June 14, 2001

Mr. Michael A. Balduzzi
Senior Vice President
and Chief Nuclear Officer
Vermont Yankee Nuclear Power Corporation
185 Old Ferry Road
P.O. Box 7002
Brattleboro, Vermont 05302-7002

SUBJECT: VERMONT YANKEE - NRC INSPECTION REPORT 50-271/01-04

Dear Mr. Balduzzi:

On May 19, 2001 the NRC completed an inspection at your Vermont Yankee facility. The enclosed report presents the results of that inspection. The preliminary findings were presented to you and other Vermont Yankee managers in an exit meeting on June 7, 2001.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel. Specifically, this inspection involved seven weeks of resident inspection and region-based inspections in the areas of radiation safety, security, and in-service inspection.

The inspectors identified one issue of very low safety significance (Green) that was determined to involve a violation of NRC requirements regarding procedures for operation of electrical breakers. However, because of its safety significance and because the issue has been entered into your corrective action program, the NRC is treating this issue as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk, Washington, D.C. 20555-001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement; and the NRC Resident Inspector at Vermont Yankee.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

***/RA/***

Glenn W. Meyer, Chief
Projects Branch 3
Division of Reactor Projects

Docket No. 50-271
License No. DPR-28

Enclosure: Inspection Report 50-271/01-04
Attachment: Supplemental Information

cc w/encl:
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| OFFICE | RI:DRP | | RI:DRP | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| NAME | McDermott /GWM for/ | | Meyer /GWM/ | | | | | | | |
| DATE | 06/14/01 | | 06/14/01 | | | | | | | |

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REGION I

| | |
|---|---|
| Docket No. | 50-271 |
| Licensee No. | DPR-28 |
| Report No. | 50-271/01-04 |
| Licensee: | Vermont Yankee Nuclear Power Corporation |
| Facility: | Vermont Yankee Nuclear Power Station |
| Location: | Vernon, Vermont |
| Dates: | April 1, 2001 - May 19, 2001 |
| Inspectors: | Brian J. McDermott, Senior Resident Inspector<br>Edward C. Knutson, Resident Inspector<br>Joseph T. Furia, Senior Health Physicist<br>Gregory C. Smith, Senior Physical Security Inspector<br>Alfred Lohmeier, Engineering Inspector |
| Approved by: | Glenn W. Meyer, Chief<br>Projects Branch 3<br>Division of Reactor Projects |

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SUMMARY OF FINDINGS

IR 05000271-01-04, on 04/01/01-05/19/01; Vermont Yankee Nuclear Power Station; Vermont Yankee Nuclear Power Corporation; Mitigating Systems

This inspection was performed by the resident inspectors and region-based specialists in the areas of radiation protection, security, and in-service inspection. The inspection identified one Green finding which is being treated as non-cited violation. The significance of a finding is indicated by its color (Green, White, Yellow, Red) and is determined using the Significance Determination Process (SDP) in Inspection Manual Chapter 0609. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

Inspector Identified Findings

**Mitigating Systems**

- **Green.** The 4 kV breaker for residual heat removal (RHR) pump C failed to close when operators attempted to start the pump for shutdown cooling. At the time the RHR pump was considered available to meet key safety functions during shutdown operations. VY's investigation found that a protective interlock on the breaker had actuated because the breaker had been racked up too far in its cubicle. The inspectors concluded that VY operators had failed to rack up the 4 kV breaker in accordance with procedure OP 2142.

  This issue was considered more than minor because the failure to follow procedures for the installation of 4 kV breakers could impact the operability of multiple mitigating systems. However, the inspectors determined this issue was Green (of very low safety significance) based on a Phase 2 evaluation of the Shutdown Operations SDP. The failure of RHR Pump C to start did not degrade VY's ability to provide sufficient defense in depth for the decay heat removal or inventory control safety functions. The operators' failure to rack up the 4 kV breaker in accordance with the procedure was treated as a non-cited violation in accordance with Section VI.A.1 of the NRC's Enforcement Policy. This issue was entered in VY's corrective action program as ER 2001-0140.

## Report Details

Summary of Plant Status: At the beginning of the inspection period, Vermont Yankee was operating at 100 percent power. On April 27 the plant was shut down for its twenty-second refueling outage. At the close of the inspection period on May 19, the reactor was critical and a plant startup was in progress. On May 20 operators synchronized the main generator to the grid marking the end of a 23 day refueling outage.

### 1. REACTOR SAFETY
**Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness**

1R04 Equipment Alignment

.1 Residual Heat Removal (RHR) Pump Failure To Start On Demand

a. Inspection Scope

On May 7 the 4 kV circuit breaker for RHR Pump C failed to close when a control room operators attempted to start the pump. Operators subsequently started RHR pump A for shutdown cooling and there was no need to use any of the available backup systems for decay heat removal.

VY's investigation of the as-found condition revealed that the breaker was racked up too high in the switchgear cubicle following maintenance. VY suspects that this "over racked" condition allowed an interlock switch to change state the first time the breaker was operated at 11:08 am on May 7. The interlock switch prevented operators from starting RHR pump C shortly after 1:00 pm that same day. Following the as-found inspection of the breaker, VY maintenance personnel inspected the remaining safety-related 4 kV breakers for similar conditions and no problems were identified.

VY's initial event investigation associated with ER 2001-1027 determined that the over-racked condition was caused by the use of a new breaker elevating motor. However, the inspectors noted that a visual inspection of the racked-up breaker required by procedure OP 2142, "4KV Electrical System," should have detected this problem.

The inspectors reviewed VY's initial response to this event, actions to address the potential for common mode failure, and the risk assessment for on-going maintenance. The inspectors subsequently discussed the ongoing ER investigation with cognizant operations and maintenance department personnel.

b. Findings

Procedure OP 2142, "4KV Electrical System," requires operators to visually verify the clearance of mechanical linkages for breaker interlocks after a 4 kV breaker is racked up into the switchgear. The inspectors determined that VY personnel had apparently not properly performed this verification for the C RHR pump’s breaker on May 5, based on the as-found condition of the breaker on May 7.

VY procedure PP 7102, "Work Management - Outages" provides the guidelines for ensuring sufficient equipment is available on key safety functions during shutdown conditions. The procedure defines three levels of defense in depth (preferred, normal, minimum) for each key safety function. When RHR pump C failed to start on May 7, the plant was in cold shutdown with a 42 hour time-to-boil and the preferred compliment of equipment for the key safety functions of decay heat removal and inventory control. With RHR Pump C unavailable, VY's inventory control capability remained at the preferred level and the decay heat removal capability was normal.

This issue was considered more than minor, because the failure to properly install 4 kV breakers could impact the operability of multiple mitigating systems. However, the inspectors determined this issue was Green (of very low safety significance) based on a Phase 2 evaluation of the Shutdown Operations SDP (Inspection Manual Chapter 0609, Appendix G) and discussions with a Region I Senior Reactor Analyst. The failure of RHR Pump C to start did not degrade VY's ability to provide sufficient defense in depth for the decay heat removal or inventory control safety functions.

The inspectors observed that VY took reasonable immediate actions to ensure that other 4 kV breakers were properly racked up in the safety related switchgear. Final corrective actions to prevent recurrence of this event (ER 2001-1027) will not be developed until July 6. Interim corrective actions were considered adequate.

Technical Specification 6.4.A, requires that written procedures for the normal operation of components be established, implemented and maintained. On May 5 VY personnel failed to properly verify the condition of breaker interlocks for RHR Pump C as required by OP 2142. As a result, the breaker failed to close when operators attempted to start the C RHR pump for shutdown cooling on May 7. This violation is being treated as a non-cited violation, consistent with Section VI.A.1 of the Enforcement Policy, issued May 1, 2000 (65FR25368). This issue was entered in VY's corrective action program as ER 2001-0140. **(NCV 50-271/01-04-01)**

.2 Partial System Walkdowns

a. Inspection Scope

The inspectors performed partial system walkdowns (visual inspections) to the standby alignment of the equipment and to identify any discrepancies that would impact system operability. The inspectors selected portions of safety systems inside the containment because this area is not accessible during power operation:

- Residual heat removal system in the drywell
- Safety relief system in the drywell

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors evaluated plant areas important to reactor safety in order to assess VY's control of transient combustibles and ignition sources, and the material condition and operational status of fire protection systems, equipment, and barriers. The inspectors identified fire areas important to plant risk based on the Fire Protection Program and the Individual Plant Examination External Events (IPEEE). The inspection elements identified in NRC Inspection Procedure 71111.05, “Fire Protection,” were used in evaluating the following plant areas:

- Cable spreading room - significant fire hazard area (IPEEE), due to extensive material pre-staging prior to the outage in preparation for main station battery replacement

- Reactor building northeast corner room - Appendix R fire zone RB-1, due to extensive scaffolding installed prior to the outage to support various outage activities

b. Findings

No findings of significance were identified.

1R08 Inservice Inspection (ISI) Activities

a. Inspection Scope

The inspectors observed VY's Inservice Inspection Program implementation during RFO-22 to verify VY was meeting the requirements of the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel (B&PV) Code Section XI - Nuclear Components, the Boiling Water Reactor Vessel and Internals Project (BWRVIP), and the in-service inspection requirements of 10 CFR Part 50. The inspectors reviewed the planning documents and observed implementation of VY's ISI Program, which monitors for degradation of the reactor coolant system boundary, risk-significant piping system boundaries, containment boundary, and reactor vessel internals. The nondestructive examination (NDE) activities during refueling outage (RFO) 22 are part of the third ten year interval of the VY's ISI program.

The inspectors observed the performance of remotely controlled ultrasonic testing (UT) of in-vessel core spray welds 1P9, 2P9 and 3P9 by contracted technicians. In addition, the inspectors observed the in-vessel remote UT examination of selected jet pump riser and jet pump assembly welds.

The inspectors reviewed the identification, characterization, sizing and disposition of four indications found in jet pump riser welds during RFO 21. One indication was found in each of welds N2B-RS-1, N2C-RS-1, N2H-RS-1 and N2K-RS-1. The origin of the indications was determined to be intergranular stress corrosion cracking (IGSCC). VY Technical Evaluation 2001-029 dispositioned the flaws as “accept as is” until RFO 29

based on an engineering analysis of flaw growth. However, the technical evaluation also recommended that another UT examination be performed prior to RFO 29 to confirm flaw growth rates have not exceeded the rates bounded in the analysis. These confirmatory UT examinations were performed during RFO 22 and the results were evaluated by the inspectors. During RFO 22 one additional indication was reported in weld N2K-RS-1 and flaws reported in welds N2B-RS-1 and N2C-RS-1 were not detectable. The flaw reported during the previous examination in weld N2H-RS-1 was confirmed during this examination. The inspectors discussed the examination results with VY and concluded testing was valid and the test data provided sufficient data to confirm the integrity of the jet pump risers examined.

The inspectors observed a non-code repair of small leak in reactor building recirculation unit 8 (RRU-8) through examination of digital color photographs showing the completed repair and the confined area within which the repair was made. Several attempts were necessary to successfully complete the repair of the leaking heat exchanger manifold. Following this corrective maintenance, VY identified minor service water seepage from a brazed joint that could not be reasonably repaired (see Section 1R15 Operability Evaluations).

The inspectors observed selected video tapes of visual and volumetric internals inspection during RFO 22. The scope of the inspection included control rod guide tubes, core plate, core shroud support, core spray piping, core spray sparger, core spray sparger welds, feedwater welds, jet pump, steam dryer support bracket, and top guide bolting. The inspectors discussed results of the reactor internals inspection with responsible VY personnel.

The inspectors reviewed VT-3 examination results of the effect of several arc strikes on pipe supports RSW-H261 and HD261B. VY determined these arc strikes did not affect the function of the lugs in supporting the pipe to which they are attached. The inspectors reviewed Technical Evaluation 2001-014 and attached calculations in support of this conclusion.

The inspectors reviewed the corrective action process to ascertain whether the appropriate procedures were being followed when the degradation of components had been found through in-service inspection. When required in-service inspection procedures can not be performed, requests are made by VY to obtain relief from the requirements. Several such requests for core spray pipe, jet pump risers, reactor pipe support lugs, were reviewed by the inspectors to ascertain if the appropriate conditions for seeking relief were presented to the NRC by VY.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed VY's implementation of program procedure PP 7009, "10 CFR 50.65, Maintenance Rule Program," in response to the failure of an auxiliary contact on a reactor protection system relay associated with the backup scram valves. This failure caused a reactor scram on March 19.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed planned and emergent maintenance at VY based on the guidance in Attachment 13, “Maintenance Risk Assessment and Emergent Work Control.” The following activities were reviewed:

- Troubleshooting of small magnitude oscillations of the A feedwater regulating valve on April 2
- Emergent maintenance to repair the service water pressure control valve for the A emergency diesel generator on April 23

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed a sample of operability evaluations prepared by VY. The inspectors used the guidance provided in NRC Generic Letter 91-18 to assess VY's evaluation of the degraded or non-conforming conditions. The following plant issues were reviewed:

- Minor service water leakage from the cooling coil (RRU-8) serving the southeast corner room of the reactor building identified by VY during the RFO. This leakage was discovered after repairs of a different brazed connection on the same coil. Due to the minor nature of this leak and the impracticality of a braze repair in this tube-to-header interface, VY was planning to replace the cooler coil. An operability evaluation for this degraded condition was documented in Event Report 2001-1173.

- Degradation of columns and bracing for Cooling Tower Cell 2-1 identified during RFO 22 preventive maintenance inspections. The operability of the cooling tower cell was evaluated in ERs 2001-1032 and 2001-1082.

- In-service test failure of a high pressure coolant injection (HPCI) system check valve. Isolation valve HPCI-18, a tilting disc check valve, failed its initial open stroke test during RFO 22 due to problems with the test methodology. No physical problems with the valve were identified and the test failure was evaluated under ER 2001-1097.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed and/or observed portions of the post maintenance testing associated with the following work activities using the guidance provided in Attachment 19 of NRC Inspection Procedure 71111:

- A emergency diesel generator following repair of the service water pressure control valve on April 26

- C source range neutron monitor following replacement of the instrument pre-amplifier on April 27

- Reactor pressure vessel operational system leakage test following completion of outage activities on May 16

- Leak rate testing of the HPCI turbine exhaust line check valve HPCI-4 on May 18

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

a. Inspection Scope

Prior to the start of the outage, the inspectors reviewed VY's outage plan. Specifically, the inspectors reviewed the outage schedule to verify that VY had appropriately considered risk, and confirmed that mitigation strategies and response procedures had been developed for losses of key safety functions.

The inspectors observed portions of the reactor and plant shutdown to verify that control room personnel were appropriately focused on plant operations and that technical specification requirements were satisfied.

During the outage the inspectors reviewed what equipment was out of service to verify compliance with technical specifications, and what equipment was available to satisfy key safety functions. The inspectors verified that configuration changes accounted for scheduler variances in equipment and system availabilities.

The inspectors observed refueling activities and verified that fuel handling operations were performed in accordance with technical specifications and approved procedures.

At the conclusion of the outage, the inspectors performed a walkdown of the drywell to verify that debris had not been left which could affect performance of the containment and core cooling systems.

The inspectors observed portions of the reactor and plant startup to verify, on a sampling basis, that prerequisite conditions had been met and that control room personnel were appropriately focused on plant operations.

The inspectors referenced the following procedures and guidelines during review of VY's outage implementation:

- PP 7102, "Work Management - Outage"
- AP 0173, "Work Schedule Risk Management - Outage"
- NRC Inspection Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process"
- NRC Inspection Procedure 71111.20, "Refueling and Outage Activities"

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed and/or observed portions of the following surveillance test activities:

- B core spray pump quarterly testing, performed in accordance with procedure OP 4123 on April 2
- Logic testing of the low pressure coolant injection A subsystem, performed in accordance with procedure OP 4354 on May 7
- Standby liquid control - borated solution recirculation testing, performed in accordance with procedure OP 4114 on May 11

- Emergency core cooling system - integrated automatic initiating testing, performed in accordance with procedure OP 4100 on May 14
- Control rod cycling and timing, performed in accordance with procedure OP 4111 on May 15
- Differential pressure testing of service water valves SW-19 and SW-20, performed in accordance with STP 2001-001 on May 15
- Excess flow check valve functional testing, performed in accordance with procedure OP 4378 on May 16

b. Findings

No findings of significance were identified.

## 2. RADIATION SAFETY
## Cornerstone: Occupational Radiation Safety

2OS1 Access Control

a. Inspection Scope

The inspectors determined exposure significant work areas, high radiation areas, and airborne radioactivity areas in the plant, and reviewed associated controls and surveys of these areas to determine if controls (i.e., surveys, postings, barricades) were acceptable. Areas examined were determined by the work being performed in support of the refueling outage, and included: local power range monitor removal; main steam isolation valve inspection, testing and repair; turbine and generator inspection and repair; feedwater heater inspection and repair; and, safety relief valve removal/installation.

Observation of work activities occurred during both day and night shifts. For these areas, the inspectors reviewed all radiological job requirements and attended job briefings; determined if radiological conditions in the work area were adequately communicated to workers through briefings and postings; verified radiological controls, radiological job coverage and contamination controls; and verified the accuracy of surveys and applicable posting and barricade requirements.

The inspectors determined if prescribed radiation work permits (RWPs), procedure and engineering controls were in place, whether surveys and postings were complete and accurate, and that air samplers were properly located. Reviews were performed of RWPs used to access these and other high radiation areas, and to identify what work control instructions or control barriers have been specified. Areas examined were determined by the work being performed in support of the refueling outage, and included: in-service inspection; turbine/generator valve inspection and repair; feedwater heater inspection and repair; local leak rate testing; drywell seal replacement; and,

safety relief valve removal/installation. Observation of work activities occurred in the reactor, turbine, radwaste and advanced off-gas buildings.

Plant Technical Specification 6.5 and 10 CFR 20, Subpart G were the standard for necessary barriers. The inspectors reviewed electronic pocket dosimeter alarm set points (both integrated dose and dose rate) for conformity with survey indications and plant policy.

The inspectors also examined the programmatic controls for highly activated/ contaminated materials (non-fuel) stored within the spent fuel pool.

b. Findings

No findings of significance were identified.

2OS2 ALARA Planning and Controls

a. Inspection Scope

The inspectors reviewed work performance during RFO 22. Areas reviewed included a review of the use of low dose waiting areas; review of on-job supervision provided to workers; and, a review of individual exposures from selected work groups. Engineering controls utilized to achieve dose reductions were evaluated and source term reduction plans were analyzed.

The inspectors observed radiation worker and RP technician performance during high dose rate or high exposure jobs and determined if workers demonstrated the ALARA philosophy in practice. The inspectors observed radiation worker performance to determine whether the training/skill level was sufficient with respect to the radiological hazards and the work involved.

The inspectors reviewed ALARA job evaluations, exposure estimates and exposure mitigation requirements and ALARA plans were compared with the results achieved. The integration of ALARA requirements into work procedures and RWP documents, the accuracy of person-hour estimates and person-hour tracking, and generated shielding requests and their effectiveness to dose rate reduction were reviewed.

Actual exposure results versus initial exposure estimates were reviewed, including comparison of estimated and actual dose rates and person-hours expended; determination of the accuracy of estimations to actual results; and determination of the level of exposure tracking detail, exposure report timeliness and exposure report distribution to support control of collective exposures to determine compliance with the requirements contained in 10 CFR 20.1101(b).

b. Findings

No findings of significance were identified.

2OS3 Radiation Monitoring Instrumentation

a. Inspection Scope

The inspectors reviewed field instrumentation used by health physics technicians and plant workers to measure radioactivity, including portable field survey instruments, friskers, portal monitors and small article monitors. The inspectors reviewed instruments observed during the refueling outage, specifically verification of proper function and certification of appropriate source checks for these instruments, which are utilized to ensure that occupational exposures are maintained in accordance with 10 CFR 20.1201.

b. Findings

No findings of significance were identified.

## 3. SAFEGUARDS
**Cornerstone: Physical Protection**

3PP4 Security Plan Changes

a. Inspection Scope

An in-office review was conducted of changes to the Physical Security Plan, identified as Revision 30, submitted to the NRC on November 22, 2000, in accordance with the provisions of 10 CFR 50.54(p). The review confirmed that the changes were made in accordance with 10 CFR 50.54(p), and did not decrease the effectiveness of the plan(s).

b. Findings

No findings of significance were identified.

## 4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification - Initiating Events

a. Inspection Scope

The inspectors reviewed plant records to assess the accuracy and completeness of performance indicator (PI) data submitted by VY. The definitions provided in NEI 99-02, "Regulatory Assessment of Performance Indicator Guideline," Revision 0 and clarifications provided by the NRC in response to Frequently Asked Questions were used to evaluate this information. The plant records reviewed by the inspectors included selected control room logs, licensee event reports, and event reports in VY's corrective action process.

- Unplanned scrams per 7,000 critical hours (Q2/2000 - Q1/2001)

- Scrams with loss of normal heat removal (Q2/2000 - Q1/2001)

• Unplanned power changes per 7,000 critical hours (Q2/2000 - Q1/2001)

b. Issues and Findings

No findings of significance were identified.

4OA6 Exit Meeting

On June 7, 2001, the resident inspectors presented their overall findings to members of VY management led by Mr. Michael Balduzzi, Vice President of Operations. VY management acknowledged the findings presented and did not contest any of the inspectors' conclusions. Additionally, they agreed that none of the information reviewed by the inspectors was considered proprietary.

## ATTACHMENT 1

## SUPPLEMENTAL INFORMATION

a. List of Items Opened and Closed

| | |
|---|---|
| NCV 50-271/01-04-01 | Failure to properly verify 4kV breaker installation as required by OP 2142. |

b. List of Acronyms Used

| | |
|---|---|
| ALARA | As Low As Is Reasonably Achievable |
| ASME | American Society of Mechanical Engineers |
| B&PV | Boiler and Pressure Vessel |
| BWRVIP | Boiling Water Reactor Visual Inspection Program |
| DRS | Division of Reactor Safety |
| CFR | Code of Federal Regulations |
| EDG | Emergency Diesel Generator |
| ER | Event Report |
| HVAC | Heating, Ventilation, and Air Conditioning |
| IGSCC | intergranular stress corrosion cracking |
| IPEEE | Individual Plant Examination External Events |
| ISI | Inservice Inspection |
| LCO | Limiting Condition for Operation |
| MSIV | Main Steam Isolation Valve |
| NDE | Nondestructive Testing |
| NRC | Nuclear Regulatory Commission |
| PRA | Probabilistic Risk Assessment |
| RCA | Radiologically Controlled Area |
| RFO | Refueling Outage |
| RHR | Residual Heat Removal |
| RPS | Reactor Protection System |
| RRU | Reactor Building Recirculation Unit (room cooler) |
| RWP | Radiation Work Permit |
| SDP | Significance Determination Process |
| TS | Technical Specifications |
| UT | Ultrasonic Test(ing) |
| VY | Vermont Yankee |
| VT | Visual Test(ing) |
| YYDC | Vermont Yankee Design Change |