Vermont Yankee
2Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Nov 18, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Vermont Yankee Personnel did not Perform an Adequate Cause Evaluation for a Condition Adverse to Quality.
A very low safety significance, self-revealing non-cited violation was identified because Vermont Yankee personnel did not adequately evaluate the cause(s) in regards to a 2002 spurious high pressure coolant injection (HPCI) system suction realignment from the condensate storage tank to the the suppression pool (torus). As a result, the cause of the spurious actuation (i.e., degarded condensate storage tank (CST) low level alarm units) remained uncorrected and additional spurious actuations occurred in 2005.

The finding is greater than minor because it is associated with the Equipment Performance Attribute of the Mitigating Systems Cornerstone and because it affects the associated Cornerstone Objective. Specifically, not identifying and correcting the cause of the 2002 spurious HPCI system suction realignment reduced the reliability of a system that responds to initiating events to prevent undesirable consequences. The inspectors determined that the finding is of very low safety significance becuase it is not a design or qualification deficiency; does not represent a loss of system safety function; and does not screen as potentially risk significant due to a a seismic, flooding, or severe weather initiating event.

A contributing cause of this finding is related to the cross-cutting element of problem identification and resolution (PI&R). VY personnel did not adequately evaluate the cause(s) of the 2002 spurious HPCI system suction realignment. As a result, the cause of the spurious actuation remained uncorrected and additional spurious actuations occurred.
Inspection Report# : 2005005*(pdf)*

Significance: G Nov 04, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Entergy did not Maintain an Adequate Procedure for the Operation of the Reactor Protection System.
A very low safety significance, self revealing non-cited violation was identified because Entergy did not maintain an adequate procedure for the operation of the reactor protection system (RPS). Specifically, system interdependencies between the RPS and the primary containment isolation system (PCIS) were not accurately described in Vermont Yankee Operating Procedure (OP) 2134, "Reactor Protection System." Lack of an adequate procedure left operators unaware of the fact that transferring the "A" RPS bus power supply concurrent with having the breaker for the "B" channel of PCIS logic tagged open for maintenance would result in an actuation of PCIS including a Group 4 shutdown cooling isolation, which ultimately occurred resulting in a loss of shutdown cooling for approximately 18 minutes.

The finding is more than minor because it is associated with the Mitigating Systems Cornerstone Attribute of Equipment Performance and affects the Cornerstone objective of ensuring the availablity, reliability, and capability of systems that respond to an initiating event to prevent undesirable consequences; in this case, an isolation of shutdown cooling resulting in maintaining less than one loop of residual heat removal in shutdown cooling operation. The finding is of very low safety significance because it did not increase the likelihood of a loss of reactor coolant system (RCS) inventory or degrade Entergy's ability to terminate a leak path or add RCS inventory if needed.

A contributing cause of this finding is related to the cross-cutting element of human performance. Entergy did not maintain an adequate procedure for the operation of the RPS. The procedure did not describe system interdependencies between the RPS and PCIS. As a result, during the transfer of power supplies for the "A" RPS bus, a PCIS Group 4 isolation was inadvertently initiated which isolated shutdown cooling (SDC).
Inspection Report# : 2005005*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Sep 29, 2005
Identified By: NRC
Item Type: FIN Finding
Results of Biennial Problem Identification and Resolution Inspection
The team determined that implementation of the corrective action program (CAP) at Vermont Yankee was generally good. The team determined that Entergy was effective at identifying problems and entering them in the CAP. Once entered into the system, the items were screened and prioritized in a timely manner using established criteria. Items entered into the CAP were properly evaluated commensurate with their safety significance. The causal evaluations for equipment issues/events and for human performance/process issues reasonably identified the causes of the problems and developed appropriate corrective actions. Corrective actions were typically implemented in a timely manner.
Inspection Report# : 2005006*(pdf)*

Last modified : August 25, 2006