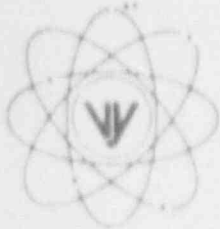


VERMONT YANKEE NUCLEAR POWER CORPORATION



P.O. Box 157, Governor Hunt Road
Vernon, Vermont 05354-0157
(802) 257-7711

February 13, 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 92-01

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER v2-01.

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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NRC Form 366 U.S. NUCLEAR REGULATORY COMMISSION (6-89) LICENSEE EVENT REPORT (LER)	APPROVED OMR NO. 3150-0164 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 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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FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION	DOCKET NO. (2) 0 5 0 0 0 2 7 1	PAGE (3) 0 1 OF 0 3
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TITLE (4) Spurious HPCI Suction Transfer due to unknown cause

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (*)			
MONTH	DAY	YEAR	YEAR	SEQ #	REV#	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NO. (8)
1	2	1 9 9 1	9 2	0 0 1	0 0	0	2	2 0 9 2				0 5 0 0 0

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO REQ'MTS OF 10 CFR §: CHECK ONE OR MORE (11)									
POWER LEVEL (10) 1 0 0	20.402(b)	20.405(c)	X	50.73(a)(2)(iv)	73.71(b)					
	20.405(a)(3)(i)	50.36(c)(1)		50.73(a)(2)(v)	73.71(c)					
	20.405(a)(3)(ii)	50.36(c)(2)		50.73(a)(2)(vii)	OTHER:					
	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)(ix)						

LICENSEE CONTACT FOR THIS LER (12)

NAME DONALD A. REID, PLANT MANAGER	TELEPHONE NO. AREA CODE 8 0 2 2 5 7 - 7 7 1 3
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYST	COMPONENT	MFR	REPORTABLE TO NPRDS	...	CAUSE	SYST	COMPONENT	MFR	REPORTABLE TO NPRDS	...
N/A					N/A				
N/A					N/A				

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED SUBMISSION DATE (15)	MO DAY YR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	

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

On 12/19/91 at 1010 hours, during normal operation with Reactor power at 100%, a spurious High Pressure Coolant Injection (HPCI) (*BJ) Condensate Storage Tank (CST) low level alarm was received and suction to HPCI transferred from CST to the Torus. Approximately 15 minutes later at 1025 hours, after reviewing plant parameters (proper CST level), operators returned HPCI suction back to the CST.

The root cause of the event is unknown. A functional test was performed on the all applicable HPCI suction transfer logic. The tests did not reveal any failed components, out of calibration components, or any other abnormalities which would allow for root cause analysis.

The event was determined to be not-reportable by Vermont Yankee. However, as a result of subsequent discussions with the on-site resident inspector this event is being voluntarily considered as an Engineered Safety Feature (ESF) actuation and reported under 50.73 (a)(2)(iv).

* Energy Information Identification System (EIIS) Component Identifier

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.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NO (2)	LER NUMBER (6)				PAGE (3)	
		YEAR	SEQ #	REV #			
VERMONT YANKEE NUCLEAR POWER STATION	75000271	92	001	00	02	OF	03

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

DESCRIPTION OF EVENT

On 12/19/91 at 1010 hours, during normal operation with Reactor power at 100%, a spurious High Pressure Coolant Injection (HPCI) (*BJ) Condensate Storage Tank (CST) low level alarm came in and out. Valves to HPCI transferred to align the system suction from the CST to the Torus. This was the expected system response upon receipt of a CST low level signal. No initiation of other HPCI system equipment occurred.

Approximately 15 minutes later at 1025 hours, after verifying proper CST level, operators successfully returned HPCI suction back to the CST to perform a functional test and verify operability of HPCI. A successful functional test was completed at 1300 hours. The HPCI system remained operable throughout the event.

CAUSE OF EVENT

An extensive testing and troubleshooting effort was performed to determine the cause of the HPCI suction transfer. The functional test consisted of the testing of both CST level transmitters loops including all associated level switches, power supplies, level recorders and process computer monitoring. The applicable HPCI pump suction control logic, HPCI suction transfer valve control, and HPCI Condensate Storage Tank low level annunciation were also tested. All equipment responded properly, tests results were reviewed as satisfactory and there was no evidence of component failure.

The root cause of the event is unknown. However, the circuitry that performs the valve transfer is normally energized and momentary interruption of power or circuit continuity would cause the resultant HPCI suction transfer. There was no evidence of a CST low level signal on the process computer or the level recorder. This is consistent with expected indications if a momentary loss of power or circuit continuity occurred. Initial and subsequent interviews with plant personnel did not reveal any ongoing activities which would have caused a power interruption or loss of circuit continuity. There were no testing, surveillances or systems operations being conducted at the time of the event. Due to the single occurrence and the successful testing performed, this is considered as an isolated event.

ANALYSIS OF EVENT

The events of this report did not have adverse safety implications. The HPCI system remained operable throughout the event. Proper CST and Torus levels were available. HPCI suction transferred as designed on receiving a transfer signal. Operators successfully transferred the HPCI suction back to CST fifteen minutes later.

This event was determined to be not reportable by Vermont Yankee on 1/3/92. However, the onsite NRC Resident Inspector thought it was reportable as an Engineered Safety Feature (ESF) actuation and as such meetings were held on 1/17/92 and 1/21/92 to discuss VY's basis for determination. Vermont Yankee's basis was the fact that although HPCI is an ESF, the HPCI suction transfer to the Torus is not an ESF and actuation of a non-ESF part of an ESF system was therefore not reportable. This conclusion was a result of a review of the applicable FSAR sections, NUREG-1022 and Supplements 1 and 2. Since Vermont Yankee and the NRC Resident

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (6-89)		APPROVED ONS 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 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.								
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION		FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION		DOCKET NO (2) 0 5 0 0 0 2 7 1		LER NUMBER (6) YEAR SEQ # REV # 9 2 - 0 0 1 - 0 0 0			PAGE (3) 3 OF 3	

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

ANALYSIS OF EVENT (cont'd)

Inspector did not agree on this issue, VY committed to conservatively assess the event as an ESF actuation and submit this as an LER within 30 days of 1/21/92.

CORRECTIVE ACTIONS

SHORT TERM CORRECTIVE ACTIONS

Immediate corrective actions included verifying proper CST level, transferring HPCI suction to its preferred source the CST and functional testing of all HPCI suction circuitry.

LONG TERM CORRECTIVE ACTIONS

Long term corrective actions will consist of continued monitoring of HPCI suction transfer circuitry. If any similar events occur, additional investigation and corrective actions will be initiated as appropriate.

ADDITIONAL INFORMATION

There have been no similar events of this type reported to the commission in the past five years.