the NRC intentionally misinterpreted V23-19 failure to open event. They illegally thought making HPCI "failure to become operational" on June 6, 2007 and the valve V23-19 failure to open on June 8 were separate events. By making it a separate event they wrongly assumed HPCI met the tech spec requirement of being operational within 24 hours of exceeding 150 psig.

"The contactors were noted to be carbonized and pitted. This was an expected condition due to the load on these contacts during MOV operation. The contacts were cleaned and no unusual indications were observed." (Vermont Yankee LER 2007-002-01)

"Prior to implementing the corrective actions developed by the Root Cause Analysis Team, the contactors were inspected at 6 year intervals and replaced when signs of degradation such as pitting were present." (Vermont Yankee LER 2007-002-01)

1) I don't get it, the NRC says VY didn't have appropriate quantitative or qualitative acceptance criteria, but the root cause says they had a criteria of replacing the relays if "degradations such as pitting were present". Everyone knows in critical safety systems if carbonization and pitting shows up in any relays you don't repair it or sand paper over it. These guys are all profession trades and higher educated nuclear professional. This isn't a back yard mechanical oil monkey operation going on. It is a nuclear power plant. You are talking about pennies here compared to the risk of the safety system is not working in a accident and the risk of \$750,000 a day risk of a shutdown. You never repair a nuclear grade safety relay. You reinstall it with brand new high quality safety grade relay. You call immediately that god dam machine or circuit INOP when you get any pitting. You make the component a "critical path" for reactor start-up...to energize all your staff to come up with a new relay before it starts costing us big bucks. Yet again, how times do we have to hear of the opportunities that Vermont should not have started up that reactor, or once it was operational the broken relay should have caused them to immediately shutdown?

2) The above italicized sentences are prima facie evidence coming from the horse's mouth that Vermont Yankee had reason to know that they started up that reactor illegally and unsafely. And it is evidence that the NRC accepted VY secretly violating tech specs because they haven't called VY on the big sin in this event.

Discussion

<http://www.topix.net/forum/source/brattleboro-reformer/TIV7LM9Q4F0JS8QI1> *"Revise procedure OP-5210, "MCC Inspections", to provide criteria for determining contact wear and replacement.*

See, everything is about this is perspectives. There is fabricated or designed perspective or point of view...then there is the real story. These guys are so deep into lying they can't keep track where they lied in the past. Everything written in these procedures is there for a purpose, or what is legally required to be there and is missing is absolutely intentional. These things are so

unbelievably scrutinized. The primary function of these procedures is to provide operational flexibility and to conserve corporate cash. There never is a mistake or incompetence in these procedures because a comma misplacement could cost them many millions of dollars.

Incompetently written up procedures or invaluable federal regulatory criteria's missing from them are a sure sign those procedures are designed to improperly enhance operational flexibility, and god knows how risky that is. So the procedure "MCC Inspections" is a generic procedure defining how all breaker inspections are to occur throughout the plant. They got many 100's of motor operated valves and they got a breaker for each one...they probably got 1000's of relays.

<http://www.topix.net/forum/source/brattleboro-reformer/TIV7LM9Q4F0JS8QI1>: "Think about all the issues over degraded contracts over the years at VY...the enormous experience the nuclear industry has with electrical contact problems. Does it seem plausible that they wouldn't have a written criteria for the relay contact wear and replacement...even as it was required in 10 CFR 50, Appendix B, Criterion V? Who would a non disclosed or documented criteria benefit? Can Entergy possibly be this incompetent?"

If they had a relay wear inspection criteria on 05/31/07 then the electrician's would have had to follow the directions of the procedures. They would be held accountable for falsification of documents and not following procedures. If the criteria was in the MCC inspection procedure they would had to call HPCI INOP on 05/31. Once it is written down and a known criteria...the paper trail begins...then they known a cover-up is a impossibility. Can't start up the plant with HPCI inoperable. So the absence of the relay wear criteria was the intentional tool that allowed VY to look incompetent with not having a relay degradation criteria in their procedure. The "we are so unbelievably stupid defense" was their ticket to start up that reactor unsafely and illegally.

The absence of the criteria was an intentional strategy to give them exactly the operational wiggle room that allowed them to start up the reactor. I'll bet you the operational testing on V23-19 on 6/01 was because they were nervous with the reliability of the relay. It was designed to give the NRC the assurance of due diligence if it failed immediately upon start-up like it did. The managers could say the "pitting and wear" was normal, we, the so called tested that hand grenade with a pulled pin over and over again, knowing the reactor startup was right around the corner, then illegally start the reactor up on 06/06/07. If Vermont yankee ran into trouble upon start-up, they knew that relay would be cycled over and over again, the chance of failure was high. They want a phony rationale we certainly tested in enough between 5/31 and start-up. They want to drawl the NRC away from the cover-up of 5/31...give the NRC the flimsiest excuse to overlook the broader cover-up. You see what I an getting at, I think it is a industry wide problem, if you give the NRC the flimsiest excuse or rational they will ignore blatant rule breaking. What kind of parent is that if the NRC accepts any stupid excuse from their children?

The smoking gun would be if on 5/31/07 they went through the paper work process of looking for a repair parts relay for HPCI. Hmm, they might see the limitation of that, gin up a reason to inspect the relay at operation weeks later, then put in the paper work starting the search for a repair part replacement. These guys are all into the knowledge of the meaning of the paperwork trail. They are all aware of the paperwork trail game. You can't accuse us anything if you can't prove it."

I broadly question if the NRC are meeting the community's needs of maintaining a safe Vermont Yankee organization. The NRC inspector's on the very next inspection associated the June 6, 2007 start-up with should have fully captured in writing the events in detail of the HPCI in their next inspection report. Both violations should have been uncovered because all the information was there. The first mention of a violation was in Dec 07, then the next one occurred in a upcoming inspection report. This is completely unsatisfactory. It is like a cop giving you a speeding ticket and failure to inspect you vehicle a year after the date when it occurred. I get it, if you got the safety inspection after the violation, entered into you known defective corrective action problem, then the year old car safety inspection never happened, and this new information make it inconsequential. You can't charge or accuse anyone with anything if it is not written down. Why was the first mention of this in a few paragraphs in December 07 inspection report? How could we be talking about a new violation for a 2007 event, and it be the middle of 2009? Why wasn't the public immediately notified that there was two violations surrounding this event in the first inspection report opportunity. The not meeting 10 CFR 50, Appendix B, Criterion and then not have a appropriate safety evaluation saying that the "carbonized and pitting" relay could meet the full intended function of HPCI in any designed accident. I bet you it would have turned into a sited violation or higher if it was fully disclosed in the first inspection opportunity after early June 07?

There is a whole idea here that the NRC doesn't capture Vermont Yankee operation events that interest the community in their inspection reports. I have in mind the steam tunnel clean up leak and the cleanup problems where they injected air or resin into the primary system causing the evacuation of the reactor building. The NRC is just not meeting the needs of the community through the ROP and the depth of the inspection reports. I believe if the NRC met the communities needs, this would make the nuclear plants a lot more stronger and safer.

<http://www.topix.net/forum/source/brattleboro-reformer/TIV7LM9Q4F0JS8QI1> : *"Imagine you are a licensed operator in Vermont Yankee. Some people know that there are degraded relays in HPCI...but nobody in the control room is allowed to know. If you tell a licensed individual that unreliable relays are in the HPCI he is likely to call that machine INOP on his own. He'd be looking up the wiring diagrams on his own and he would make a independent judgment. You see the incentives from keeping degradation information away from the licensed people?"*

So an accident occurs with the need of HPIC...the relay slowly fails. The crews gets stuck in diagnosing the completely unknown problem that is really known by everyone. They make a easy human error with over focusing on fixing and operating HPCI when they should be trying to cool the core. They get behind the eight ball and they then overreact. Remember the operation's department doesn't know about the degradation...but engineers and executives know about this? Can you see the magnitude of the cover-up when the operator's makes a screw-up?

All bets are off if two known safety degradations show up in a emergency on separate equipment in the same accident. You can't predict the human interaction and it is highly risky. If they get caught taking a short cuts once (such as carbonized and pitted relays" ...you can depend on this was occurring for 5 years or more and everyone was doing it. You got to know there are a lot of secret component degradation, lots of safety equipment that will break down in the stress of a accident, information is being kept from the license operator. Many off control room engineers and executives know about a lot of secretly degraded safety equipment. This is all below documentations...so nobody is able to keep tract of the magnitude of it.

The more right way of dealing with this(not correct) is notifying all the control room employees of the degradation. Everyone does training on the degradation symptoms...everyone is fully trained on the unreliability of HPCI. So the plant has a accident with the necessity of HPCI, the whole control room is thinking many steps ahead that it is a expected condition when HPCI fails. During the startup of the machine they are fully trained on what symptoms that will show up with a failing relay. That machine blinks or burps they will drop that machine like a ugly women. They already have thought ahead in that it will fail ahead of time. They are prepared to immediately continue on with their emergency procedures. It would just be a inconvenient blip...they would use the rest of the equipment to protect the public.

Right, you don't have that confusion with a unknown safety system failing and the delay time. Fiddling around with dead, but not known dead machine eats up licensing resources and severely eats up control room intellectual resources.

The problem is once you get the control room licenses involved with accommodating the failing relay...then the cover-up of degraded equipment can't be maintained. There are all sorts of documents and peoples testimony proving that HPCI wasn't functional and the plant was knowingly gaming the allowable outage time. That is intentional falsification of the condition of nuclear safety equipment and it is provable in a court.

If you play the very profitable roulette betting game of intentionally not having the expensive repair parts on site...then you should be punished with a very expensive reactor shutdown. If you are not competent with maintaining a nuclear power plant's repair parts warehouse and inventory ...then you need to be severely punished for the good of everyone. That is the only way you are going enforce the integrity of the warehouse repair parts requirements...that is how you limit the number of lying employees and cover-ups.

If you called one plant on this it, it would never happen again. If you let VY get away with it then everyone else will do the exact same thing....and they will keeping taking chances until there is a huge accident. They will compete to the death."

<http://www.topix.net/forum/source/brattleboro-reformer/TIV7LM9Q4F0JS8QI1> : You see what I am saying, these control room people are so smart. They all have been trained so much, they all have gone over and over tech spec training so often. They had so many quizzes and test questions thrown at them in license school and requal training about the tech spec requirements upon startupthey know these things in and out. They are seeing these things through a professional eyes and we are seeing it through outsiders eyes.

Imagine you are a young fresh licensed operator up in the control room. Nobody admit these things straight out. You'd seen the NRC inspectors come in and out and they have thoroughly questioned everyone including the shift supervisor. You know everyone is aware of what occur. They started that plant up, and the management with the NRC's knowledge fiddled with the tech specs and the rules. The pulled their punching in publicly reporting this. Management and the NRC colluded to falsify the whole thing. The young licensed operator would say, really what kind of a risk was this to the public. Especially thinking about it after it was all fixed on 06/13. He would say it was absolutely no risk to the public.

But in the astonishing chilling thought in the back of his mind he's know management and the

NRC were colluding together potentially saving the company millions of dollars. If I catch a safety defect that is going to cost Entergy millions of dollars what chance does my career have to prevail if the NRC and management are in cahoots for the big bucks. They could both lie saying I am a incompetent operator with a mental illness...and I would lose my job over reporting safety defects that crosses the NRC and my company. .

So is this isn't about the isolated risk of core damage associated with the offending relay...could you get to core damage through our risk studies with a welded relay and HPCI not operational.

Or is it about a completely different accident than the simple assumption. What if the site and the licensed operator's lived with the idea that the nuclear industry was brutally "unjust" and they thought they faced the fear of being fired for raising legitimate safety concerns. There was only "one" way to talk about conditions in the industry and everyone only talks with the nuclear industry's single voice. The industry and the NRC held absolute and infinite brutal power over these employees with absolutely no human rights.

How much money is human rights worth? How much salary would you need if they told you your US Constitution would "not" apply while working on corporate property? Would you sell your constitutional rights for \$100,000 a year and benefits.

Right, the utility and the NRC are saying our story is the absolute facts....our story can't be contradicted...truth is disconnected from real reality....your story or evidence will never have any standing in our system.

If that isn't brutal dehumanization nothing is.

The only remaining questions is, what would have happened if Vermont Yankee asked the NRC's permission to start up with HPCI inop. What would have happened if they couldn't make the HPCI operational within 24 hours upon start-up, could they asked the NRC permission to keep running until its fixed?

Sincerely,

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Received: from mail1.nrc.gov (148.184.176.41) by TWMS01.nrc.gov
(148.184.200.145) with Microsoft SMTP Server id 8.1.393.1; Tue, 2 Mar 2010
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Received: (qmail 5913 invoked by uid 60001); 2 Mar 2010 20:31:02 -0000

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Received: from [24.63.202.49] by web58807.mail.re1.yahoo.com via HTTP; Tue, 02
Mar 2010 12:31:02 PST

X-Mailer: YahooMailRC/300.3 YahooMailWebService/0.8.100.260964

References: <94A2A4408AC65F42AC084527534CF41608634C895C@HQCLSTR01.nrc.gov>

Date: Tue, 2 Mar 2010 12:31:02 -0800

From: Michael Mulligan <steamshovel2002@yahoo.com>

Subject: 2.206 petition concerning HPCI and torus cooling: 05000271/2009005

To: "Kim, James" <James.Kim@nrc.gov>

CC: allegation@nrc.gov

In-Reply-To: <94A2A4408AC65F42AC084527534CF41608634C895C@HQCLSTR01.nrc.gov>

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