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July 31, 2008
BVY 08-045

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

**Subject: Vermont Yankee Nuclear Power Station
License No. DPR-28 (Docket No. 50-271)
Reportable Occurrence Number: LER 2008-001-00**

Dear Sir or Madam,

As defined by 10 CFR 50.73(a)(2)(i)(B), we are submitting the attached revised Licensee Event Report, LER 2008-001-00, for a Reportable Occurrence that was discovered on June 10, 2008.

There are no regulatory commitments contained within this correspondence.

If there are any questions regarding this letter please contact Mr. David Mannai at (802) 451-3304.

Sincerely,


Ted A. Sullivan
Site Vice President
Vermont Yankee Nuclear Power Station

cc: (next page)

IE22
NRR

cc: Mr. Samuel J. Collins
Regional Administrator, Region 1
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406-1415

Mr. James S. Kim, Project Manager
U.S. Nuclear Regulatory Commission
Mail Stop O8C2A
Washington, DC 20555

USNRC Resident Inspector
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Mr. David O'Brien, Commissioner
VT Department of Public Service
112 State Street – Drawer 20
Montpelier, Vermont 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 F52), 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 05000-271	3. PAGE 1 of 3
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4. TITLE
Crane Travel Limit Stops not Installed as Required by Technical Specifications due to an Inadequate Procedure

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
06	10	2008	2008	-- 001 --	00	07	31	2008	None
									DOCKET NUMBER
									None

9. OPERATING MODE N	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)				
10. POWER LEVEL 100%	<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)	
	<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 checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A	

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Chris Wamser, 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
NA					NA				

14. SUPPLEMENTAL REPORT EXPECTED	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
YES (If Yes, complete EXPECTED SUBMISSION DATE). X NO				

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

On 06/10/08, with the reactor at 100 percent power, Vermont Yankee (VY) identified that the reactor building crane travel limit mechanical stops were not installed in accordance with Technical Specification (TS) 4.12.G.2 "Crane Travel". TS 4.12.G.2 requires crane travel limit mechanical stops to be installed during cask handling operations to prohibit movement of the cask over irradiated fuel. VY was performing dry fuel storage activities and had just removed a loaded spent fuel cask from the spent fuel pool. The cask was suspended above the refuel floor adjacent to the spent fuel pool. Once the cask is removed from the fuel pool, the crane limit mechanical stops need to be rearranged to prohibit movement over fuel assemblies in the fuel pool. The reactor building crane was de-energized and the crane travel limit mechanical stops were rearranged. Subsequently, VY determined that the sequence that the stops were removed and reinstalled did not comply with the requirements of the TS. There were no personnel or public safety implications because the crane was de-energized during the period of time the travel stops were rearranged and VY personnel were providing oversight of the evolution. The event was determined to be the result of an inadequate procedure. The procedure has been revised to address the identified weaknesses. No release of radioactivity or personnel injury occurred as a result of this event. No similar events have occurred in the last 5 years. This event is reportable as a Licensee Event Report per 10CFR50.73(a)(2)(i)(B) as a condition that is prohibited by TS.

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

DESCRIPTION

On 06/10/08, with the reactor at 100 percent power, Vermont Yankee (VY) identified that the reactor building crane (EISS=DF) travel limit mechanical stops were not installed in accordance with Technical Specification (TS) 4.12.G.2 "Crane Travel". TS 4.12.G.2 requires "Crane travel limit mechanical stops shall be installed on the crane trolley rails prior to cask handling operations to prohibit cask travel over irradiated fuel assemblies."

VY was performing dry fuel storage (DFS) activities and had just removed a loaded cask from the spent fuel pool. The cask was suspended over the refuel floor adjacent to the spent fuel pool. Once the cask is removed from the pool there is a need to rearrange the crane travel limit mechanical stops to provide a means to prohibit movement of the cask over irradiated fuel. To prepare for this the refuel crane was de-energized and the stops were rearranged. The procedure provided the sequence that the stops were to be installed and removed to comply with the station Technical Specifications but provided allowance for performing steps out of sequence as allowed by the DFS supervisor. The DFS Supervisor decided that the order that the stops were installed was not significant since the crane was de-energized.

VY subsequently determined that the sequence that the crane travel limit mechanical stops were removed and reinstalled did not comply with the requirements of the TS in that there was a time, with the cask suspended, where the crane travel limit mechanical stops were not installed to prohibit travel over the fuel. It was determined that having the crane de-energized did not satisfy the TS requirement to have mechanical travel limit stops installed.

This event is reportable as a Licensee Event Report per 10CFR50.73(a)(2)(i)(B) as a condition that is prohibited by TS.

CAUSE

Root Cause:

The cause was determined to be a lack of sufficient detail in the procedure controlling the activity. The procedure did not provide adequate emphasis that the specific steps be performed in the required sequence to ensure compliance with the station Technical Specifications.

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

ASSESSMENT OF SAFETY CONSEQUENCES

The intent of the Technical Specifications, related to handling spent fuel casks, is to provide a means to prohibit movement of a spent fuel cask over spent fuel assemblies stored in the fuel pool. During the time the crane travel limit mechanical stops were being rearranged, the reactor building crane was de-energized. The crane was suspended adjacent to the fuel pool over an area that was evaluated to handle the weight of the loaded cask. VY personnel were in the area monitoring the evolution and in contact with the crane operator. There was no movement or intended movement of the cask during the period of time the stops were being re-arranged. At all times while the stops were being relocated the crane was de-energized and administrative barriers were in place to prohibit cask movement over the irradiated fuel assemblies. Consequently, the event did not have an adverse impact on the health and safety of the public.

CORRECTIVE ACTIONS

Immediate Actions

- 1) Ensured that current DFS qualified personnel were trained on what constitutes "cask handling operations" and how to comply with TS 4.12.G.2 requirements.
- 2) Ensured that all TS related steps in dry fuel storage procedures will be performed in the sequence written.
- 3) As an interim action, the specific controlling procedure was revised to require steps to be performed out of sequence to require the approval of the DFS Project Manager and to require TS required steps to be performed in the order specified.

Long Term Corrective Actions

- 4) Ensure that future DFS training includes a discussion of this operating experience and address the impact of following the subject steps to ensure compliance with the TS.
- 5) Revise DFS procedures to eliminate the ability to perform any step out of sequence. Specific steps may still be allowed to be performed out of sequence however will need to be specifically identified.

ADDITIONAL INFORMATION

No similar events have occurred at VY within the past five years.