

MEMORANDUM

TO: VSnap Members

FROM: Elizabeth H. Miller, Commissioner

DATE: December 9, 2011

SUBJECT: VY Plant Incident Reports

Loss of Shutdown Cooling Root Cause Report

On October 11, 2011, several days into the refueling outage at VY, during a tagging order (R29-AOG-016) a partial loss of vital AC occurred which resulted in loss of "A" loop Residual Heat Removal (RHR) shutdown cooling. The tag-out order noted the wrong breaker to be opened. Shutdown cooling was restored 11 minutes later. Reactor Pressure Vessel and coolant temperatures increased 1-2 F. (One decay heat removal system remained functional to remove decay heat to maintain the fuel pool temperature.) This event was entered into the VY correction action program as CR-VTY-2011-4203 where a root cause analysis was conducted and completed on November 15, 2011. This event required a 60 day telephone notification to the NRC which VY conducted on December 6, 2011 per 10CFR50.73(a)(2)(iv)(A).

The primary root cause was found by the plant to be that the tag-out preparer was misled by the lack of clarity in and between the Control Wire Drawing and the eSOMS equipment description of the breaker load used to develop the tag out. (eSOMS (Electronic Shift Operations Management System) is a computer database that includes a tagging module...it is the main computer database for the plant). Several contributing causes were identified where the required independent reviewer was not "independent" from the individuals who were involved with the development of the tag-out order.

This is the first time a tag-out order was prepared for this piece of equipment; most equipment in the plant has been tagged-out in the past forty years and has a master tag-out list. The error contained in the eSOMS program could be extended to other power feeds to sub panels. Therefore corrective actions were assigned to address all power feeds to the sub-panels.

Trip of "A" Emergency Diesel Generator with "B" EDG inoperable

Another tag-out issue occurred on December 2, 2011, while the "B" Emergency Diesel Generator (EDG) was tagged-out. Under a scheduled LCO for cable replacement, an Auxiliary Operator (AO) was dispatched to the "B" EDG room to trip the fuel rack on the "B" EDG which cuts off the fuel supply to the engine. However, instead of conducting the operation on the "B" EDG, the AO went to the "A" EDG room instead and performed the operation there which made the "A" EDG inoperable setting off an alarm in the control room where the operators identified the problem and corrected it so the "A" EDG was operable again. The "A" EDG was declared inoperable for 2 minutes, but since the "B" EDG was not

available either, this was reportable to the NRC within an 8 hour window. (When both EDGs are inoperable that places the plant into a 24 hour LCO per tech specs.)

A root cause analysis is being conducted on this event, but a preliminary look at the causes and precursors reveals that several procedures were not followed. Plant personnel have been notified by plant management that this event could have been prevented if procedures were followed.

We will follow up with NRC regarding whether there is a common thread between the two events where procedures in place to tag-out equipment were not followed.