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Title: COLUMBIA GENERATING STATION:
FAILURE BY A (b)(7)(C) TO FOLLOW PLANT PROCEDURES
IN ASSOCIATION WITH REPLACEMENT OF HIGH PRESSURE CORE
SPRAY PUMP

Licensee: Case No.: 4-2008-003
Energy Northwest Report Date: February 26, 2008
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Reported by: *[Signature]* Reviewed and Approved by:

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SYNOPSIS

This investigation was initiated by the Nuclear Regulatory Commission (NRC), Office of Investigations, Region IV, on October 15, 2007, to determine if a (b)(7)(C) from Columbia Generating Station (Columbia), Richland, Washington, willfully directed employees of Williams Plant Services (WPS), Stone Mountain, Georgia, to perform work that breached a contamination boundary without the proper health physics support and authorization resulting in violation of required procedures.

Based on the evidence developed during this investigation, the allegation that a (b)(7)(C) from Columbia deliberately directed WPS employees to violate required procedures was substantiated.

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LIST OF INTERVIEWEES

Exhibit

(b)(7)(C)	Columbia.....	12
(b)(7)(C)	Rockville, Maryland.....	16
(b)(7)(C)	Columbia.....	2
(b)(7)(C)	WPS.....	13
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DETAILS OF INVESTIGATION

Applicable Regulations

10 CFR 50.36: Technical Specifications (2007 Edition) (Allegation No. 1)

10 CFR 50.5: Deliberate Misconduct (2007 Edition) (Allegation No. 1)

Purpose of Investigation

This investigation was initiated by the Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region IV (RIV), on October 15, 2007, to determine if (b)(7)(C) (b)(7)(C) Columbia Generating Station (Columbia), Richland, Washington, willfully directed employees of Williams Plant Services (WPS), Stone Mountain, Georgia, to perform work that breached a contamination boundary without the proper health physics (HP) support and authorization resulting in violation of required procedures [Allegation No. RIV-2007-A-0103] (Exhibit 1).

Background

7c On September 26, 2007, Zachary K. DUNHAM, Branch Chief, Division of Reactor Projects, RIV, NRC, received information from (b)(7)(C) Columbia, regarding (b)(7)(C)

According to (b)(7)(C) directed plant employees not to follow plant procedures associated with the replacement of a high pressure core spray (HPCS) pump at Columbia. The violations occurred during the refueling outage RFO-18 between May-June 2007. Specifically, (b)(7)(C) directed workers to violate a contamination boundary without proper HP support or authorization, and he directed the use of tools contrary to the tools specified in a work procedure.

The violations directed by (b)(7)(C) were brought to Columbia management's attention through the licensee's Employee Concerns Program (ECP). During a licensee investigation, (b)(7)(C) confirmed he directed employees not to follow required procedures. Subsequently, (b)(7)(C) was allowed to resign from his position at Columbia.

On October 15, 2007, a RIV Allegation Review Board met to discuss the allegation against (b)(7)(C) and requested the NRC's OI:RIV initiate an investigation to determine if (b)(7)(C) willfully directed Columbia employees to violate required procedures. Potential violations: 10 CFR 50.36 (Technical Specifications) and 10 CFR 50.5 (Deliberate Misconduct).

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Coordination with NRC Staff

On November 14, 2007, OI:RIV met with DUNHAM at Columbia to discuss the allegations and investigative interviews to be conducted.

Allegation No. 1: Determine if (b)(7)(C) willfully directed employees to violate required procedures.

Evidence

Document Review

ECP Internal Report No. (b)(7)(C) dated (b)(7)(C) (Exhibit 2)

The internal report provides a summary of the investigation conducted by (b)(7)(C) (b)(7)(C) Columbia, and concludes that (b)(7)(C) clearly understood his actions, and he admitted he may have been overly focused on progressing this high priority job at the expense of considering other less important information. Additionally (b)(7)(C) provided Work Order No. 0111148040 for HPCS repair reflecting the names of 15 individuals working in the area during HPCS repair.

Energy Northwest Condition Report (CR), CR No (b)(7)(C) (Exhibit 3)

This CR was prepared by (b)(7)(C) and reflected that while providing oversight on the HPCS-P-1 flange repair, the night shift field engineer providing oversight for the HPCS flange repair allowed a "reach-across" a contaminated boundary without permission from the HP organization. This was a violation of the Radiation Work Permit (RWP).

ECP Intake Form for (b)(7)(C) WPS, dated (b)(7)(C) (Exhibit 4)

This is a summary of (b)(7)(C) interview as conducted by (b)(7)(C) and reflects that (b)(7)(C) had previously complained to (b)(7)(C) about some of the craftsman and wanted them removed from the project. During the HPCS flange repair job (b)(7)(C) directed that (b)(7)(C) craftsman reach across a contaminated area, over the objection of (b)(7)(C) who wanted to contact HP before proceeding. According to (b)(7)(C) directed him by stating, "No, do it now." (b)(7)(C) went on to state that during a review of CR No (b)(7)(C) it appeared that (b)(7)(C) wrote the CR as if someone else had allowed for the contamination to occur and it was not directed by (b)(7)(C)

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Technical Specification Section 5.0 Administrative Controls, 5.4 Procedures, undated (Exhibit 5)

5.4.1 Written procedures shall be established, implemented, and maintained covering the following activities: Regulatory Guide 1.33, Revision 2, Appendix A, February 1978; NUREG-0737, Supplemental 1; and radiological environmental monitoring.

Energy Northwest, Columbia Plant Procedures Manual, GEN-RPP-04, Entry Into, Conduct In, and Exit From Radiologically Controlled Areas, dated September 28, 2007 (Exhibit 6)

Section 4.2.6 (e), page 16 of 27. Do not reach over, or cross Contaminated Area (CA) boundaries without Radiation Protection (RP) approval except to enter and exit the area or to remove personnel dosimetry, hard hat, hand tools, or M&TE from the area as described in Section 4.2.7.

Letter of Resignation from (b)(7)(C) dated (b)(7)(C) (Exhibit 7)

(b)(7)(C) resigned his position as (b)(7)(C) at Columbia.

Letter from (b)(7)(C) accepting resignation of (b)(7)(C) dated (b)(7)(C) (Exhibit 8)

(b)(7)(C) letter of resignation was accepted by (b)(7)(C) in lieu of discharge and reflected that his employment records would be marked as ineligible for rehire.

Performance Plan for (b)(7)(C) dated July 1, 2006, to June 30, 2007 (Exhibit 9)

The performance plan for (b)(7)(C) reflected that he met his FY07 Goals and Focus Areas and was cited for additional achievements regarding the HPCS-P-1 replacement project.

Energy Northwest General Employee Training Manual, dated July 1, 2006 (Exhibit 10)

This manual provided detailed instruction and guidance for Plant Access Training (PAT) and Radiation Worker Training (RWT) to new employees, and (b)(7)(C) would have received a copy. Applicable cites as follows after page 101:

- B. Procedure Compliance, page 7, indicates that "if the job you are performing requires a procedure, COMPLIANCE WITH THE PROCEDURE IS MANDATORY; you must follow the procedure exactly as it is written or get it changed."

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- INTEROFFICE MEMORANDUM from (b)(7)(C) (b)(7)(C) dated November 28, 2006, and detailed information on "... GEN-RPP-04, 'Entry Into, Conduct In, and Exit From Radiologically Controlled Areas,' " dated September 28, 2007. Also, "if the work scope of a job in a Radiologically Controlled Area changes, then Radiation Protection must be notified prior to proceeding."

- RWP PRECAUTIONS and USE, A. Precautions, page 40, "If it becomes necessary to exceed the scope of the RWP to perform work, or if work conditions deviate from those described on the RWP, STOP WORK AND CONTACT HP," page 41, "All work within an RCA MUST BE authorized by the radiation work permit."

- RWP COMPLIANCE, page 42, "Not complying with the requirements . . . could result in the plant being fined, or other regulatory action, as well as possible disciplinary action."

AGENT'S NOTE: Because of the volume of this exhibit, it will not be included. This exhibit will be maintained in the OI:RIV office and made available if requested.

7c Energy Northwest Training Attendance Record for (b)(7)(C) dated (b)(7)(C) (Exhibits 11)

(b)(7)(C) received training from COLUMBIA on (b)(7)(C), passing Fitness for Duty/Behavior Observation, RAD Worker Training, and Protected Area Access Training.

Testimony

Interview of (b)(7)(C) (Exhibit 2)

On November 14, 2007, (b)(7)(C) was interviewed at Columbia by OI:RIV and related the following information in substance.

(b)(7)(C) Columbia, (b)(7)(C) regarding the HPCS incident that occurred during Refuel Outage 18 (R-18 outage). (b)(7)(C) acknowledged receipt of an allegation from an individual who was dissatisfied with the resolution of CR No. (b)(7)(C) reflecting that (b)(7)(C) directed employees of WPS to violate a contamination boundary in the HPCS P-1 during a flange repair. (b)(7)(C) interviewed (b)(7)(C) and (b)(7)(C) both of WPS, and who related they were present when (b)(7)(C) directed them to violate a contamination boundary in order to complete work on the HPCS. (b)(7)(C) learned from (b)(7)(C) that he intervened and asked (b)(7)(C) to allow HP to review and approve the work, but was directed by (b)(7)(C) who stated, "No, do it now." At which time (b)(7)(C) informed his general pipe fitter foreman (b)(7)(C) to complete the work. (b)(7)(C) related that the incident happened during the R-18 outage in the May to June 2007 time frame (Exhibit 2).

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According to (b)(7)(C) during the interview (b)(7)(C) advised that a few days prior to the HPCS repair (b)(7)(C) had approached him and asked that two of WPS laborer's [NFI] be removed from one of the jobs. Due to this previous action on the part of (b)(7)(C) informed (b)(7)(C) that he (b)(7)(C) felt threatened and feared for his job if he did not comply with (b)(7)(C) directed request to repair the HPCS flange. Later, when (b)(7)(C) reviewed the CR, he felt like it had been incorrectly written by (b)(7)(C) and reflected that the night shift field individual [who would have been (b)(7)(C)] "inappropriately allowed" the touch "reach-across" into a contaminated boundary without permission from the HP organization, when it should have reflected "directed" the touch "reach-across" a contaminated area (Exhibit 2).

(b)(7)(C) advised that he interviewed (b)(7)(C) Columbia, (b)(7)(C) and (b)(7)(C) and summarized their interviews into his final report without writing separate ECP Intake forms for each individual (b)(7)(C) project (Exhibit 2).

7c Interview of (b)(7)(C) (Exhibit 12)

On November 14, 2007 (b)(7)(C) was interviewed at Columbia by OI:RIV and related the following information in substance.

(b)(7)(C) advised he had no first-hand knowledge of the actual incident and first learned of the incident involving the HPCS pump located in the 422 reactor building by (b)(7)(C) on August 10, 2007 although the actual incident happened approximately June 20, 2007. According to (b)(7)(C) related that two pipefitters (b)(7)(C) and (b)(7)(C) both from WPS, were upset about the way CR No (b)(7)(C) for Energy Northwest (Exhibit 3) had been written by (b)(7)(C) related that (b)(7)(C) had been assigned as the management oversight for that project during the night shift of the fuel outage. (b)(7)(C) reviewed the CR and determined that it was written as if a field engineer had directed the action, and (b)(7)(C) did not address the fact that he was the one who directed the WPS pipefitters [NFI], giving them directions which resulted in the violations (Exhibit 12, pp. 7-9).

(b)(7)(C) recalled that (b)(7)(C) was upset that (b)(7)(C) had "directed" the violation and had written a CR describing the action by the night shift engineer, who was (b)(7)(C) as "inappropriately allowed" a "reach-across" a contaminated boundary. (b)(7)(C) advised this action on the part of (b)(7)(C) was a violation, and yet (b)(7)(C) still directed (b)(7)(C) to proceed with the task to reach across a contaminated boundary knowing it was a violation of an RWP. (b)(7)(C) indicated that (b)(7)(C) had reminded (b)(7)(C) that this action would result in a violation, yet he (b)(7)(C) believed he had no choice but to proceed with the activity. (b)(7)(C) related that according to (b)(7)(C) he felt like [his job] was being threatened, since a direct order had been given to him by (b)(7)(C) (Exhibit 12, pp. 10-11).

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(b)(7)(C) was questioned as to why (b)(7)(C) when being directed by (b)(7)(C) would have allowed (b)(7)(C) and (b)(7)(C) to perform the work violation without any intervention. (b)(7)(C) recalled that according to (b)(7)(C) he tried to get (b)(7)(C) to allow an HP to review the request before performing the task. However, this was denied by (b)(7)(C). (b)(7)(C) advised he did not know which worker (b)(7)(C) or (b)(7)(C) had actually performed the task (Exhibit 12, p. 12).

(b)(7)(C) confirmed that the contamination occurred, and (b)(7)(C) directed the task in direct violation of Technical Specification Section 5, 5.4.1 and Energy Northwest Plant Procedures Manual, GEN RTP-04, 4.2.6, Section E (Exhibits 5 and 6). (b)(7)(C) advised the procedures were common in the industry, and with (b)(7)(C) being a (b)(7)(C) he would have been expected to know the procedures (Exhibit 12, pp. 15-17).

(b)(7)(C) advised that (b)(7)(C) offered his resignation on September 7, 2007, and the resignation was accepted in lieu of termination (Exhibits 7 and 8) by (b)(7)(C) on September 10, 2007 (Exhibit 12, p. 18).

7c Interview of (b)(7)(C) Exhibit 13)

1 On November 14, 2007 (b)(7)(C) was interviewed at Columbia by OI:RIV and related the following information in substance.

(b)(7)(C) recalled the incident regarding the HPCS flange repair during the R-18 refueling outage, approximately May/June 2007 time frame, involving himself (b)(7)(C) and (b)(7)(C) as he told it to (b)(7)(C) ECP Intake Form dated (b)(7)(C) (Exhibit 4). (b)(7)(C) contended the problem was with (b)(7)(C) who was put in charge to help finish this job. Prior to the HPCS incident, (b)(7)(C) began giving unsafe work practice directions to his (b)(7)(C) WPS craftsman involving the use of improper tools. (b)(7)(C) related there had been a lot of accidents during the outage. (b)(7)(C) recalled that the day before the HPCS incident, (b)(7)(C) had requested that (b)(7)(C) remove (b)(7)(C) and (b)(7)(C) WPS employees, from the job because he (b)(7)(C) was unhappy with their performance and with how they were taking direction from him (Exhibit 13, pp. 5-10).

(b)(7)(C) advised that during the HPCS incident, he and (b)(7)(C) were called to the pump room by (b)(7)(C) and immediately (b)(7)(C) started directing (b)(7)(C) to grab a sling from outside the contaminated zone, reach inside the contaminated zone, wrap the sling around the spring can on the bottom of the pipe, bring it back out of the zone, and hook it up to a chain fall, all of which required an RWP before work could be performed. (b)(7)(C) indicated he challenged (b)(7)(C) and told him (b)(7)(C) could not perform the work without an HP's presence. (b)(7)(C) explained the HP would oversee the work to keep the workers safe from the contamination, but it would have caused a delay of approximately 1 to 1 1/2 hours to have the HP arrive and evaluate the request (Exhibit 13, pp. 11-13).

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(b)(7)(C) advised that (b)(7)(C) stated in a very authoritative manner, "No. You'll do it now. And I'll take full responsibility," while pointing his finger at (b)(7)(C) and then to the work that needed to be performed with the flange. (b)(7)(C) interpreted (b)(7)(C) direction as we (b)(7)(C) and (b)(7)(C) had our marching orders, were expected to follow them, and (b)(7)(C) would take care of any fallout that came from the task being performed incorrectly. (b)(7)(C) advised his perception was that if they did not follow the order, (b)(7)(C) was probably going to go to his (b)(7)(C) management and try and relieve him (b)(7)(C) from his job (Exhibit 13, pp. 4-15).

(b)(7)(C) indicated (b)(7)(C) did not have on any protective clothing, only his work gloves, regular street clothes, and dosimetry when he performed the task as directed by (b)(7)(C). (b)(7)(C) related that (b)(7)(C) would have received low contamination with the completion of the task (Exhibit 13, pp. 16-17).

(b)(7)(C) opined (b)(7)(C) was fully aware that violating the contamination zone was a problem, and even after being challenged to have the HP evaluate the request, (b)(7)(C) made it clear that every time he talked to us he was here to get this job done, and get it done fast. (b)(7)(C) advised there was a problem with time constraints, and (b)(7)(C) was not going to delay the outage, which would delay bonuses. The workers had been told many times that if this job did not get done in time, bonuses were on the line (Exhibit 13, pp. 8-19).

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According to (b)(7)(C) reached through and brought the sling out of the contamination zone, hooked it up to a chain fall that was out of the contaminated zone, and put tension on it. The pipe would not move, and (b)(7)(C) then stopped the job. (b)(7)(C) recalled that he and (b)(7)(C) left the area and walked through the IPM8, which performed a full body frisk, and no contamination was noted (Exhibit 13, pp. 21-23).

(b)(7)(C) related he was later visited by (b)(7)(C) advising that (b)(7)(C) had not been pleased with (b)(7)(C) at which time explained to (b)(7)(C) the whole story. According to (b)(7)(C) confronted (b)(7)(C) regarding the incident, and (b)(7)(C) did not deny his involvement. (b)(7)(C) was instructed by (b)(7)(C) to write a CR (Exhibit 13, pp. 24-25).

(b)(7)(C) indicated he was later approached by (b)(7)(C) who had obtained a copy of CR (b)(7)(C) (Exhibit 3) and provided it to him for review. (b)(7)(C) wrote, "While providing oversight on the HPCS pump 1 flange repair, the night shift field engineer providing oversight for the HPCS flange repair inappropriately allowed a reach across a contamination boundary without permission from HP organization. This is a violation of RWP for this task." (b)(7)(C) indicated the CR was not correct in that (b)(7)(C) was not a field engineer and he did not "allow a reach across," he "directed the reach across." (b)(7)(C) directed (b)(7)(C) even after being challenged by (b)(7)(C) to reach across the contaminated area. Further (b)(7)(C) made the CR sound like someone else [field engineer] was present when it was (b)(7)(C) who was present and directed the task, and (b)(7)(C) felt as if (b)(7)(C) was trying to cover it up (Exhibit 13, pp. 26-29).

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Interview of (b)(7)(C) (Exhibit 14)

On November 14, 2007, (b)(7)(C) was interviewed at Columbia by OI:RIV and related the following information in substance.

(b)(7)(C) recalled the incident with the HPCS that happened during the R-18 refueling outage in approximately the May or June 2007 time frame. (b)(7)(C) explained the night shift pipefitters had been given the task of trying to get a spacer plate put into the face of the pump because they had made a cut to replace the pump and it was too short. They were trying to make a spacer plate to put it back together. (b)(7)(C) indicated that in order get the spacer plate in, they were going to have to pry a pipe line apart. According to (b)(7)(C) wanted them to run a choker around a piece of pipe that was located in a radiation contamination zone and then come back and tie onto a hanger to apply pressure to pull the line apart (Exhibit 14; pp. 5-7).

(b)(7)(C) recalled the crew of pipefitters were comprised of (b)(7)(C) and one other person [NFI]. (b)(7)(C) related that (b)(7)(C) directed them to put the choker through, hook it around, and bring it back out. (b)(7)(C) stated (b)(7)(C) was informed that HP needed to come down and evaluate his request, and (b)(7)(C) advised he did not want to take the time to involve HP. According to (b)(7)(C) stated, "I will take full responsibility for it. Just do it now" (Exhibit 14, pp. 7-9).

(b)(7)(C) was informed that during the interview with (b)(7)(C) he (b)(7)(C) claimed that (b)(7)(C) was the individual who performed the work. (b)(7)(C) claimed he had not performed the work. (b)(7)(C) advised (b)(7)(C) and (b)(7)(C) were the workers who crossed into the contaminated area and actually performed the work as directed by (b)(7)(C).

(b)(7)(C) recalled (b)(7)(C) was in the contaminated zone and (b)(7)(C) was on the outside of the contamination zone, and they were both wearing protective clothing (Exhibit 14, pp. 10-13).

(b)(7)(C) stated that in hindsight had they not accepted (b)(7)(C) direct order, they [he and (b)(7)(C)] should have stopped and called the HP, and HP would have observed and okayed the task at hand, with a delay of approximately 10 minutes. (b)(7)(C) insisted that normally the workers did not ever cross into a contamination zone, but the perception was the job was a high priority (b)(7)(C) wanted it done and he wanted it done now. (b)(7)(C) advised that he felt threatened [for his job], and the perceived threat weighed in making the decision to cross into the contaminated zone. (b)(7)(C) related that had HP been present, it would have been under their direction to cross from a clean to contaminated zone (Exhibit 14, pp. 15-18).

(b)(7)(C) recalled that once (b)(7)(C) and (b)(7)(C) hooked up the rigging, they made the attempt at spreading the flange and it did not give. Engineering came down to reassess the task, and (b)(7)(C) and (b)(7)(C) went on break while (b)(7)(C) reported the incident. (b)(7)(C) advised that he, (b)(7)(C) and (b)(7)(C) exited via the IPM8, and no contamination was noted on any part of their persons (Exhibit 14, pp. 19-21).

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Re-interview of (b)(7)(C) (Exhibit 15)

On December 17, 2007 (b)(7)(C) was telephonically re-interviewed by OI:RIV regarding his testimony provided to OI:RIV on November 14, 2007.

During the interview on November 14, 2007 (b)(7)(C) reported he was present when (b)(7)(C) directed a violation of a contamination boundary in order to complete work on the HPCS. According to (b)(7)(C) (b)(7)(C) intervened and asked (b)(7)(C) to allow the HP to approve the work, but was directed by (b)(7)(C) who stated, "No, do it now," at which time (b)(7)(C) instructed his crew to complete the work. (b)(7)(C) advised that the actual work was conducted by (b)(7)(C) and (b)(7)(C) and he (b)(7)(C) provided supervision over the work. (b)(7)(C) was informed that according to (b)(7)(C) he (b)(7)(C) completed the repair, and both (b)(7)(C) and (b)(7)(C) denied any direct involvement in the repair (Exhibit 15).

(b)(7)(C) advised that to the best of his recollection, he did not conduct the HPCS repair and wanted to stand on his previous testimony provided to OI:RIV on November 14, 2007 (Exhibit 15).

Interview of (b)(7)(C) (Exhibit 16)

On November 15, 2007 (b)(7)(C) was interviewed at Green Bay, Wisconsin, by OI:RIV and related the following information in substance.

(b)(7)(C) related that on approximately June 15, 2007, he was asked by the (b)(7)(C) (b)(7)(C) and his supervisor (b)(7)(C) to provide some assistance, oversight, and support for the ongoing repairs to the HPCS pump discharge flange piping project to ensure the project was completed in a timely manner. (b)(7)(C) recalled he had come to work the morning of June 15, 2007, at approximately 5:30 a.m., and was asked if he could work the night shift from approximately 6 p.m. to 6 a.m., the same day, June 15, 2007 (Exhibit 16, pp. 9-12).

(b)(7)(C) related that at approximately 7 p.m. on June 15, 2007, it was determined the plan that was in place to correct the problem with the HPCS would not work. (b)(7)(C) stated the HPCS pump was located within a radiation contaminated area, and as this was his first day on the assignment, he believed the area was too congested to be able to effectively perform maintenance activities. (b)(7)(C) revealed that on this particular assignment, he was acting as (b)(7)(C) and the actual (b)(7)(C) Columbia. According to (b)(7)(C) he decided to have HP send a technician to clean up the area around the HPCS where the WPS workers had made a mess (Exhibit 16, pp. 14-18).

(b)(7)(C) advised that virtually everything the HP frisked from the HPCS area was clean of radiation contamination, and the items removed from the radiation contaminated area had no need for decontamination and could be used again for work if needed. (b)(7)(C) related the cleanup took place just prior to the actual incident in question, but he considered it to be part of the same flow of events. (b)(7)(C) related that one of the items removed during the cleaning

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of the contaminated area by the HP technician was a non-contaminated 3-ton nylon sling, which (b)(7)(C) had set aside with the thought that it might be needed later to try and spread the flange. (b)(7)(C) went on to describe the steps in determining how he planned to move the flange, and recalled engineer technicians came and authorized the use of approximately 3 tons of force on the flange. (b)(7)(C) advised he had a come-along rated for 3 tons, a nylon sling rated for 3 tons, and an additional nylon sling that had not been in the contaminated area (Exhibit 16, pp. 9-22).

(b)(7)(C) indicated that he looked over the survey map before going into the HPCS area, and was signed in on a general RWP, not the specific RWP, to his recollection, because his intent had been to never cross into the contaminated area. (b)(7)(C) was going to be in the vicinity, and the general RWP had all of the appropriate set points for providing coverage, and he had validated the set points with HPs. (b)(7)(C) stated that when it actually came time to pull on the pump, a nylon sling that was needed to attach to the pipe was not available. (b)(7)(C) advised that from a leadership standpoint, WPS employee supervisors (b)(7)(C) and (b)(7)(C) were standing in the area with him, and there were two or three millwrights [NFI] standing in the radiation contaminated area, and one or two support people [NFI] outside the contaminated area, all from WPS (Exhibit 16, pp. 23-24).

7c

(b)(7)(C) recalled that when he tasked the WPS millwrights to spread the flange, they turned to (b)(7)(C) and advised there was not a nylon sling in the radiation contaminated area and (b)(7)(C) then turned to (b)(7)(C) and (b)(7)(C) stated they needed to get an HP. (b)(7)(C) recalled stating, "Yes, we need an HP, go ahead and pass it on in. I'll authorize that and I'll take responsibility." (b)(7)(C) advised it was okay to pass the nylon sling that had been set aside earlier in [to the radiation contaminated zone] because the sling was going from a clean to a contaminated area, but in order to attach the chain fall, a portion of that sling looked like it was going to have to come out [of the radiation contaminated zone and into the non-contaminated area], a potential violation of the RWP. (b)(7)(C) remembers thinking it was okay, the sling was clean, and there is a possibility they won't have to do anything other than pass it in, slide the hook over it, and complete the task. However, according to (b)(7)(C) once he stated, "... I'll authorize that and I'll take responsibility," (b)(7)(C) turned to his WPS workers both inside and outside the radiation contaminated area and told them to go ahead and complete the task.

(b)(7)(C) reflected that in performing the task, the WPS workers were a little more aggressive than he had expected and their hands came across the boundary [into the radiation contaminated zone]. (b)(7)(C) advised he said nothing at the time and did not try and stop them (Exhibit 16, pp. 26-27).

(b)(7)(C) was asked to explain his statement "... I'll authorize that and I'll accept responsibility." (b)(7)(C) explained that virtually every RWP has a stipulation that any kind of reach-across be covered or be provided oversight and/or assistance via an HP technician. He did not want to wait for the HP technician to come in and provide the coverage needed because sometimes they came quickly and sometimes not so quickly. (b)(7)(C) related that his vision of risk on this particular job [with HPCS] would be for someone not to become contaminated, and he thought that based on the clean nylon sling, the possibility of contamination would not happen.

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(b)(7)(C) stated he was aware that violation of the RWP was also a procedural violation because it was standard procedure within the nuclear industry (Exhibit 16, pp. 26-30).

(b)(7)(C) advised he knew that not having the job completed by the time day shift showed up was not a smart thing to have happen because they had too many bad experiences with this particular pump. Furthermore, the job had been going on 10 days longer than needed.

(b)(7)(C) advised the pump repair was approaching what was called critical path or very close to critical path on the outage schedule (Exhibit 16, p. 31).

(b)(7)(C) advised he realized that if somebody became contaminated, he would have to answer why he had authorized the violation, and that was his mind set, right, wrong, or indifferent.

(b)(7)(C) recalled that the fact he was violating a Technical Specification and he was a

(b)(7)(C) never came into his mind. Additionally, (b)(7)(C) indicated he felt there was an extremely low risk of any personal contamination, based on the fact that the HP had earlier been in the HPCS area and cleaned it. (b)(7)(C) recalled the WPS individuals outside the contamination zone were the ones that did not have the protective clothing. They wore no gloves only street clothes, so the risk was to the individuals outside the area, not to the individuals inside the area. (b)(7)(C) could not recall the names of the WPS employees handling the nylon sling, but was sure it was no (b)(7)(C) or (b)(7)(C) (Exhibit 16, pp. 32-36).

(b)(7)(C) advised he did not convey through verbal tone or body language that the jobs of (b)(7)(C) or (b)(7)(C) might be on the line had they not obeyed his directions to complete the task. However, (b)(7)(C) indicated he had dealt with WPS before, was dissatisfied with the service, and did not feel like they [Columbia] were getting their dollar value (Exhibit 16, pp. 41-43).

(b)(7)(C) who has (b)(7)(C) experience, was questioned whether or not he was familiar with Technical Specification Section 5, 5.4.1. (b)(7)(C) reviewed the specification (Exhibit 5) and Energy Northwest Columbia Plant Procedures Manual, GEN-RPP-04 dated 9/28/07 (Exhibit 6), particular the paragraph that states, "Do not reach over or cross contaminated area boundaries without radiation protection approval, except to enter and exit the areas or to remove personal dosimetry, hard hat, hand tools, or measuring and test equipment from the area as described in Step 4.2.7, which is the subsequent step to 4.2.6." and (b)(7)(C) agreed that he did not comply and violated both the procedure and the Technical Specification (Exhibit 16, p. 51).

(b)(7)(C) advised that at the time of the incident, and probably not until the night that he wrote the CR (Exhibit 3) associated with this particular event, did he begin thinking and realized the depth, the severity or the significant nature of his decision-making related to the incident.

(b)(7)(C) confirmed that with (b)(7)(C) of experience in the nuclear industry, and positions as a (b)(7)(C) he knew what the procedures were and he was in violation of these two (Exhibit 16, p. 52).

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(b)(7)(C) was questioned regarding the general training that he had with Energy Northwest as a new employee and shown documents called Path to Plant Access Training and the RWT, dated July 1, 2006 (Exhibit 10). (b)(7)(C) advised he did not read the book because he had a good understanding of the material and acknowledged that he passed the training examination. (b)(7)(C) was shown documents dealing with the Protected Area Access training dated (b)(7)(C) Fitness For Duty/Behavior Observation training dated (b)(7)(C) and Radiation Worker Training, dated (b)(7)(C) (Exhibits 11), and acknowledged passing all three examinations (Exhibit 16, pp. 53-54).

(b)(7)(C) was shown a copy of CR No. (b)(7)(C) (Exhibit 3) and (b)(7)(C)

wrong. (b)(7)(C) (b)(7)(C) "While providing oversight on the high-pressure core spray pump flange repair, the night shift field engineer [that was me (b)(7)(C)] providing oversight for the high-pressure core spray flange repair inappropriately allowed a reach across a contaminated boundary without permission from the health physics organization. This is a violation of the RWP for the task. The immediate actions taken were that the individual discussed this issue with supervision. Further actions to be taken as necessary" (Exhibit 16, pp. 60-61).

(b)(7)(C) advised that the word "directed" may have been a better word to have used and explained that any time a member of management observes anything inappropriate, whether by direction or by allowance, they are authorizing the performance of that particular activity.

(b)(7)(C) indicated he gave authorization, whether it be tacit approval through not stopping the activity or by directing. However (b)(7)(C) did not recall making the statement, "No, do it now," and certainly did not recall being firm or intimidating in his use of the words, if they were used (Exhibit 16, p. 62).

(b)(7)(C) was provided with a copy of his resignation dated (b)(7)(C) (Exhibit 7), and confirmed he authored the resignation. (b)(7)(C) was also provided with a performance evaluation while at Energy Northwest from "7/1/06 to 6/30/07" (Exhibit 9), and confirmed his work with HPCS pump was recognized under his "additional achievements" (Exhibit 16, pp. 69-70).

(b)(7)(C) admitted that time pressure played a role during the HPCS incident, and he did not want to get stuck being used as an example of ineffectively executing a project for a work plan at one of their meetings either while personally present or in his absence (Exhibit 16, pp. 76-77).

Results of Screening Interviews (Exhibit 17)

On November 14 and December 31, 2007, telephonic screening interviews with (b)(7)(C) (b)(7)(C) and (b)(7)(C) were conducted by OI:RIV in an attempt to determine the former WPS employee responsible for the actual repair of the HPCS pump flange as directed by (b)(7)(C) and (b)(7)(C) all denied participation in performing the task as directed by (b)(7)(C) and could provide no additional information as to the individual who performed the repair on the HPCS pipe flange (Exhibit 17).

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Agent's Analysis

(b)(7)(C) was the (b)(7)(C) during the R-18 outage at Columbia, and he personally directed WPS employees to perform repair work on the HPCS pipe flange project. The direction given to both (b)(7)(C) and (b)(7)(C) supervisors WPS, to use a nylon sling tool from a non-contaminated area and cross a boundary by passing into a radiation contaminated area was in violation of Technical Specification 5, 5.4.1. and Columbia Procedures Manual, GEN-RPP-04, which clearly directs, "Do not reach over or cross a contaminated area boundaries without radiation protection approval . . . (b)(7)(C) admitted to having knowledge and understanding of both the specification and procedure, and to stating, "I'll authorize that and I'll accept full responsibility." Even after being informed by (b)(7)(C) that it was a violation, (b)(7)(C) denied (b)(7)(C) request to have an HP at the site to review the request and observe the procedure. Further, (b)(7)(C) admitted to not requesting an HP because it would further delay the repair, and he was already facing time pressure and was close to critical path on the outage schedule. (b)(7)(C) admitted that he did not want to be used as a personal example of ineffectively executing a project for a work plan at meetings.

7c. (b)(7)(C) attempted to mitigate his action by claiming that just prior to the incident, he had HP perform cleanup in the HPCS area and the nylon sling that was used by WPS employees to cross into a radiation contaminated area had previously been frisked and was determined to be clean. Further, once Columbia management learned of the incident (b)(7)(C) was directed to prepare a CR. (b)(7)(C) authored the CR to reflect that the field engineer "inappropriately allowed" a reach-across a contaminated boundary without the permission from HP. During the testimony of both (b)(7)(C) and (b)(7)(C) they recalled that they were "directed" by (b)(7)(C) to "Do it now" [referring to the task], and felt as if their jobs would be in jeopardy had they not complied with the (b)(7)(C) order. (b)(7)(C) denied the use of language that would lead (b)(7)(C) and (b)(7)(C) to believe their jobs were being threatened, but conceded that the CR could have been written better and the word "directed" would have more accurately reflected his instructions to (b)(7)(C) and (b)(7)(C) confirmed that with 30 years of experience in the nuclear industry and positions held as a (b)(7)(C) he knew the procedures and admitted to committing the violations.

Witness interviews were inconsistent as to who was involved in the incident (b)(7)(C) claiming that (b)(7)(C) performed the task, and (b)(7)(C) named (b)(7)(C) and (b)(7)(C) as the two WPS employees who completed the task. Testimony of (b)(7)(C) and (b)(7)(C) reflected they did not perform the task. While testimony from (b)(7)(C) reflected that it was neither (b)(7)(C) nor (b)(7)(C) he could not identify the WPS employees who actually performed the task. (b)(7)(C) and (b)(7)(C) testified they were present during the violation regarding the pump. Both heard (b)(7)(C) direct the crew to violate the procedure and that he would "accept full responsibility." In the end (b)(7)(C) with (b)(7)(C) experience, testified he understood the requirement and violated them anyway in an effort to save time.

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Conclusions

Based on the evidence developed during this investigation, the allegation that a (b)(7)(C) from Columbia deliberately directed WPS employees to violate required procedures was substantiated.

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SUPPLEMENTAL INFORMATION

On January 31, 2008, Barbara CORPREW, Associate Deputy Chief, Fraud Section, Criminal Division, U.S. Department of Justice, was apprised of the results of the investigation. Ms. CORPREW advised that, in her view, the case did not warrant prosecution and rendered an oral declination.

On November 15, 2007, during the interview of (b)(7)(C) by OI:RIV, it was revealed that (b)(7)(C) was presently employed as a (b)(7)(C)

7c (b)(7)(C) (b)(7)(C) advised that his supervisor, (b)(7)(C) had been made aware of the NRC investigation. (b)(7)(C) advised that to the best of his knowledge he had not falsified any documentation in order to gain employment with (b)(7)(C) (Exhibit 16, pp. 81-86).

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LIST OF EXHIBITS

<u>Exhibit No.</u>	<u>Description</u>
1	Investigation Status Record, dated October 15, 2007 (1 page).
2	Results of Interview with (b)(7)(C) dated November 14, 2007 (27 pages).
3	Energy Northwest CR No (b)(7)(C) (3 pages).
4	ECP Intake Form for (b)(7)(C) dated (b)(7)(C) (4 pages).
5	Technical Specification Section 5.0 Administrative Controls, 5.4 Procedures, undated (1 page).
6	Energy Northwest, Columbia Plant Procedures Manual, dated September 28, 2007 (27 pages).
7	Letter of resignation from (b)(7)(C) dated September 7, 2007 (1 page).
8	Letter from (b)(7)(C) accepting resignation of (b)(7)(C) dated September 10, 2007 (1 page).
9	Performance Plan for (b)(7)(C) dated July 1, 2006, to June 30, 2007 (14 pages).
10	Energy Northwest General Employee Training Manual, dated July 1, 2006 (154 pages). (Because of the volume of this exhibit, it will not be included. This exhibit will be maintained in the OI:RIV office and made available if requested.)
11	Energy Northwest Training Attendance Record for (b)(7)(C) dated (b)(7)(C) (3 pages).
12	Interview of (b)(7)(C) dated November 14, 2007 (20 pages).
13	Interview (b)(7)(C) dated November 14, 2007 (26 pages).
14	Interview (b)(7)(C) dated November 14, 2007 (26 pages).
15	Re-Interview (b)(7)(C) dated December 17, 2007 (1 page).
16	Interview of (b)(7)(C) dated November 15, 2007 (94 pages).
17	Results Screening Interviews, dated December 31, 2007 (1 page).

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