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March 15, 2012

William Dean, Regional Administrator
U.S. NRC, Region 1
475 Allendale Road
King of Prussia, PA 19406-1415

RE: Incidents at Vermont Yankee

Dear Mr. Dean:

I am writing to express my concern regarding the number of incidents at the Vermont Yankee Nuclear Power Station within the last 15 months that have some relationship to human performance errors. I have reviewed NRC reports and a recent event and have compiled the enclosed list. I understand that NRC has found all of the reviewed events to constitute non-cited violations, and I further understand that the recent event listed may or may not qualify for NRC investigation or citation; nevertheless I am requesting from the NRC an explanation regarding why the pattern of incidents does not rise to a level that would justify additional oversight or other response from the NRC. I look forward to hearing from you.

Very truly yours,

A handwritten signature in black ink, appearing to read "Elizabeth H. Miller". The signature is fluid and cursive, with a large loop at the end.

Elizabeth H. Miller
Commissioner

Enclosure

cc: Christopher J. Wamser



Significance: **G** Jan 02, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Foreign Material Exclusion Procedure

The finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Practices component, because Entergy personnel did not follow EN-MA-118. Specifically, they did not establish a FME Zone 1 after the system closeout inspection.

Inspection Report# : [2011002 \(pdf\)](#)

This event was when VY was replacing a pump in the Residual Heat Removal Service Water (RHRSW) system and they failed to remove the plastic cover on the pump (which prevents material from getting in it) before installing it.

Significance: **G** Feb 16, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Steam Leak on High Pressure Coolant Injection (HPCI) During Surveillance Testing

This finding had a cross-cutting aspect in the Human Performance cross-cutting area, Decision Making component, because Vermont Yankee personnel did not obtain interdisciplinary input on the decision to use a different, incorrect gasket material in a steam trap in the HPCI system.

This event was when VY Maintenance substituted another gasket material than the material replaced when working on the High Pressure Coolant Injection System (HPCI) steam trap without checking with Engineering resulting in a steam leak.

Inspection Report# : [2011002 \(pdf\)](#)

Significance: **G** Oct 11, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Loss of Shutdown Cooling due to Tag Out Error

The inspectors determined that this finding had a cross-cutting aspect in the Human Performance cross-cutting area, Resources component, because components in the tagging database were not labeled correctly [H.2(c)].

Inspection Report# : [2011005 \(pdf\)](#)

This event occurred because a drawing/schematic was of poor quality; when it was misread, it resulted in designating a tag-out order on the wrong breaker resulting in the loss of shutdown cooling for 12 minutes.

Significance: **G** Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadvertent Trip of an Emergency Diesel Generator's Fuel Rack

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance, work practices component, because Entergy did not ensure supervisory oversight of work activity such that nuclear safety was supported [H.4(c)].

Inspection Report# : [2011005 \(pdf\)](#)

This event was when an auxillary operator mistakenly tripped the "A" Emergency Diesel Generator (EDG) fuel rack when the tag-out order was for the "B" EDG.

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Incomplete Inventory for Spent Resin Shipment

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance, work control component, because Entergy did not appropriately coordinate work activities by incorporating actions to address the need for interdepartmental coordination and communication. Specifically, the impact of flushing a reactor water cleanup resin transfer line by the ALARA group on the radwaste shipping group was not sufficiently communicated or coordinated to ensure all solid radioactive wastes discharged from the plant into the waste container were accounted for in a subsequent radioactive waste shipment [H.3(b)].

Inspection Report# : [2011005 \(pdf\)](#)

This event was associated with a shipment of radioactive resins (on September 19, 2011) where the dose rate of the liner was not measured properly and the accounting of radioactivity was incorrect.

Recent event not reflected in NRC report:

Deck Plate left in Condenser after completion of RFO 29

On March 5, 2012 VY down-powered to troubleshoot ongoing above normal condenser back pressure and discovered that a deck plate used during RFO29 for condenser maintenance had not been removed and was restricting the flow in inlet #2 to some degree. This was a failure to follow procedures to prevent Foreign Material Exclusion (FME). The back pressure levels in the condenser continued to register above normal after the removal of the deck plate and VY is conducting further investigation into the reason(s) and solution(s).