- VERMONT YANKEE NUCLEAR POWER CORPORATION



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April 14, 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 92-008

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 92-008.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

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Donald A. Reid Plant Manager

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

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NRC FORB 366 U.S. NUCLEAR REGULATORY COMMISSION (6+59) LICENSEE EVENT REFORT (LER)					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 REFORTS MANAGEMEN' BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFI OF MANAGEMENT AND BUDGET, WASHINGTON, DC 2060									
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ABSTRACT (Limit to 1400 spaces, i e., approx. fifteen single-space typewritten lines) (16)

On 3/15/92 at approximately 0021 hours, with the reactor in cold shutdown and the plant in an outage, one half of a Group III Primary Containment Isolation System (PCIS) (EIIS=JM) and the "A" Standby Gas Treatment System (SBGTS) (EIIS=VA) initiated. The PCIS initiation was the result of a blown fuse that occurred when a technician incorrectly shorted a terminal to ground

The fuse was replaced and at approximately 0053 hours on 3/15/92 the trip was reset and the systems were returned to normal.

The root cause of this event is a personnel error. The technician working in the instrument cabinets incorrectly touched an energized terminal screw with a grounded lead. This caused the fuse to blow removing power from one-half of the FCIS logic.

The technician involved in the event was counseled regarding attention to detail when working around energized equipment.

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

On 3/15/92 at approximately 0021 hours, with the reactor in cold shutdown and the plant in an outage, one half of a Group III Primary Containment Isolation System (PCIS) (EIIS=JM) and the "A" Standby Gas Treatment System (SBGTS) (EIIS=VA) initiated. Technicians were replacing coils in the PCIS auxiliary relays. In order to accomplish this task, a neutral jumper must be installed around the coil that is being replaced in order to maintain continuity. The energized terminal is located adjacent to the neutral, or ground terminal. When the technician went to install the neutral jumper he incorrectly touched the energized terminal which shorted to ground, and blew the supply iuse for one-half of the PCIS logic. This caused one-half of the logic to deenergize, closing the valves that receive a signal from that logic and starting the "A" SBGT System.

The fuse was replaced and at approximately 0053 hours on 3/15/92 the trip was reset and the systems returned to normal.

CAUSE OF EVENT

The root cause of this event is a personnel error. This was a cognitive error in that the technician failed to recognize which terminal was the neutral terminal.

A possible contributing cause of this event is a human factors consideration in that the relay that was being worked on was the last of approximately 10 relays that required the same coil change but whose terminals were configured differently. The terminals on the last relay are all positioned to the left of the coil while the terminals on the other relays are positioned on both sides of the coil. This change in arrangement led to confusion as to which terminal was the neutral terminal.

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 one-half PCIS Group III isolation operated as designed and successfully isolated the appropriate outboard valves of the Primary and Secondary Containment Ventilation System. A half PCIS Group III Isolation and "A" SBGTS initiation are the expected results of a blown fuse in the outboard logic.

Although the configuration and location of the relays could have contributed to the cause of this event as a human factors problem, relocation or reconfiguration of these relays is not a realistic corrective action as various configurations exist throughout the facility.

CORRECTIVE ACTIONS

Immediate

1. The immediate corrective action was to replace the blown fuse, reset the logic and return the systems to normal.

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CORRECTIVE ACTIONS (CONT.)

Subsequent

- Subsequent corrective action involved counseling the technician regarding attention to detail and ensuring that he was thoroughly cognizant of his mistake.
- I&C Department personnel and contractors will receive training in this LER during the 1992 training cycle.

ADDITIONAL INFORMATION

No similar events have been reported to the commission in the last five years.