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EM

Christopher J. Wamser
Site Vice President

BVY 12-004

January 20, 2012

ATTN: Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, DC 20555-0001

SUBJECT: Licensee Event Report 05000271/2011-002-00, Inoperability of Both Emergency Diesel Generators due to a Lack of Adherence to Procedures
Vermont Yankee Nuclear Power Station
Docket No. 50-271
License No. DPR-28

Dear Sir or Madam:

As defined by 10CFR50.73(a)(2)(v)(D) we are submitting the attached Licensee Event Report, LER 05000271/2011-002-00.

There are no new regulatory commitments contained within this correspondence.

Should you have any questions concerning this letter, please contact Mr. Robert J. Wanczyk at (802) 451-3166.

Sincerely,

[CJW/JMD]

STATE OF VERMONT
DEPT. OF PUBLIC SERVICE
MONTPELIER, VT.
05620-2601
2012 JAN 24 A 9:15

Attachment: LER 05000271/2011-002-00, Inoperability of Both Emergency Diesel Generators due to a Lack of Adherence to Procedures

cc list: (next page)

cc: Mr. William M. Dean
Region 1 Administrator
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406-1415

Mr. James S. Kim, Project Manager
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, DC 20555

USNRC Resident Inspector
Vermont Yankee Nuclear Power Station
320 Governor Hunt Road
Vernon, VT 05354

Ms. Elizabeth Miller
Commissioner
VT Department of Public Service
112 State Street, Drawer 20
Montpelier, VT 05620-2601

LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F55), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Vermont Yankee Nuclear Power Station	2. DOCKET NUMBER 05000271	3. PAGE 1 of 3
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4. TITLE
Inoperability of Both Emergency Diesel Generators due to a Lack of Adherence to Procedures

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	02	2011	2011	002	00	01	20	2012	N/A	N/A

9. OPERATING MODE N	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)			
	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)
10. POWER LEVEL 100	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(D)	

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Michael Gosekamp, General Manager Plant Operations	TELEPHONE NUMBER (Include Area Code) (802) 257-7711
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If Yes, complete EXPECTED SUBMISSION DATE). <input checked="" type="checkbox"/> NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On December 2, 2011, with the plant at 100 percent power, Vermont Yankee (VY) was modifying the tagging lineup on the "B" Emergency Diesel Generator (EDG) that was out of service for scheduled maintenance. During the tagging evolution, an operator mistakenly entered the "A" EDG room and tripped the "A" EDG fuel rack making the "A" EDG inoperable. This resulted in both EDGs being inoperable requiring entry into a 24 hour limiting condition for operation. This event is reported in accordance with 10CFR50.73(a)(2)(v)(D) as an event or condition that could have prevented the fulfillment of a safety function since both EDGs were inoperable. The investigation determined that this event was caused by a lack of adherence to procedures that provide administrative controls over tagging evolutions and direct the use of human performance tools to prevent occurrence of this type of an event. The condition was immediately identified by operations personnel due to alarms received in the main control room and the "A" EDG was returned to operable status in two minutes. There were other sources of AC power available and therefore, this event did not pose a threat to public health and safety.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form (366A))

Description of Event

On December 2, 2011, with the plant at 100 percent power, Vermont Yankee (VY) was modifying the tagging lineup on the "B" Emergency Diesel Generator (EDG) (EIS=EK) that was out of service for scheduled maintenance. The 4KV cables that connect the "B" EDG to the safety bus were being replaced. During the tagging evolution, an operator mistakenly entered the "A" EDG room and tripped the "A" EDG fuel rack making the "A" EDG inoperable. This resulted in both EDGs being inoperable and required entry into a 24 hour limiting condition for operation.

This event is reported in accordance with 10CFR50.73(a)(2)(v)(D) as an event or condition that could have prevented the fulfillment of a safety function.

Cause of Event

The investigation determined that this event was caused by a lack of adherence to procedures that provide administrative controls over tagging evolutions and direct the use of human performance tools to prevent occurrence of this type of an event.

Analysis of Event

The safety objective of the Station Auxiliary Power System, described in Updated Final Safety Analysis Report, Section 8.4, is to provide a reliable power supply for the starting and operation of engineered safety feature loads during and following design basis accidents. Normal power is supplied through the unit auxiliary transformer which is supplied by the main station generator. An alternate off-site supply is provided via the start-up transformers from the off-site 345/115kV transmission systems and the ability to back-feed the station through the main transformer. In addition to the normal off-site power sources, a station blackout source from the Vernon Hydroelectric Station (VHS) can be manually aligned to supply adequate capacity to support safe shut down of the station. Plant analysis demonstrates that the plant can cope with a complete loss of normal and back up EDG power for up to two hours.

During this event, the "B" EDG was inoperable for planned maintenance and the "A" EDG was inoperable for approximately two minutes. The normal and alternate power sources as well as the VHS were available while the "A" EDG was inoperable. The condition was immediately identified by operations personnel due to alarms received in the main control room and the "A" EDG was returned to operable status in approximately two minutes. There were other sources of AC power available and therefore, this event did not pose a threat to public health and safety.

Corrective Actions

- 1) The "A" EDG was returned to operable status in two minutes.
- 2) The qualifications of the individuals directly involved were removed until restored by station management.
- 3) All operating shifts were briefed on the details of the incident.

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17. NARRATIVE *(If more space is required, use additional copies of NRC Form (366A))*

- 4) Procedure changes and training are planned to consolidate, clarify and reinforce management expectations related to the lessons learned from this event.

Previous Similar Events

No previous similar tagging events that resulted in the loss of a safety function have been reported in the last 5 years.