NRC Form 366 (4-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): VERMONT YANKEE NUCLEAR POWER STATION

DOCKET NUMBER (2): 0 5 0 0 0 2 7 1

PAGE (3): 1 OF 0 3

TITLE (4): ISOLATION OF RADIATION MONITORS DUE TO PERSONNEL ERROR

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR
0 4	2 0	8 8	8 8	0 0 4	0 0	0 5	2 0	8 8

OTHER FACILITIES INVOLVED (8)	
FACILITY NAMES	DOCKET NUMBER(S)
N/A	0 5 0 0 0
N/A	0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

	20.402(b)	20.405(c)	50.73(a)(2)(iv)
	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)
	20.405(a)(1)(ii)	50.36(c)(2)	X 50.73(a)(2)(vii)
	20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)

	73.71(b)
	73.71(c)
	OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME: JAMES P. PELLETIER, PLANT MANAGER

TELEPHONE NUMBER — AREA CODE: 8 0 2 2 5 7 - 7 7 1 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
N/A						N/A					
N/A						N/A					

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

ABSTRACT

At 17:00 hours on 4-20-88, with the plant operating at 100% power, it was determined that the manual isolation valves in the supply and return lines to the two Advanced Off Gas (EIIS=WF) Radiation Monitors were closed, thus preventing them from supervising stream radiation levels. These monitors initiate automatic system isolation upon detection of high radiation levels. Upon discovery, the valves were reopened and flow was immediately restored to the monitors.

Investigation of this event has found the root cause to be personnel error. The monitor inlet and outlet valves were closed as part of a routine draining operation and were inadvertently left closed after draining was complete.

Corrective action consisted of a discussion with the personnel involved concerning the importance of returning the subject valves to their open position. In addition, the specific draining operation steps have been incorporated into a procedure to be used during future draining evolutions. This will assure a return to the proper valve alignment after draining is complete.

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NRC Form 366A (9-83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Vermont Yankee Nuclear Power Station	0 5 0 0 0 2 7 1	8 8	— 0 0 4	— 0 0	0 2 OF 0 3

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

DESCRIPTION OF EVENT

At 17:00 hours on 4-20-88, with the plant at 100% power, it was determined that the manual isolation valves in the supply and return lines to the two Advanced Off Gas (AOG)(EIIS=WF) Radiation Monitors were closed, thus preventing the monitors from supervising stream radiation levels. These monitors initiate automatic system isolation upon detection of high radiation levels.

Upon discovery, the valves were reopened and flow was restored to the monitors. It was determined that the isolation valves were closed for a period of approximately 24 hours.

CAUSE OF EVENT

On the outlet line from the Advanced Off Gas (AOG) system, which processes plant gaseous effluents prior to discharge to the plant stack, there are two vacuum pumps which draw the effluent through the system. Downstream of these pumps are two effluent sample streams each consisting of a flow indicator, a condensing chamber, and a radiation monitor which are supplied by another small vacuum pump.

Since the above vacuum pumps use water for sealing, some of the water carries over into the downstream piping. To prevent this water from affecting the operation of the downstream flow indicators and radiation monitors, it is collected in the condensing chambers. These chambers are therefore drained on a routine basis.

To allow draining of the condensing chambers, which are at a vacuum, their inlet and outlet valves must be closed and a drain valve opened. During this draining process, the sample flow is therefore interrupted.

On 4-19-88, after routine chamber draining, the inlet and outlet valves were inadvertently left closed. This condition was found on the following day when the chamber was to be drained again.

The root cause of this event has been determined to be personnel error.

ANALYSIS OF EVENT

Although the AOG effluent radiation monitors were valved out of service and the automatic system isolation function was lost for approximately 24 hours, the following equipment was operable and monitoring gaseous effluents during this period as required by Vermont Yankee Technical Specifications:

a) Stack Gas Monitors I and II, which are downstream of the isolated monitors, were operable at all times during this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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ALYSIS OF EVENTS (Cont.)

b) AOG system temperature and pressure were continuously monitored during this event and were in their normal ranges.

Therefore, it can be concluded that a release in excess of 10CFR20 limits did t occur and that there were no adverse safety implications to plant equipment, rsonnel, or to the public. In addition, Limiting Conditions for Operation as spe- fied in Vermont Yankee Technical Specifications were satisfied at all times and the pability to manually isolate the effluent stream was available if necessary.

RRECTIVE ACTION

Corrective action consisted of a discussion with the person involved concerning e importance of reopening the subject valves after condensing chamber draining.

Since the individual understood the need to isolate the monitors prior to aining due to the vacuum present, further training is not necessary. This event curred as a result of simple personnel oversight.

In addition, the specific draining operation steps have been incorporated into a ocedure to be used during future draining evolutions. This will assure a return to e proper valve alignment after draining is complete.

DITIONAL INFORMATION

No similar occurrences have been reported to the Commission in the last five ars.

VERMONT YANKEE NUCLEAR POWER CORPORATION

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GOVERNOR HUNT ROAD
VERNON, VERMONT 05354

May 20, 1988
VYV 88-107

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 88-04

Dear Sirs:

As defined by 10CFR50.73, we are reporting the attached Reportable Occurrence as LER 88-04.

Very truly yours,

VERMONT YANKEE NUCLEAR POWER CORPORATION

James P. Pelletier
Plant Manager

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

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