VERMONT YANKEE NUCLEAR POWER CORPORATION



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February 12, 1992

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

REFERENCE: Operating License DPR-28

Docket No. 50-271

Reportable Occurrence No. LER 92-002

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LEP 92-002.

Very truly yours,

VERMONT YANKET NUCLEAR POWER CORPORATION

Donald A. Reid Plant Manager

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

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REC POIN 366 U.S. NUCLEAR REGULATORY COMMISSION (6-89) LICENSEE EVENT REPORT (LER) PACILITY NAME (1)				APPROVED OMS 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 REFORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OPFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.							
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ABSTRACT (Limit to 1400 spaces, i.e., approx. fifteen single-space typewritten lines) (16)

On 1/15/92, with the reactor operating at 100% power, the Surveillance Test Coordinator discovered that the Boron concentration check of the Standby Liquid Control (SLC)(EIIS=BR) tank had not been performed within the Technical Specifications time limits.

Subsequent tests showed that the concentration was normal.

The immediate cause for this event was an error in the published surveillance schedule. The root cause of this event was a personnel error due to inattention to detail. When the data was transferred from the 1991 schedule to the 1992 schedule the test in question, which had been moved back one week in 1991, was inadvertently left in the originally scheduled week. A contributing cause was an inadequate procedure in that the procedure does not include specific instructions regarding the extent of the independent review required.

The test schedule has been reviewed, and no similar problems were identified. Additionally, procedure AP 4000, Surveillance Testing Control will be revised to specifically state the depth of the review required for the schedule.

NRC FORE 366A U.S. NUCLEAR REGULATORY COMMISSION (6-89)

> LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

AFFROVED OMB 30. 3150-0104 EXPIRES 4/30/92

EXPIRES 4/30/92

ESTIMATED BURDER 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.

FACILITY NAME (%)	DOCURT NO (2)	LER NUMBER (6)	PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A) (17) ABSTRACT (Continued)

Similar events, involving personnel errors, were reported to the Commission as LER 90-02 and 90-06.

DESCRIPTION OF EVENT

On 1/15/92, with the reactor operating at 100% power, the Surveillance Test Coordinator noted that the Boron concentration Test of the Standby Liquid Control tank was not performed within the Technical Specifications time limit.

Technical Specification 4.4.C.2 requires that the Boron concentration be determined at least once per month. contrary to this, the interval between tests exceeded the monthly interval plus the 25% surveillance tolerance allowed by Technical specification Section 1.0.Y.

The surveillance test had been completed on 11/27/91 and again on 1/9/92. Both tests showed that the concentration was normal.

CAUSE OF EVENT

The immediate cause of this event was an error in the published surveillance schedule.

The root cause of this event was a personnel error. The 1991 surveillance schedule had been changed to move this test back one week. When the 1992 schedule was produced it was copied from the 1991 schedule incorporating any changes during the year; however, this test was inadvertently left in the originally scheduled week. This resulted in a 43 day interval between tests which is greater than the allowed interval.

A contributing cause of this event was an inadequate procedure. The procedure that controls the surveillance program requires an independent review of the schedule but does not specify the level of that review.

ANALYSIS OF EVENT

Although this event resulted in exceeding the Technical Spacification interval for the monthly test of the Boron concentration, the concentration was within specification for the period of time between the tests. The previous test was conducted on 11/27/91 and the latest test was conducted on 1/9/92.

APPROVED ONS NO. 3150-0104 EXPIRES 4/30/92 NEC Poin 366A U.S. NUCLEAR REGULATORY COMMISSION (6-89) ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST FORWARD COMMENTS RECARDING BURDEN BESTIMATE 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. LICENSER EVENT REPORT (LEE) TEXT CONTINUATION LER NUMBER (6) PAGE (3) DOCKET NO (2) FACILITY NAME (1) YEAR SEQ B REV # 0 5 0 0 0 2 7 1 9 2 0 0 2 OF VERMONT VANKEE NUCLEAR FOWER STATION

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

Two similar events involving missed surveillance tests due to personnel error have been reported to the Commission in previous years. LER 90-02, involved a missed surveillance of a Key Fire Protection Valve due to a procedural deficiency caused by a personnel error and LER 90-06 involved a missed Technical Specification surveillance requirement due to a failure to include the Technical Specification basis on the tracking list. This also was attributable to a personnel error. However, neither of the two LER's dealt with a personnel error from inattention to detail, subsequently there is no trend in this direction. This particular event is considered an isolated incident.

Corrective actions associated with previous surveillance LER's have been effective and no problem repetition has been observed.

CORRECTIVE ACTIONS

Immediate:

 There was no immediate corrective action necessary to correct this event as a sample of the boron concentration had already been taken who the error was discovered.

Subsequent:

- 1. The surveillance schedule was reviewed to ensure that the test in this event was scheduled correctly for the remainder of the year.
- The surveillance schedule was reviewed to ensure that no similar problems existed with other tests.
- The surveillance schedule has been sent to the appropriate supervisors, directly responsible for the conduct of the tests, for review. This review will be completed by 2/14/92.
- 4. The procedure that controls the surveillance program will be revised to include specific instructions regarding the independent review of the surveillance schedule. This will be completed by 4/10/92.
- A review comparing the required tests to the same tests in previous time periods to ensure that there is no recurrence of the same problem will be completed by 4/10/92.

ADDITIONAL INFORMATION

Two similar events involving personnel errors have been reported to the Commission in the last five years as LER 90-02 and LER 90-06.