



VERMONT YANKEE NUCLEAR POWER CORPORATION

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April 29, 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 92-013

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 92-013.

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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*Handwritten initials/signature*



NRC Form 366A U.S. NUCLEAR REGULATORY COMMISSION (6-89)		APPROVED OMS NO. 3150-0104 EXPIRES 4/30/92			
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION		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 20607.			
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		92	013	01	

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

DESCRIPTION OF EVENT

On 4/10/92, with the reactor shutdown for the 1992 refueling outage it was discovered that the monthly surveillance test, "Maintenance of Filled Discharge Piping for Core Spray" had not been performed for the month of February.

Technical Specification 4.5.I.1 requires that the Core Spray discharge piping be vented from the high point and water flow observed every month. Contrary to this, the test was not completed within the monthly interval plus the 25% tolerance allowed by Technical Specifications, Section 1.0.Y.

The surveillance test has since been completed on Feb 9, 1992 and again on March 29, 1992.

CAUSE OF EVENT

The immediate cause of the event was an error in the published 1992 surveillance schedule.

The root cause of this event was a personnel error due to inattention to detail. When the 1992 schedule was created this test was not included in the month of February. Consequently, the surveillance test was not completed within the allowable tolerance.

ANALYSIS OF EVENT

Although this event resulted in exceeding the technical specifications interval, for the monthly test that ensures the Core Spray discharge piping was filled, the test was completed within 2 days of the Technical Specification maximum requirement with no adverse effect to the Core Spray System.

The previous corrective actions from LER 92-02 resulted in revising the surveillance procedure to include specific steps to ensure that each test from the previous year is included in the schedule and that the test is placed within the correct timeframe.

Although LER 92-02 and this LER have the same root cause, the problem involved errors made at the same time and during production of the same schedule; therefore this is an isolated case and is not indicative of any developing trends.

CORRECTIVE ACTIONS

Immediate:

1. There was no immediate action necessary to correct this event since the March test had been completed for the Core Spray system at the time this event was discovered.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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 20603.

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Subsequent:

1. The corrective action initiated due to LER 92-02 that resulted in the comparison study has corrected the problem described in this LER and should preclude the event from recurring. This review is complete and no other Technical Specification intervals were found to be exceeded. Therefore no additional corrective actions are warranted for this LER.

ADDITIONAL INFORMATION

Three similar events have been reported to the Commission in the last five years as LER 92-02, 90-02 and 90-06.