February 11, 1988

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-88-11

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region IV staff on this date.

FACILITY:
Public Service Co. of Colorado
Fort St. Vrain
DN: 50-267

Licensee Emergency Classification:
_X__ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
____ Not Applicable

SUBJECT: MANUAL REACTOR SCRAM AND UNPLANNNED RADIOACTIVE RELEASE

On February 10, 1988 at 3:47 p.m. (MST), a helium circulator tripped due to an erroneous low speed signal with reactor at 75% power. The circulator trip resulted in a reactor runback to between 50-60% reactor power and then reactor power was further reduced by the plant operators to 25% power. While attempting to balance feedwater between Loop 1 and Loop 2, an upset in the helium circulator auxiliaries supplied by feedwater resulted in the tripping of B and D helium circulators at 4:07 p. m. (MST).

The tripping of two circulators in one loop (A & B) resulted in a loop shutdown (ESF actuation). The reactor operators manually scrammed the reactor from 25% power with only one helium circulator running.

At 6:40 p.m. (MST), the licensee identified that an unplanned release was occurring and an unusual event was declared. An operator had been dispatched to vent the surge tank associated with the liner cooling water system. He had vented the tank to the plant stack rather than to the gaseous radwaste system. The total release over approximately 200 minutes was small; i.e., 4.26×10^5 microcuries of noble gas activity.

The licensee has elected to remain in the unusual event while verifying that the source of the release was only the one leak path. The licensee has identified that there is an additional small primary helium leak past a 5 psig safety valve associated with the core support floor vent system.

The plant maintained forced circulation cooling at all times. The Senior Resident Inspector (SRI) responded to the event and was on site all night . The Colorado Department of Health was in contact with the site and were briefed by the licensee as well as the SRI.

The licensee has subsequently determined that the A helium circulator trip occurred due to an apparent inter-change of speed indication signal cables during a recent maintenance operation. The trip occurred when B helium circulator was placed in manual control during trouble shooting that was going on at the time.

DRP
LJCallan:cnm
2/ /88

RA
RDMartin
2/11 /88

Transmitted via 5520 @ 1:17 2/11/88

IE34

The Commissioner's Assistants, NRR, and AEOD were briefed at 8:30 a.m. (CST) this morning.

The Resident Inspector is following the licensee's plans for recovery.

The licensee has issued a press release and responded to news media inquiries.

The State of Colorado has been informed by the licensee..

Region IV received notification of this occurrence from HQ Duty Officer at 7:15 p.m. CST.

This information has been confirmed with a licensee representative.

CONTACT: Tom Westerman (728-8145).

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