

EXECUTIVE SUMMARY

Vermont Yankee Nuclear Power Station NRC Inspection Report 50-271/99-07

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a six week period of routine activities by the resident inspectors assigned to the facility. In addition, reviews of selected maintenance and surveillance activities, and a review of the VY Quality Assurance program, were performed by resident inspectors from two other Region I sites.

Operations

- Appropriate control of safety systems, implementation of Technical Specification required actions, and adequate operability reviews for degraded equipment were observed during routine control room tours. (Section O1.1)
- The refueling mast sustained damage when the refueling bridge computer was used to direct movement of a fuel bundle out of the new fuel preparation machine, as was allowed by the operating procedure. Operators responded appropriately to the problem and the overall recovery was well planned and executed. (Section O1.2)
- VY's failure to develop an adequate procedure for operation of the refueling bridge is a violation of the Technical Specifications. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. The issue was entered in VY's corrective action program as ER 99-1019. (Section O1.2)
- A generally effective quality assurance program was being implemented. The use of annual functional area assessments in each department, followed by a general plant assessment, provided good information to VY management regarding overall station performance. Good interaction between the plant staff and the contracted QA group was evident. (Section O7.1)
- VY made progress in the trending of human performance errors and maintenance rework. Initial human performance training in early 1999 is being followed up with a second class, to be conducted just prior to the Fall 1999 refueling outage. The newly developed definition of maintenance rework encompassed most repeat work activities and was considered a positive initiative. (Section O7.1)

Executive Summary (cont'd)

Maintenance

- Routine maintenance and surveillance activities were performed well. A degraded condition identified during a high pressure coolant injection system surveillance was appropriately evaluated for operability impact and was then entered into the corrective action program for further evaluation. The replacement of a failed traversing in-core probe detector was carefully controlled, with good consideration of the radiological hazard. (Section M1.1)
- Operators performed the RCIC pump surveillance test well. The test acceptance criteria provided adequate margin to account for instrument loop uncertainty. (Section M1.2)
- The inspector concluded that in the licensee's tracking of open items resulting from the set point upgrade program calculations was weak. However, this concern had been previously identified by the licensee during a self-assessment and corrective actions were initiated. No operability problems were identified by the inspector and the licensee's review of similar calculations was scheduled to be completed by December 31, 1999. (Section M1.2)
- The initial 4 kV circuit breaker overhauls using a new preventive maintenance procedure were performed well. The procedure was adequate and incorporated corrective actions from evaluations of previous breaker failures at VY. Electrical maintenance personnel were knowledgeable of their activities and implemented proper verifications and peer checks.

Engineering

- As of September 16, 1999, VY completed Y2K Readiness Program activities for the systems required by NRC regulation and for those systems necessary for continued operation. The Security Computer, Plant Process Computer Software, and Refueling Platform remediation projects were completed ahead of the October 31, 1999 target date reported by VY in their response to Generic Letter 98-01. (Section E8.1)

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ATTACHMENTS

Attachment 1 - List of Acronyms Used

Attachment 2 - Items Opened, Closed, or Discussed

Report Details

Summary of Plant Status

Throughout most of the inspection period, the Vermont Yankee (VY) plant was operated at 100 percent power. During the period August 3-5, the plant operated in the range of 95-100 percent to support troubleshooting and repair of a hydraulic control unit valve. Power reductions were made on August 16, 26, and September 7 for control rod pattern adjustments and minor power reductions were made to support routine surveillance testing.

I. Operations

O1 **Conduct of Operations**¹

O1.1 Observation of Routine Plant Operations

a. Inspection Scope (71707)

The inspectors routinely toured the control room to assess the conduct of activities, verify safety system alignment, and verify compliance with Technical Specification (TS) requirements. Equipment deficiencies identified in control room logs were reviewed and discussed with shift supervision to evaluate both the equipment condition and the adequacy of VY's initial response to the issue.

b. Observations and Findings

No problems were identified with the status of plant safety equipment during the control room tours or review of Event Reports (ERs). A sample review of work orders and ERs found that the basis for operability of degraded equipment was adequately evaluated and documented.

c. Conclusions

Appropriate control of safety system alignment, implementation of Technical Specification required actions, and adequate operability reviews for degraded equipment were observed during routine control room tours.

O1.2 Refueling Mast Damaged During New Fuel Handling

a. Inspection Scope (71707)

On August 25, operators were moving new fuel bundles (non-irradiated) from the new fuel preparation machine to locations in the spent fuel pool in preparation for the 1999 refueling outage. During one move, the refueling mast made contact with the preparation machine and became pinched between the refueling bridge and the

¹Topical headings such as O1, M8, etc., are used in accordance with the NRC standardized reactor inspection report outline. Individual reports are not expected to address all outline topics.

this event, attended recovery planning meetings, and observed portions of the recovery actions on the refueling floor.

b. Observations and Findings

The refueling mast problem occurred when operators instructed the refueling bridge computer to move the bundle out of the preparation machine in the semi-automatic mode. The computer system is designed to move the refueling bridge and mast along the shortest path to the spent fuel pool location selected by the operators. During this event, the selected spent fuel pool location required the refueling bridge and mast to begin moving diagonally from the fuel preparation machine. Since the mast had not cleared the fuel preparation machine's structure, it became pinched between the refueling bridge and the fuel preparation machine. When this occurred, the operators immediately took manual control and stopped the refueling bridge.

The VY staff properly suspended the work activity, notified the control room and initiated an event report. A conservative recovery plan was developed and carefully implemented, with good management oversight. On August 26, the new fuel bundle was returned to the preparation machine without incident. Subsequent inspections of the fuel bundle found no problems, which was consistent with the bridge operator's observation that the fuel bundle had not come in contact with other equipment during the event. The refueling mast was removed from the bridge and required minor repairs.

The inspector determined the safety impact of this event was minimal because no fuel was damaged and potential consequences were bounded by design basis events described in Section 14.6 of the Final Safety Analysis Report.

Subsequent reviews by VY found that the design of the refueling bridge computer did not include the capability to move fuel from the fuel preparation machine in the semi-automatic mode. During the design of the system, it was expected that operators would use the manual mode to move fuel in and out of the fuel preparation machine. However, VY procedure OP 1100, Refuel Platform Operation, does not address this limitation or otherwise prohibit operators from using the semi-automatic feature to move fuel out of the preparation machine.

VY Technical Specification 6.4, Procedures, requires that written procedures be established, implemented, and maintained, covering maintenance activities and refueling operations. VY procedure OP 1100, Refuel Platform Operation, Revision 23, provides the instructions for operation of the refueling bridge. Contrary to the above, OP 1100 was inadequate because it allowed operators to use the semi-automatic function for moving fuel out of the preparation machine. This violation was entered in VY's corrective action program as ER 99-1019. **(NCV 99-07-01: Inadequate Procedure for Operation of Refueling Bridge)**

c. Conclusions

The refueling mast sustained minor damaged when the refueling bridge computer was used to direct movement of a fuel bundle out of the new fuel preparation machine, as was allowed by the operating procedure. Operators responded appropriately to the problem and the overall recovery was well planned and executed. However, VY's failure to develop an adequate procedure for operation of the refueling bridge is a violation of the Technical Specifications. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. The issue was entered in VY's corrective action program as ER 99-1019.

O7 Quality Assurance in Operations

O7.1 VY Quality Assurance Program Implementation

a. Inspection Scope (71707, 40500)

The inspector reviewed a sample of quality assurance program activities including audits and surveillances. Included in this review were the 1997/1998 Functional Area Assessment (FAA) and the related general plant assessment. As part of this inspection, interviews were held with the quality assurance manager and other VY management.

b. Observations and Findings

The quality assurance (QA) function at the site is implemented by a contractor, Duke Engineering and Services (DE&S). A staff of approximately five employees is maintained onsite, while additional resources are provided by an offsite pool of DE&S workers. Additionally, audit teams are staffed using a combination of industry peers and VY personnel. The planning and scheduling of audits is generally well controlled with good interaction between the QA personnel and plant staff. The inspector noted that mechanisms are in place to allow feedback from the plant staff to the QA group on the effectiveness of the audits. The inspector considered this a positive measure.

Each plant department conducts an annual self-assessment in which the results of the routine self-assessment activities are systematically analyzed for performance trends. The individual FAAs are collected and reviewed by the QA manager who, in turn, completes an annual general plant performance assessment. The inspector observed that this process should provide a good general plant level assessment and is a positive self assessment initiative.

The inspector reviewed the QA department's FAA for the period June 1997 to May 1998, in which QA conducted a self assessment of their own performance. A draft report of the current period was also reviewed. The inspector noted that these assessments are primarily focused on process, rather than on performance. Specifically, the assessments did not include performance oriented information with solid examples of strengths and weaknesses. The inspector discussed this observation with the QA manager who acknowledged the inspector's concern.

The inspector's review of past QA audits and surveillances covering other departments found that QA personnel were identifying some performance issues. For example, QA surveillance VY-98-53 identified that the overload trip associated with the reactor building crane load sensing capability was essentially bypassed during heavy load lifting activities. This problem was documented and corrected by the licensee (reference ER 98-0567). Also, Audit VY 98-11 identified engineering configuration control weaknesses during calculation reviews. This issue was also evaluated and corrected by the licensee (reference ER 98-2174).

The inspector reviewed previous NRC and licensee identified concerns such as human performance and maintenance rework trending. The technical support group issued the first quarterly ER trend report in May 1999. The report showed the most frequent causal factors involved self checking, use of procedures, and the quality of written procedures. The plant manager informed the inspector that numerous actions were taken to improve overall human performance. Phase one human performance training was completed in April 1999 and phase two training was scheduled for September 1999. In the area of maintenance rework, the licensee recently developed a formal definition. Although no trending data was yet available, the inspector noted that VY's definition of maintenance rework was detailed and included all extra iterations of work, not just those after the component was returned to service. The inspector considered this approach to be a strength that would be useful for future trending.

The inspector reviewed the 1998 Joint Utility Management Audit (JUMA) that focused on the QA services provided by DE&S. The onsite JUMA review was performed the week of October 5, 1998. The JUMA report concluded that VY provided effective oversight of the contracted QA organization. Also, the FAA process has led to improved self assessment by the line organizations. The JUMA review identified five strengths, no significant findings, and 16 recommendations for improvement. The inspector independently verified that the QA organization had entered the 16 recommendations into a tracking process to ensure completion. The majority of the JUMA recommendations had been incorporated and were completed. No problems were identified by the inspector relative to the corrective actions taken in response to the JUMA inspection.

c. Conclusions

A generally effective quality assurance program was being implemented. The use of annual functional area assessments in each department, followed by a general plant assessment, provides good information to VY management regarding overall station performance. Good interaction between the plant staff and the contracted QA group was evident.

VY has made progress in the trending of human performance errors and maintenance rework. Initial human performance training in early 1999 is being followed up with a second class, to be conducted just prior to the Fall 1999 refueling outage. The newly developed definition of maintenance rework encompassed most repeat work activities and was considered to be a positive step.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Routine Maintenance and Surveillance

a. Inspection Scope (62707, 61726)

The inspector observed portions of planned maintenance and surveillance activities to verify that correct procedures were used, applicable industry codes and Technical Specification requirements were satisfied, and that the status of plant equipment was properly controlled. When applicable, the tracking of equipment unavailability and component failures were reviewed against the VY program requirements for the Maintenance Rule.

b. Observations and Findings

The inspector observed all or portions of the following activities:

- Vital Bus motor-generator (MG) pedestal maintenance
WO 97-008606-018, observed September 8

Adequate measures were in place to prevent debris from reaching the vital MG that was created by cement grout removal. Temporary ventilation was used to take a suction on the general area and a worker used a vacuum cleaner to immediately clean up dust and debris from the chipping operation. Workers were wearing appropriate protective equipment. Radiological protection personnel were consulted prior to commencement of work.

- High pressure coolant injection (HPCI) system quarterly surveillance, observed August 31

This quarterly surveillance included an annual verification of the HPCI system startup time that was developed in response to vendor information (GE SIL 597). FSAR Section 6.4, states that HPCI will start and reach rated flow within 25 seconds of its initiation signal. During this surveillance the system's response time was 25.14 seconds. The licensee initiated event report, ER 99-1047, as a result of this test and an operability evaluation was performed. VY concluded that although the system was degraded, it continued to be operable. This determination was based on the Cycle 20 LOCA analysis (for 10 CFR 50.46 ECCS Acceptance Criteria) which assumed a 38.1 second delay for HPCI to begin delivering full flow. The inspector concluded that VY appropriately addressed the immediate operability concern and entered the deficiency in the corrective action program for further evaluation.

- Emergency diesel generator (EDG) surveillances, performed on August 23-24.

During the "B" EDG surveillance on August 24, an apparently spurious signal coincident with the EDG start resulted in a low water level indication at the condensate storage tank (CST). The low level indication caused the HPCI system logic to transfer the HPCI pump suction from its normal alignment (from the CST), to its alternate alignment (from the torus). Operators quickly identified the condition and restored the normal HPCI suction alignment. This event was appropriately captured by VY in their corrective action process and the HPCI system remained operable.

- Traversing In-Core Probe (TIP) Detector Replacement
WO 99-008992-001, performed on August 18

The inspector observed pre-job briefings and portions of the infield maintenance activity. Appropriate consideration was given to the potential complications that could occur or have arisen during the replacement of the detector and its follower cable. The Radiation Protection staff provided a good ALARA briefing and support during the maintenance. Oversight of the activity was provided by I&C supervision. No problems were identified by the inspector during observation of this activity.

c. Conclusions

Routine maintenance and surveillance activities were performed well. A degraded condition identified during a high pressure coolant injection system surveillance was appropriately evaluated for operability impact and was then entered into the corrective action program for further evaluation. The replacement of a failed traversing in-core probe detector was carefully controlled, with good consideration of the radiological hazard.

M1.2 Reactor Core Isolation Cooling Pump Surveillance Test

a. Inspection Scope (61726)

On September 2, the inspector observed portions of the reactor core isolation cooling (RCIC) pump quarterly surveillance test performed by Operations personnel per procedure OP 4121. The inspector walked down accessible portions of the RCIC system and reviewed the surveillance procedure to ensure it accurately captured the Technical Specification (TS) surveillance requirements. Additionally, the inspector interviewed field personnel and reviewed applicable system calculations.

b. Observations and Findings

Control room operators and field personnel communicated and coordinated the activities well. The inspector observed that no pressure boundary leakage existed on the accessible portions of the RCIC pump and its associated piping during this test. The

inspector also verified that the surveillance requirement acceptance criteria specified in TS Section 4.5.G were properly captured in the surveillance procedure (OP 4121).

Operations department personnel satisfactorily performed the surveillance procedure and the test acceptance criteria were met. The inspector reviewed a licensee calculation that evaluated the instrument loop accuracy associated with the flow measurement for this test. VYC-709, RCIC System Flow Control and Indication Loop Accuracy, demonstrated that when a value of 400 gpm is displayed by the instrument, the actual flow is at least 421 gpm. Based on this calculation, the inspector determined the 400 gpm acceptance criteria specified in OP 4121 was adequate.

During review of calculation VYC-709, the inspector noted that the 21 gpm flow margin was derived primarily by changing a previous assumption regarding the inside diameter (ID) of the flow orifice. Specifically, the engineers changed the orifice ID from 3.824 to 3.624 inches in the calculation after VY had determined that the orifice flange pipe was schedule 120, rather than schedule 80. At the time of this inspection, this assumption had not been formally validated. After discussions with the inspector, the licensee provided a reasonable justification for this calculation change based on the procurement document for the orifice and ultrasonic test results obtained during the week of September 13, 1999.

The inspector observed that the licensee had not entered the identified problem with calculation VYC-709 into a tracking system to ensure that it was formally revised and considered this to be a weakness in the approval process. After further discussion with engineering personnel, the inspector found that this concern had already been identified during a licensee self-assessment and was documented in event report, ER 99-0929, issued on August 5, 1999, by the Configuration Management Group. Based on interviews, the inspector verified that investigations and subsequent corrective action to close this ER will include generic implications regarding the set-point program calculations and open item tracking. Additionally, an AP 0028 Commitment has been opened for Design Engineering to review other calculations developed under the set point upgrade program for similar deficiencies. This licensee internal commitment is due December 31, 1999, and the inspector had no further questions.

c. Conclusions

Operators performed the RCIC pump surveillance test well. The test acceptance criteria provided adequate margin to account for instrument loop uncertainty.

The inspector concluded that in the licensee's tracking of open items resulting from the set point upgrade program calculations was weak. However, this concern had been previously identified by the licensee during a self-assessment and corrective actions were initiated. No operability problems were identified by the inspector and the licensee's review of similar calculations was scheduled to be completed by December 31, 1999.

M1.3 Standby Gas Treatment System (SGTS) Surveillance Testing

a. Inspection Scope (61726, 62707)

The inspector observed portions of a SGTS surveillance test on September 8, 1999. The test was performed to satisfy Technical Specification (TS) surveillance requirements 4.7.B.2.d and 4.7.B.1.b. The inspector also reviewed the test results, and applicable licensing and design documents.

b. Observations and Findings

The test was performed in accordance with operations procedure, OP 4117, "Standby Gas Treatment System Surveillance." The inspector reviewed the test results and identified the following concerns:

- The operators record operational data by rounding the measured parameter to the closest readable gage indication. During this test the operators rounded the measured bus voltage and the heater current reading up to the next highest gage indication. This introduced a non-conservative bias into the calculated heater power since it is proportional to the product of the bus voltage and the heater current. The licensee initiated event report (ER 99-1074) to review the methodology for reading gage indications.
- The licensee committed in the bases for TS 3.7 to periodically test the system to meet the intent of ANSI N510-1975. The ANSI N510 standard specifies that the heater power circuit will be checked with a "clamp on" ammeter, and also that the "balance between phases of a circuit shall be within 5% of one another." During this surveillance, the inspector noted that operators were using the installed bus current meters to measure the current to the SGTS heaters. Additionally, procedure OP 4117 did not require a comparison of the heater current readings to check the heater current phase balance. The licensee initiated ER 99-1075 to review the acceptability of using the installed current meters to measure the heater power, and the system engineer (SE) initiated an action to evaluate whether the current test method met the intent of the ANSI standard regarding checking the circuit phase balance.

The installed heater current meters are calibrated every 3 years, and have an "as left" calibration tolerance of +/- 0.5 amps. This could introduce a +/- 5 percent potential error into the heater power calculation and can be significant when the measured heater output is close to the TS minimum value. The measured "A" SGTS heater power during the test was close to the TS limit and the SE initiated a work request to check the heater current output using a clamp-on ammeter. The test methodology questions discussed above will remain unresolved pending the review of the licensee disposition of these issues. **(URI 99-07-02: SGTS Heater Testing and ANSI N510 Commitments).**

c. Conclusions

Several concerns were identified by the NRC during a Standby Gas Treatment System surveillance test. These included the adequacy of the of the surveillance procedure for the testing of the Standby Gas Treatment System heaters, and questions with regards to meeting the intent of ANSI Standard N510 contained in the TS Bases. These issues will be tracked as an unresolved item pending NRC review of the licensee's evaluation.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 4160 Volt AC Circuit Breaker Overhauls

a. Inspection Scope (62707)

On August 31, the inspector observed portions of electrical maintenance activities for overhauling two spare 4160 volt (4 kV) circuit breakers. This activity is part of a newly implemented breaker overhaul program. The inspector interviewed personnel, reviewed the procedure (OP 5227), and independently inspected the breakers.

b. Observations and Findings

The 4 kV circuit breakers used at VY are Magne-blast circuit breakers manufactured by General Electric. A total of thirty-seven breakers of this type are installed in VY's vital and non-vital 4 kV busses. The breakers are used as power supply breakers to plant engineered safety features components, as well as for distribution isolation breakers in VY's vital electrical distribution system.

The overhaul activities observed by the inspector involved work on two of six newly procured spare breakers which VY plans to use as replacement breakers during the upcoming refueling outage. At the time of the inspection, electrical maintenance personnel had completed overhauls on two of these breakers. The spare breakers were procured as "used" breakers from another nuclear power station. Only one of these breakers was originally manufactured as safety related; the remaining five were commercially dedicated by Vermont Yankee.

The new 4 kV breaker overhaul activities were performed well. The inspector found the overhaul procedure to be adequate and to have incorporated corrective actions from evaluations of previous breaker failures at VY. Electrical maintenance personnel were knowledgeable of their activities and implemented proper verification and peer checking. The technicians properly identified potential procedure improvements to the maintenance engineer.

The inspector learned that technicians had identified some failed components on two of the four breakers previously overhauled. Specifically, two days prior, the workers found that one of the breakers had a broken number 2 prop spring and a cracked spring discharge mechanism roll pin. Two weeks earlier, a cracked roll pin had also been identified.

The inspector noted that the system engineer was aware of these issues and had determined that no operability concern existed. Specifically, the engineer stated that the number 2 prop spring was a manufacturer's modification incorporated into newer breaker's design and did not apply to the existing VY breakers. Additionally, the engineer determined that the degraded roll pins provide only a personnel protection function and therefore, their failure would not have affected the operability of the breakers.

c. Conclusions

The initial 4 kV circuit breaker overhauls using a new preventive maintenance procedure were performed well. The procedure was adequate and incorporated corrective actions from evaluations of previous breaker failures at VY. Electrical maintenance personnel were knowledgeable of their activities and implemented proper verifications and peer checks.

M8 Miscellaneous Maintenance Issues

M8.1 Review of LERs Related to Maintenance (90712)

An in-office review of the Licensee Event Report (LER) listed below was performed to determine whether further NRC actions were required. The adequacy of the overall event description, immediate actions taken, cause determination, and corrective actions were considered in making this determination.

(Closed) LER 98-06-01: Inadequate Maintenance Procedure for Safety Class Breakers Establishes Condition Which Could Have Led to the Failure of Multiple Safety Class Breakers

The original LER and the licensee's immediate corrective actions were previously reviewed and closed in NRC Inspection Report 50-271/98-10. The supplemental LER 98-06-01 revised the expected completion dates for two of the long term corrective actions. The 4 kV breaker overhaul program is currently in progress and an NRC inspection of this activity has been performed (see Section M2.1). No additional NRC follow up for this issue is necessary and the supplemental LER is closed.

III. Engineering

E8 Miscellaneous Engineering Issues

E8.1 Remediation of Computer Systems for Year 2000 Rollover

a. Inspection Scope (TI 2515/141)

Vermont Yankee responded to Generic Letter 98-01, "Year 2000 Readiness of Computer Systems at Nuclear Power Plants," in letters dated June 28, 1999 and June 29, 1999. The licensee identified three systems that were not expected to be Year 2000 (Y2K)

ready as of July 1, 1999. This inspection was performed to verify the licensee's completion of Y2K activities for these three systems.

b. Observations and Findings

The voluntary response provided by VY for GL 98-01 identified the Security Computer, Refueling Platform, and Plant Process Computer as systems which still required remediation as of July 1, 1999. The planned completion date for all three systems was listed as October 31, 1999. The remediation projects and testing were completed as follows:

<u>System Requiring Remediation</u>	<u>Actual Project Completion Date</u>
Security Computer	August 23, 1999
Plant Process Computer Software	August 31, 1999
Refueling Platform	September 16, 1999

The inspector reviewed a closeout package prepared by VY for each remediation project. Validation testing was performed for each system, demonstrating that the systems will not fail during the Y2K rollover.

c. Conclusions

As of September 16, 1999, VY completed Y2K Readiness Program activities for the systems required by NRC regulation and for those systems necessary for continued operation. The Security Computer, Plant Process Computer Software, and Refueling Platform remediation projects were completed ahead of the October 31, 1999 target date reported by VY in their response to Generic Letter 98-01.

E8.2 Administrative Closure of Items Related to Engineering

The following open items were closed based on the licensee's having entered the issues into their corrective action program. Because no violations of NRC requirements were identified during the initial NRC review of these issues, no additional followup is planned.

IFI 97-05-05: HPCI Suction Appendix J Program Weakness

IFI 97-05-06: Primary Containment Coating Qualification

V. Management Meetings

X1 **Exit Meeting Summary**

The resident inspectors met with licensee representatives periodically throughout the inspection and following the conclusion of the inspection on October 6, 1999. At this meeting, the purpose and scope of the inspection was reviewed, and the preliminary findings were presented. The licensee acknowledged the preliminary inspection findings.

The inspector asked the licensee whether any material examined during the inspection should be considered proprietary. No proprietary information was identified.

LIST OF ACRONYMS USED

ALARA	As Low As Reasonably Achievable
CFR	Code of Federal Regulation
CST	Condensate Storage Tank
ECCS	Emergency Core Cooling System
EDG	Emergency diesel generator
ER	Event Report
FAA	Functional Area Assessment
FSAR	Final Safety Analysis Report
GE	General Electric
HPCI	High Pressure Coolant Injection
I&C	Instrumentation and Control
IFI	Inspection Follow-up Item
JUMA	Joint Utility Management Audit
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
QA	Quality Assurance
RCIC	Reactor Core Isolation Cooling
RP	Radiation Protection
SGTS	Standby Gas Treatment System
SIL	Service Information Letter
TS	Technical Specifications
VY	Vermont Yankee

ITEMS OPENED, CLOSED, OR DISCUSSED

OPENED

URI 99-07-02: SGTS Heater Testing and ANSI N510 Commitments (page 8)

CLOSED

LER 98-06-01: Inadequate Maintenance Procedure for Safety Class Breakers Establishes Condition Which Could Have Led to the Failure of Multiple Safety Class Breakers (page 10)

IFI 97-05-05: HPCI Suction Appendix J Program Weakness (page 11)

IFI 97-05-06: Primary Containment Coating Qualification (page 11)

NON-CITED VIOLATIONS

NCV 99-07-01: Inadequate Procedure for Operation of Refueling Bridge (page 2)