

SieneI, Beth

From: Bronson, Kevin
Sent: Tuesday, March 02, 2004 12:25 PM
To: VTY - All Users
Subject: Yellow Memo on Tubing Failure during HPCI surveillance

Please open and read the Yellow memo attached, and discuss within your work areas how this can apply to you.

There are multiple opportunities for lessons learned and improvements.

Thanks, Kevin

(Remember, Safety and Quality first and foremost!)

A-171

Yellow Memo

March 2, 2004

Memorandum: Vermont Yankee Personnel
From: Kevin Bronson, General Manger Plant Operations
Subject: Use of Incorrect Tubing during HPCI Surveillance

The Event:

Condition Report 2004-0436 identified the use of incorrect instrument tubing during the HPCI pump surveillance performed on February 26, 2004. **White plastic tubing with a nominal rating of approximately 700 psig was used in a system with an operating pressure of approximately 1100 psig.**

To support the pump surveillance, a high pressure discharge pressure test gauge was connected at an instrument rack using the plastic instrument tubing. When the Auxiliary Operator valved in the test gauge for the first time, a small pinhole leak developed and was immediately isolated. The test gauge line was replaced with identical tubing and when the gauge was valved in the second time, the tubing split and the Operator was wetted slightly. The test line was then isolated. I&C obtained the proper tubing, and the surveillance was completed.

What went right?

- RP was present at the job site.
- The operator notified the control room after experiencing the first tubing leak.

What went wrong?

- The tubing failure posed an **industrial safety threat** to the operator and other personnel in the area.
- Operations **did not exhibit a strong questioning attitude** after the initial leak was identified. They assumed that the tubing was defective.
- There is **no formal process** to identify the pressure rating of temporary instrument tubing.
- The HPCI pump was operated longer then necessary, resulting in unnecessary water inventory being sent to Radwaste.

Where did we get lucky?

- No personnel were injured or contaminated.
- No plant equipment was damaged.

What's the message?

We cannot depend upon luck to keep us safe. We cannot depend upon luck to keep us error-free. The failure of test equipment due to over pressurization poses a serious industrial safety threat. We must **PAY ATTENTION**. We must capitalize upon our **KNOWLEDGE AND TRAINING**. Furthermore, we must employ a strong **QUESTIONING ATTITUDE** at all times to ensure that we're doing the right thing in the right manner.