



VERMONT YANKEE NUCLEAR POWER CORPORATION

P. O. BOX 157
GOVERNOR HUNT ROAD
VERNON, VERMONT 05354

May 12, 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 92-014

Dear Sirs:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 92-014.

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

IF22
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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)

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)
INADVERTENT SCRAM AND ECCS INITIATION WHILE SHUTDOWN WHEN RESTORING FOUR LEVEL TRANSMITTERS TO SERVICE

EVENT DATE (5) MONTH DAY YEAR 0 4 1 2 9 2	LER NUMBER (6) YEAR SEQ # REV# 9 2 - 0 1 4 - 0 0	REPORT DATE (7) MONTH DAY YEAR 0 5 1 2 9 2	OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NO. (8) 0 5 0 0 0
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OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO REQ'TS OF 10 CFR §: CHECK ONE OR MORE (11)			
POWER LEVEL (10) 0 0 0	20.402(b)	20.405(c)	XX 50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(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)(vi)(1)(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 1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYST	COMPONENTS	MFR	REPORTABLE TO NPRDS	CAUSL	SYST	COMPONENT	MFR	REPORTABLE TO NPRDS
N/A				NO					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	X	NO	EXPECTED SUBMISSION DATE (15)	MO	DAY	YR
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ABSTRACT (Limit to 1400 spaces, i.e., approx. fifteen single-space typewritten lines) (16)

On April 12, 1992 at 0526 while the plant was shutdown for routine refueling and maintenance, a Reactor Scram and ECCS (ECCS=JE) initiation were received as a result of valve operation in the improper sequence. A tagging order had been initiated on 4/11/92 to support the replacement of an excess flow check valve on 4/12/92 when the system was being returned to normal, the I&C technician was instructed by the control authority, to restore the four level transmitters associated with the excess flow check valve replacement work. Unknown to the I&C Technician, the tagging order request to restore the root valve to their normal position had been delayed. Consequently when the valves were opened the level transmitters sensed a false low water level signal which initiated the Scram and ECCS initiation. All systems responded as expected to the signals sensed by the instrumentation. The systems were all reset and returned to normal by 0533. The cause of the event was personnel error in that the communications between the control authority, the auxiliary operator, and the I&C technician was not adequate. Immediate corrective actions were to recover from the scram and return all systems to their normal lineup. In addition, supplemental operator training will be completed.

NRC Form 366A U.S. NUCLEAR REGULATORY COMMISSION (6-85)		APPROVED OMS 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) 0500271		LER NUMBER (6) YEAR SEQ # REV # 92 - 014 - 00			PAGE (3) 02 OF 13	

TEXT (If more space is required, use additional NRC Form 366A) (17)77

DESCRIPTION OF EVENT

On April 12, 1992 at 0526 while the plant was shutdown for routine refueling and maintenance, a Reactor Scram and ECCS (EHS=JE) initiation were received as a result of valve operation in the improper sequence. At the time of the event the reactor head was removed and reactor water level was just below the head flange.

A tagging order valve line-up had been initiated on 4/11/92 to support replacement of an excess flow check valve on an instrument line supplying four reactor level transmitters. As part of this effort the level transmitters were removed from service. On 4/12/92 when the system was being returned to normal valve lineup, the order was given by the control authority to the auxiliary operator to clear the tags and reopen the root valves on the instrument lines. A short time later I&C department was instructed by the control authority, to place the level instrumentation back in service. The auxiliary operator was delayed about an hour in completing the valve lineup as a result of other work going on in the area. The I&C Technician assumed that the root valve had been opened prior to him being given the order to restore the level transmitters and returning the instrument to service. Consequently when the root isolation valves were opened later, the level transmitters sensed a false low water level signal which resulted in the reactor Scram and ECCS initiation.

As a result of the ECCS initiation signal:

- HPCI and RCIC system valves lined up for injection but did not inject due to the low system pressure,
- The diesel generators started but were not loaded as normal power was available,
- The Core Spray Systems started and injected approximately 4000 gallons of water to the reactor vessel,
- RHR System which was lined up for shutdown cooling isolated. The other RHR system was removed from service for maintenance at the time of the event.

As a result of the Core Spray injection and the reactor vessel head being off of the reactor, the water overflowed the reactor vessel and spilled through open manways into the drywell and ultimately into the drywell floor drain sump, drywell equipment drain sump, and to the torus. No damage was caused as a result of this spill.

All systems responded as expected given the signal that was seen by the instrumentation. The systems were all reset and returned to normal by 0533.

CAUSE OF THE EVENT

The cause of this event is attributed to personnel error resulting from mis-communications between the Control Authority, the auxiliary operator, and the I&C technician. The Control Authority restoring the tagging order realized that the root isolation valves were required to be opened prior to I&C restoring the instrument valve lineup to normal. He initiated the order to restore the root isolation valves first, however he did not wait for confirmation that the valve lineup had been completed prior to giving the order to I&C to restore the instrumentation. The I&C technician assumed that, since the Control Authority had given the order to place the instruments back in service, that the root isolation valves had already been opened and did not verify this action had been completed before he placed the reactor level instruments back in service.

NRC Form 366A U.S. NUCLEAR REGULATORY COMMISSION (6-89)		APPROVED OMS 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 (760-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.					
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION		DOCKET NO (2)		LER NUMBER (6)		PAGE (3)	
FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION		0 5 0 0 0 2 7 1		YEAR SEQ # 9 - 0 1 4		EV # 0 0 3 OF 0 3	

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

ANALYSIS OF EVENTS

Due to plant conditions at the time, this event had minimal safety implications. The water which spilled into the drywell went either all the way through into the torus or into the drywell sumps. A walkdown/inspection was completed in these areas and did not identify any damage.

All Reactor Protection and ECCS systems responded appropriately to the signal sensed by the level instrumentation. At no time was vessel water level in jeopardy.

CORRECTIVE ACTIONS

IMMEDIATE CORRECTIVE ACTIONS

- 1) Operations personnel recovered from the scram and ECCS initiation and returned all systems to their normal configuration.
- 2) Operations personnel were reminded to verify that root isolations are open prior to requesting I&C to return instrumentation to service.

LONG TERM CORRECTIVE ACTIONS

- 1) This event and its implications will be discussed as part of operator training in the 1992 Licensed Operator Requalification(LOR) program.
- 2) A Vermont Yankee Corrective Action Report (CAR) will be written and reviewed for any further recommendations.

ADDITIONAL INFORMATION

There have been no similar events of this kind reported by Vermont Yankee to the Commission in the past five years.