



VERMONT YANKEE NUCLEAR POWER CORPORATION

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April 1, 1992

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

REFERENCE: Operating License DPR-28
Docket No. 50-271
Reportable Occurrence No. LER 92-007

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 92-07.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Donald A. Reid
Plant Manager

cc: Regional Administrator
USNRC
Region I
475 Allendale Road
King of Prussia, PA 19406

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NRC Form 366 U.S. NUCLEAR REGULATORY COMMISSION (8-89)	APPROVED OMB NO. 3150-0104 EXPIRES 4/30/92 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20463.
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) VERMONT Yankee NUCLEAR POWER STATION	DOCKET NO. (2) 0 5 0 0 0 2 7 1	PAGE (3) 0 1 OF 3
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TITLE (4) INADVERTENT PRIMAR. CONTAINMENT ISOLATION SYSTEM ACTUATION DUE TO A PERSONNEL ERROR WHEN
 RESETTNG A RADIATION MONITOR

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQ #	REV#	MONTH	DAY	YEAR	FACILITY NAMES		
0 3	0 8	9 2	9 2	0 7	0	0 4	0 3	9 2			
									DOCKET NO (8)		
									0 5 0 0 0		

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO REQ'N'S OF 10 CFR 9; CHECK ONE OR MORE (11)									
POWER LEVEL (10)	0 8	20.402(b)	20.405(c)	X	50.73(a)(2)(iv)	73.71(b)					
		20.403(a)(1)(1)	50.36(c)(1)		50.73(a)(2)(v)	73.71(c)					
		20.405(a)(1)(1)	50.36(c)(2)		50.73(a)(2)(vii)	OTHER:					
		20.405(a)(1)(1)(1)	50.73(a)(2)(ii)		50.73(a)(2)(v)(1)(A)						
		20.405(a)(1)(1)(iv)	50.73(a)(2)(iii)		50.73(a)(2)(v)(1)(B)						
		20.405(a)(1)(v)	50.73(a)(2)(1)(1)		50.73(a)(2)(x)						

LICENSEE CONTACT FOR THIS LER (12)

NAME DONALD A. REID, PLANT MANAGER	TELEPHONE NO.		
	AREA CODE		
	8 0 2	2 5 7	7 7 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYST	COMPONENT	MFR	REPORTABLE TO NRC	CAUSE	SYST	COMPONENT	MFR	REPORTABLE TO NRC
NA				NA			
NA				NA			

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MO	DAY	YR
<input type="checkbox"/> YES (if yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

ABSTRACT (Limit to 1400 spaces, i.e., approx. fifteen single-space typewritten lines) (16)

On 3/8/92 at approximately 2255 hours, with the reactor in cold shutdown and the plant in an outage, a Group III Primary Containment Isolation System (PCIS)(E1IS=JM) and subsequent Standby Gas Treatment System (SBGT)(E1IS=VA) initiation occurred. The PCIS initiation was actuated when the Refuel Floor Radiation Monitor, which had been bypassed according to procedure during steam dryer movement, was taken out of bypass with a trip signal still present.

At approximately 2305, the refuel Floor Monitor was reset, the bypass removed, and the systems were returned to normal.

The root cause of this event is a personnel error. The operator failed to realize that the Refuel Monitor was in a tripped condition before taking the monitor out of bypass.

The 1992 Operator training cycle will emphasize the need to check the trip status of monitors prior to resetting. Additionally, the reactor assembly and disassembly procedures will be revised to add specific steps to reset the monitor after dryer movement.

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION	DOCKET NO (2) 05000271	LER NUMBER (6)			PAGE (3) 2 OF 3
		YEAR 92	SEQ # - 07	REV # - 0	

TEXT (If more space is required, use additional NRC Form 366A) (17)

DESCRIPTION OF EVENT

On 3/8/92 at approximately 2255 hours, with the reactor in cold shutdown and the plant in an outage, a Group III Primary Containment Isolation System (PCIS)(EIIS-JM) and subsequent Standby Gas Treatment System (SBGT)(EIIS-VA) initiation occurred.

Prior to this, the steam dryer was moved from the reactor vessel to the dryer/separator pit. To facilitate this move, the Refuel Floor Radiation Monitor was placed in bypass to prevent an inadvertent Group III PCIS isolation due to the temporary increase in radiation levels caused by the dryer movement. The temporary increase in radiation levels subsequently produced a sealed-in trip signal on the Refuel Floor Monitor. Once the steam dryer was in place, the monitor was taken out of bypass before the trip signal was reset and a Group III isolation occurred.

At approximately 2305, the Isolation was reset and systems were returned to normal.

CAUSE OF EVENT

The immediate cause of this event was the reset of the Refuel Floor Monitor with a trip signal present.

The root cause of this event is a personnel error. This was a cognitive error in that the operator failed to realize that the Refuel Monitor was in a tripped condition before taking the monitor out of bypass.

A contributing cause of this event is an inadequate procedure. The reactor disassembly procedure includes steps to notify the operators prior to and after steam dryer movement but did not proceduralize the steps necessary to properly reset the monitor.

A possible further contributing cause is a human factors consideration due to the location of the meters and bypass switches.

ANALYSIS OF EVENT

The events that occurred as a result of the isolation did not have any safety implication to plant equipment or the public.

The PCIS Group III isolation and SBGTS operated as designed and successfully isolated the Primary and Secondary Containment Ventilation. A PCIS Group III Isolation and SBGTS initiation are the expected results of a trip of the Refuel Floor monitor.

Similar events were reported in LER 89-05 and 89-06. As a result of LER 89-05, the procedures which govern the disassembly and assembly of the reactor vessel were revised to include steps to notify the operators to bypass the Refuel Floor Monitor trip when moving the steam dryer. However, the procedures will be further revised to address the specific actions necessary to reset the monitor following a trip induced by movement of the steam dryer. LER 89-06 addressed human factors as a possible contributing cause to the LER, due to the location of the meters and bypass switches, however a subsequent study determined that it could be addressed with additional training.

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FOR AND COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.

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FACILITY NAME (1)	DOCKET NO. (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQ #	REV #	
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TEXT (If more space is required, use additional NRC Form 366A) (17)

CORRECTIVE ACTIONS

1. The immediate corrective action was to reset the isolation and return all systems to normal.
2. The reactor assembly procedure has been revised to specify the specific steps necessary to reset the Refuel Floor Monitor following dryer movement.
3. The reactor disassembly procedure will be revised to specify steps necessary to reset the Refuel Floor Monitor following dryer movement. This will be completed prior to the shutdown for the 1993 outage.
4. The Operator Requal Program will emphasize the need to check the trip status of monitors prior to resetting. This will be completed by the end of August 1992 during the 2nd cycle of operator training.
5. The human factors study that was completed as a result of LER 89-06 will be reevaluated to determine if the locations of the meters and bypass switches were a significant contributing cause of the event.

ADDITIONAL INFORMATION

Similar Events were reported to the commission as LER 89-05 and LER 89-06 (See analysis of event section).